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Original Article

Anti-Muslim Hatred in the U.S.: Couple Therapy Implications for Discriminated Muslim Couples

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Abstract

With the growing Muslim population in the United States, Islamophobia and discriminatory acts toward Muslims have been increasing. Negative images in the media, which have strengthened stereotypes about Islam, have affected Muslim individuals, couples, and families. Although the impact of islamophobia has been addressed for individuals, not enough attention has been paid to Muslim couples who experience discrimination due to their religious beliefs. Experience of harassment and negativity is likely to profoundly affect individuals' couple and family relationships. This lack of research may leave mental health professionals unprepared to sufficiently help Muslim couples that encounter discrimination. Thus, the present study discusses Muslims and their experiences in the U. S. before considering important concerns about couple relationships for mental health professionals working with this population. The purpose is to provide guidance and possible strategies to assist couple therapists for culturally competent practice with Muslim couples.

Keywords:

Couple therapy • Culturally sensitive therapy • Discrimination • Islamophobia • Muslim couples

ABD'de Müslüman Karşıtı Nefret: Ayrımcılığa Uğrayan Müslüman Çiftler için Çift Terapisi Uygulamaları

Öz

Amerika Birleşik Devletleri'nde artan Müslüman nüfusla birlikte, İslamofobi ve Müslümanlara yönelik ayrımcı eylemler artmaktadır. Medyada yer alan olumsuz imajlar soncunda İslam hakkındaki artan kalıp yargılar Müslüman bireyleri, çiftleri ve aileleri etkilemektedir. İslamofobinin bireylere yönelik etkisi alanyazında yoğun bir şekilde çalışılmış olmasına rağmen, dini inançları nedeniyle ayrımcılığa uğrayan Müslüman çiftelere yönelik çalışmalar yeterince yapılmamıştır. Halbuki, bireylerin toplumda maruz kaldığı dışlanma ve olumsuzluk deneyimlerinin çift ve aile ilişkilerini derinden etkilemesi beklenir. Alandaki bu eksiklik, ayrımcılığa uğrayan Müslüman çiftlerle çalışan ruh sağlığı uzmanlarını gerekli yardımı sağlama konusunda hazırlıksız bırakmaktadır. Bu nedenle, bu çalışmanın amacı, Müslümanları ve onların ABD'deki deneyimlerini tanıtmak, daha sonra Müslüman çiftlerin ilişkilerinde yaşadıkları sorunları tartışarak çift terapistlerine kültürel açıdan yetkin uygulamalar konusunda rehberlik edecek bir kaynak sağlamaktır.

Anahtar Kelimeler:

Ayrımcılık • Çift terapisi • İslamofobi • Kültüre duyarlı terapi • Müslüman çiftler.

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At nearly 3.5 million people,Muslims are the third largest religious group in the United States (U.S.), and this number is expected to rise to over 8 million by 2050 due to immigration from foreign countries, births,and religious conversion (Pew Research Center, 2017). However, despite this growth, Muslims remain a minority population in the U.S. and encounter difficulties, such as adapting to society, acculturation issues, mistreatment in the labor market, rejection of employment, lack of social support,and insufficient resources to preserve their religious beliefs (Ahmed, et al., 2011).

After the terrorist attacks in the U.S.on 11 September, 2001, social disapproval and bullying of Muslims increased in parallel with media propaganda portraying Muslims as extremists (Aroian, 2012). Most Americans associated Muslims with violence, extremism, war, fanaticism, and terrorism whilehostile attitudes, including hate crimes towards Muslims in the U.S., rise by 67 percent in 2015, the highest rate since 2001 (Federal Bureau of Investigation, 2016). These experiences of discrimination increased the risk of adverse mental health outcomes,including paranoia, anxiety, low self-esteem, and depression (Amer & Hovery, 2012; Ghaffari & Cifci, 2010; Lowe et al., 2019; Padela & Heisler 2010),and physical health problems, including heart disease, stroke, high blood pressure, preterm birth, cognitive impairment in children, obesity, and type 2 diabetes (Paradies et al., 2015).

Although exposure to discriminatory acts toward Muslims is very common in the U.S., little is known about the impactsthe romantic relationships of Muslim couples. Previous studies of minority couples (e.g., interracial and same-sex couples) provide some insights into minority discrimination and relationship outcomes. For instance, discrimination experiences reduce relationship satisfaction and interaction in interracial couples (e.g., Baptist et al., 2018; Genc &Su, 2021), although minority couples canmitigate the destructiveeffectsof discrimination and protecttheir relationships (e.g., Baptist et al., 2018; Gamarel et al., 2014; Genc & Su, 2021). In particular, relationship maintenance strategies, such as positivity, honesty, problem solving skills, joint coping skills, and religiosity, lessen the effects of discrimination and strengthen relationship quality (Baptist et al., 2018; Genc & Baptist, 2020; Genc & Su, 2021). These responses could be essential in lessening the destructive impacts of discrimination on Muslim couples since, like minority couples, they may also use similar strategies to improve their relationships and alleviate the effects of religion-based discrimination.

Despite the rise in discriminatory attitudes against Muslims since 9/11, there is a lack of research on the discrimination experience of Muslim couples and its effects on their relationship outcomes. The current study therefore examinesthe religion-based discrimination experiences of Muslims and how these affect Muslim couple relationships. The findings may have therapeutic implications that can better equip couple therapists working with these couples.

Muslims in the U. S.

The U.S. Muslim population consists of different national groups: 65% is foreign-born, of which 58% is from the Middle East, 25% from North Africa, 35% from South Asia, 23% from Asia Pacific,9% from sub-Saharan Africa, 4% from Europe, and 4% from other regions in the Americas (Pew Research Center, 2017). U.S.-born Muslims are also racially diverse,including Black (32%), White (35%), Asian (10%), Hispanic (17%), and mixed race (5%). WhileMuslim migration to the U.S. decreased after the Trump administration banned travel to the U.S. from seven predominantly Muslim countries (BBC News, 2018), the number of Muslims in the U.S. is projected to grow toover 8 million, makingIslam the second largestreligion after Christianity by 2050 (Pew Research Center, 2017).

Regarding the relationship status of Muslims in the U.S., 53% are married, 33% have never married, 8% are divorced, 4% are cohabitating, and 1% are widowed (Pew Research Center, 2017). Among married Muslim adults, 70% are foreign-born who married fellow Muslims (89%) compared to U.S. born Muslims (81%). According to aPew Research Center report (2017), younger Muslims (ages 18-39) are more open to marrying non-Muslims (17%) than Muslims over 39 years old (9%). Muslims are more likely to prefer co-religionist partners if religion is important to them and/or they have mainly Muslim friends.

Muslims'History in the U.S.

Muslim immigration to the U.S. startedabout 400 years ago with three major waves. The first wave began as involuntary and forced immigration in the 17th century with the arrival of African Muslim slaves. Due to race and class struggles, there was no freedom of religion and religious practice was forbidden. Nevertheless, African slaves practiced in secret and passed on their religion to their children (Turner, 1997). The second wave began in the 19th century with Arabs escaping civil war from the Ottoman Empire's Syrian province (modern-dayLebanon, Syria, Jordan, and Palestine), and continued after World War I with Eastern European Muslims. This voluntary wave brought unskilled labor pursuing economic opportunities and safety (Azzaoui, 2009). The second wave continued after World War II with Muslims from India, Pakistan, Eastern Europe, and the Soviet Union looking for democracy, liberty, and/or opportunities for higher education (Azzaoui, 2009). This group brought many well-educated Muslim immigrants from different social and economic classes. The latest wave occurred following the 1965 Immigration Act, which opened the U.S. to immigration, thereby attracting well-educated and high-skilled Middle Easterners, Asians, and Africans (Haddad et al., 2009) pursuing education and career opportunities, and family unification.

In the last three decades, Muslims have been forcefully displaced or fled from their home countries due to fear of and persecution byAl Qaeda and ISIS (Islamic State of Iraq and Syria) extremists. During the Obama administration, many Muslim refugees were resettled in the U.S., because of continued war and terrorism in the Middle East (Connor & Krogstad, 2016). Yet, although Muslims immigrants arrived in the U.S. since the 19th century, they are not always accepted by Americans who associate Muslim people with terrorism (DeSilver, 2015). Hatred of Muslim immigrants has increased further since the 2017 executive order on immigration forbidding entry from certain Muslim-majority countries, specifically Iraq, Iran,Yemen, Sudan, Libya, and Somalia (Malone, 2018).

Muslim immigrants arriving inthe U.S. to pursue a brighter future are commonly challenged by the poor reception they receive fromAmerican citizens due to the association of Muslims with terrorism, especially since the 9/11 terrorist attack. Additionally, they can struggle to adapt to living in a mainly Christian country as faith-based social support networks are limited. Muslims who settle in regions that lack fellow citizens from their home country and places for religious worship may feel particularly isolated (De, Van, & Keating 2015).The adjustment of Muslim immigrants to American culture can be conceptualized in terms of acculturation (Berry, 1997).

Acculturation and Assimilation of Muslims in the U.S.

Acculturation refers tothe process of immigrants' learning and adapting to the host country'svalues, attitudes, lifestyles, and norms (Berry, 1997). According to Berry (1997), acculturation can involve four strategies: assimilation, separation, integration, and marginalization. Assimilation happens when an immigrant adapts to the host culture and rejects their original culture. Separation happens when an immigrant embraces their own culture and rejects the host culture. Integration happens when the immigrant maintains both the host's culture and their own. Marginalization happens when an immigrant wishes to keep their original culture and cannot form strong ties with the host culture. Acculturationis affected by several factors, such as demographic features (e.g., country of origin, age, gender, length of time in the U.S, occupation, and education), level of religiosity, language skill, and level of ethnic/religious identity (Berry, 2003).

Age is an important factor helping immigrants acculturate as younger immigrants tend to adapt more quickly than adults (Abbas, Sitharthan, Hough, & Hossain, 2018; Kim & Wolpin, 2008; Kalmijn & Kraaykamp; 2018). Likewise, adolescents have more time and opportunities for exposure to the host culture, which eases their acculturation (Berry, 1997, 2003). Conversely, adult immigrants commonly struggle to adjust,particularly if they perceive that adaptation means altering cultural beliefs, values, and traditions that are deeply embedded in their identity (Abbas et

al., 2018; Chudek, Cheung, & Heine, 2015; Marsiglia,Booth, & Baldwin, 2013). Acculturation becomes easierwith time as immigrants become morefamiliar with the host culture'ssocio-cultural environment (Christmas & Baker, 2013). New immigrants may have more difficulties adjusting if they cannot speak the native language, which canincrease isolation (Chudek et al., 2015; Lueck & Wilson, 2011). Education level also affects acculturation since a high level of education is linkedwith greater competence in English (Sheikh & Anderson, 2018).Assertiveness, social connectedness, and social interactionsalso facilitate acculturation and socializing with the local community, which helps immigrants discover and bond with the local culture (López-Rodrigueza et al., 2015, Yoon, Lee, & Goh, 2008).

For Muslim immigrants, acculturation is complicatedfor several reasons. First, there is a lack of shared religious beliefs withmany Americans (Awad, 2010; Haddad, 2004). Second, it has become harder due todiscrimination experiences and negative stereotypes of Muslims in the U.S. since the 9/11 attacks (Kunst et al., 2012; Phalet, Baysu, & Van Acker, 2015). A third challenge concerns visible Islamicsymbols,such as long beards for men, and hijabs or burqas for women covering the entire body (Fozdar, 2011).The hijab and/orniqab (i.e., a veil covering the face except for the eyes) are worn by some Muslim women in public to maintain privacy from men and show their submission to Allah. However,these garments may lead tomore prejudicial and unfair treatment (Yasmeen, 2007) and even suspicion by law enforcement officers (Dellal, 2004), which may result in isolation form society. Another issue is the need to pray five times each day and eat only halal food, which is not available in many regions ofU.S. (Amer & Bagasra, 2013).These are important practices for Muslims to preserve. However, their commitment to their religious identity, culture, and continued use of their mothertonguecan increase the risk of discrimination, whichmayin turn hinder acculturation(Abbas et al., 2018; Al Wekhain, 2015).

Discrimination and Islamophobia

Islamophobia Pre- and Post-September 11, 2001

Discriminatory behaviors against Muslims have existed even before 9/11(Bakalian & Bozorgmehr, 2011). Hostile attitudes toward Arabs and Middle Easterners in the U.S. began with U.S.foreign policy supporting Israel's occupation of the West Bank in the 1960s (Bakalian & Bozorgmehr, 2011). The doublestandards in U.S.policiestowardsmajority-Muslim countriesin theMiddle East increased with World War II, and the Gulf War in the 1990s (Martin-Munoz, 2010).During the 1990s, Western media portrayedMuslims (particularly Middle Easterners) as brutal, barbaric, fierce, immoral, dishonest, extremist, and enemies(Park, Felix, & Lee, 2007; Sheridan, 2006). Following the 9/11 terrorist attacks, reported hate crimes

against Muslims (i.e., Islamophobia) increased before intensifying during the 2016 presidential election campaignwith former president Donald Trump's callfor a "total and complete shutdown of Muslim entering the U.S." (Sullivan & Zezima, 2016).

Islamophobia refers to unsubstantiated fear, intimidating attitudes and behaviors toward Muslims due to their religious beliefs that results in prejudice, hostility, discrimination, and even violence (Runnymede Trust, 1997). As a hostile attitude, Islamophobia can be either overt or covert in different settings. For instance, hate crimes are frequently reported, such asattacks on Muslim properties and places of worship, insulting messages through graffiti or drawings on mosques, verbal abuse like name calling, intimidating Muslims through leaving pork, pig heads or blood inreligious places or residential areas, and excluding Muslims from chats (Abdelkader, 2016; Lorente, 2010; Sheridan, 2006). Such hostile attitudes against Muslims increased between after9/11. Specifically, 50% of Muslims report that it has become more challenging to live in the U.S. as a Muslim in recent years, with almost half of Muslims experiencing at least one incident of discrimination per year (Pew Research Center, 2017). Hate crimes have also increased since 9/11(e.g., shooting, physical assault, removing headscarves, insulting Muslims for their attire, vandalism, damage to mosques, particularly during Friday prayer or religious holidays, and leaving pig's heads or blood) (Abdelkader, 2016). Likewise, the Pew Research Center (2017) reported that anti-Muslim attacks increased by 19% from 257 in 2015 to 307 in 2016.

People who are hostile to Muslims are often triggered by traditional Muslim garments (e.g., women's headscarves) or grooming styles (e.g., long beards). Muslims whose physical appearance makes them easily identifiable are more likely to be targeted for discriminatory acts and hate crimes. Non-Muslims have more negative attitudes toward conservative Muslim outfits (e.g., hijab, niqab, and burqa) than Muslims in general (Helbling, 2014). Womenwearing veils experience more discriminatory actions than Muslim men or Muslim women who dress in Western-style clothes (Weichselbaumer, 2019). For example, women who wear a headscarf are more likely to have their job applications rejected (Sterling & Fernandez, 2018; Weichselbaumer, 2019). Even if hired, Muslims may be asked to compromise their religious attire in the workplace or face biased performance evaluations (Ghumman & Ryan, 2013). In short, asthe Muslim population increases, their clothing will become a substantial source of discrimination for prejudiced people in the U.S.

Discrimination and Mental Health

Increased religious hostility has left Muslims fearful of hatred and hostility from American society (Love, 2009). There is clear evidence thatreligion and race-based discrimination damages psychological and physical health (Kunst et al., 2012; Samari, 2016; Schmitt et al., 2014). In particular, insecurity since the 9/11 attacks

predicts post traumatic stress disorder (PTSD) symptoms among Muslims residing in New York (Abu-Ras & Suárez, 2009). Similarly, exposure to discriminatory actsispositively correlated with mental health problems, including stress, depression, anxiety, negative affect, PTSD, somatization, internalization, and suicidal ideation, thoughts, or attempts (Kunst et al., 2012; Lowe, Tineo, & Young, 2019; Phillips & Lauterbach, 2017; Samari, 2016; Schmitt et al., 2014).

On the other hand, several factors canbuffer the effects of discrimination on mental health. Specifically, various individual and social factors, such as high self-esteem, social and family support, coping skills, religiosity, ethnic/religious identity, and religious congruence can protect the mental health of Muslims (Every & Perry, 2014; Genc & Baptist, 2020; Lowe et al., 2019). Conversely, failure to assimilate or integrate into American society can worsen their mental health (Abu-Ras & Suárez, 2009; Awad, 2010; Ghaffari & Ciftci, 2010).

Effects of Discrimination on Intimate Relationships

Although the U.S. is a diverse country that incorporates different races, faiths,and sexual orientations, certain kinds of minority couples (e.g., interfaith, interracial, and same-sex couples) still experience discriminationor social disapproval (Lehmiller & Agnew, 2006). Whether in the workplace, community, or from society in general, experience of hostility and discrimination due to minority status can significantly harm individuals,particularly iftheirreligious identity reflects theirvalues and guides theirway of life. However, adaptive strategies may help alleviatethe impact. Conversely, maladaptive strategies may exacerbate the situation byleading to conflict and harm to the victims and those close to them. Being in a minority and feeling rejected by society can often cause stress and tension between romantic partners (Baptist et al., 2018; Genc & Baptist, 2020; Genc & Su, 2021).

Such experiences can harm interaction between the partners, leading to invalidation, negative interpretation, and avoidance or withdrawal (Genc & Baptist, 2020; Markman, Stanley, & Blumberg, 2010). These negative styles of communication and interaction in turn cause relationship dissatisfaction, marital distress, reduced marital quality, relationship dissolution or separation,and higher divorce rates (Cox, Buhr, Owen, & Davidson, 2016; Genc & Baptist, 2020; Genc & Su, 2021). On the other hand, these difficult experiences may strengthen intimate relationships through creating chances for closeness and support. Thus, the relationship may function better through increased commitment, stability, and satisfaction (Baptist et al., 2018; Genc & Su, 2021; Kamen, Burns, & Beach, 2011).

Although the impacts of discrimination experiences on Muslim couples have been less studied, it can be predicted that Muslim couples, like other minority couples,

also face similar hostile attitudes from American society due to their religious beliefs. While exposure to hostile attitudes in society can harm Muslims' mental and psychical health (e.g., Lowe et al., 2019), its impacts on Muslim couples and their relationships are not well known. One recent study found that Muslim couples who experience couple discrimination in the U.S. lower relationship satisfaction and more negative interactions. However, the impacts on relationship satisfaction were buffered by their joint coping skills (Genc & Baptist, 2020). Given that the Muslim population in the U.S.is increasing, couple therapists need to better understand the discrimination experiences of Muslim couples to providemore effective therapy.

Religiosity and Muslim Couples: A religion that instructs people to be loving, faithful, patient, and forgiving promotes healthy relationship outcomes (Lambert & Dollahite, 2006; Mahoney, 2010). Accordingly, the partners' religiosity can significantly affect marital quality, satisfaction, and stability (e.g., Perry, 2014; Mahoney et al., 2008). Religiosity refers to a person's religious beliefs and behaviors as well as the subjective importance of religion to thatperson (Chapman, 2014). Religious involvement also reduces divorce rates (Brown, Orbuch, & Bauermeister, 2008; Vaaler et al., 2009), increases marital adjustment (Schramm et al., 2012) and conflict (Lambert & Dollahite, 2006; Mahoney et al., 2008), and improves couples' communication (Parker, 2009).In Islam, marriage is obligatory and its benefits are emphasized in the Quran and the Hadith of the Prophet Muhammed. Devotion to Islam can protect Muslim couples and provide stability and commitment (Alshugairi, 2010). When Muslim partners have similar levels of religiosity and pray together, they report greater marital satisfaction (Abdullah, 2017). Given the role of religion in relationships and the importance for Muslim couples to practice their religion, it is expected that religiosity may protect relationships by buffering the negative effects of discrimination on relationship satisfaction.

Clinical Implicationsfor Therapy with Muslim Couples

While couples' discrimination experiences are challenging, they could also provide a continuous source of growth in relationships. Thus, couple therapists could help Muslims to turn these negative experiences into growth opportunities. First, therapist self-awareness is essential for effective treatment, as indicated in article 1.1 of the 2015 American Marriage and Family Therapists Association (AAMFT) code of ethics: "[be] aware of and respect cultural, individual, and role differences, including those based on age, gender, ethnicity, culture, national origin, and religion". Non-Muslim therapists should therefore look closely at their own beliefs and biases while working with Muslim couples (Falicov, 2014; Kelly et al., 2013). Second, therapists must try to connect across differences with their clients in worldviews and values, experiences, and power. However, some therapists may be unfamiliar with religious-

based experiences or feel confident in addressing religious issues in therapy (Duba & Watts, 2009). To enhance their understanding of Muslim couples and establish rapport, therapists should consult and collaborate with Islamic religious leaders (imams) or religious advisors and scholars (Duba & Watts, 2009). Outreach work and environmental changescould increase therapists' awareness and help them adapt their therapeutic models (Amer, 2006; Tanhan & Young, 2021).

Given that discrimination experiences may cause distress and tension between partners, leading to conflict in romantic relationships, couple therapists should assess these experiences and identify potential conflicts in the relationship. Having established a therapeutic relationship, the therapist can identify the specific implications by exploring past experiences and hidden emotions to reveal their negative impacts on the couple's relationship. Thiscan then be used to lessen distress and increase the emotional bond between Muslim partners. Several culturally appropriate therapeutic interventions can be offered for Muslim couples. For example, using emotionally-focused therapy (EFT) techniques, anEFT therapist can outline the couple'sstruggles and conflicts in their relationship before exploring their negative interaction cycle to reframe the problems and access underlying feelings and attachment needs. Afterwards, the therapist facilitates the expression of each partner' sneeds and wants to help the couple develop a new interaction response. Finally, the therapist focuses on new solutions to old problems and consolidates the new positions of each partner by evoking reciprocal positive responses from them (Johnson, 2004).

Solution-focused couples therapy (SFCT) can alsobe applied to Muslim couples in a religiously sensitive way (Ime, 2019). Using SFCT techniques, therapists can investigate the partners' potential strengths, hopes, and expectations to improve their relationships. While focusing on therelationship's strengths, miracle questions can be changed into Quranic expressions(e.g., "If a miracle happens…" can be rephrased as "If Allah wills…"). SFCT therapists guide couples to developpositive solutions to resolve their problems by discovering the couple's strengths and hopes for the future.

Integrative behavioral couple therapy (IBCT; Jacobson & Christensen, 1996) can also be recommended for distressed Muslim couples. IBCT, which focuses on emotional acceptance and positive behavioral change through communication and problem-solving skills, includes three phases, starting with observation of the problem to encourage the partners to develop a novel and accepting view of their relationship problems. In the second phase, they develop a 'deep' understanding of their relationship difficulties. To do so, they explore differences between them, hidden emotions, external stresses, and communication patterns that might exacerbate their problems. In the final response phase, the partners develop a plan to solve their problems and improve their relationship.

Positive psychology couples therapy (PPCT; Chan, 2018) could also be useful while working with Muslim couples. PPCT explores and enhances the positive features and strengths of the couple's relationship by reducing stress and changing negative communication patterns. Several positive interventions, such as HOPE (i.e., Handling Our Problems Effectively), can be adapted for Muslim couples by integrating behavioral and solution-focused techniques for conflict resolution. Additionally, the "best possible future" exercise can help Muslim couples develop positive emotions by considering positive incidents that might occur in the future while the "emotional bank account" exercise may help couples enhance their intimacy. All these interventions teach partnersto support each other, develop empathy, express their love and gratitude, and show appreciation (Genc, 2021). This enables them to build strong ties and rely on each other when encountering distress, which ultimately helps to ease their relationship problems.

Empirically informed treatments need to be developed or formally adapted for Muslim couples experiencing discrimination. While some therapy models can be applied to distressed Muslim couples, as outlined above, it is unclear whether such treatments are effective for Muslim victims of hate crimes or other discriminatory acts. Thus, empirically tested interventions are urgentlyneeded to ensure that discriminated Muslim couples receive effective and culturally tailored treatment.

Conclusion

Since the 9/11 terrorist attacks, discrimination and bias against Muslims in the U.S. has increased sharply. Although previous studies have revealed prejudicial attitudes toward Muslims, these unfavorable experiences also impact Muslims' romantic partners and their relationships. Such unpleasant experiences lead Muslims to seek mental health services to deal with stress, depression, anxiety, and martial distress. Despite this growing need, there has been little research on the effects on a couple's relationship of perceived religious-based discrimination. Furthermore, couples and family therapy programs are not yet sufficiently culturally sensitive while many relationships therapists do not feel confident enough to help Muslim couples because they lack even a basic understanding of Islam and Muslim family life.

Therefore, this study outlined the situation and struggles of Muslims in the U.S. as a minority population. It then suggested how couples therapy practices can be used with Muslim couples who experience religious-based discrimination in the U.S. The current study suggests that therapists should remember that Muslim couples encounter unique challenges due to their religious beliefs and values. Hence, couple and family therapists are advised to a) gain awareness about Islam and use this to build rapport, b) carefully assess how Muslim couples are affected by their struggles and

how Islam operates in theirlives, and c) incorporate Islamic beliefs in the preferred therapy model that focuses on the couple's strengths to find new solutions for their relationship problems.

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Research Article

Adapting the Existential Gratitude Scale to Turkish: A Measure of Gratitude in Painful Times

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Abstract
This study aims to adapt the Existential Gratitude Scale (Jens-Beken & Wong, 2019) to Turkish culture and to examine the scale's psychometric properties in this respect. The study uses the convenience sampling method, and the sample consists of 286 participants between the ages of 18 to 53, of whom 212 (74.1%) are female and 74 (25.9%) are male. The structural validity of the scale has been examined using confirmatory factor analysis (CFA). The CFA results confirm the original EGS' one-dimensional structure over a Turkish sample, and the scale has good fit indices (χ^2=94.655, *df*=34, χ^2/df =2.784, *GFI*=0.936, *NFI*=0.930, *CFI*=0.954, *SRMR*=0.0420, and *RMSEA*=0.079). The factor loadings range from .46 to .77. For the criterion validity, Pearson correlations were calculated for the EGS with the Short Gratitude, Resentment, and Appreciation Scale and Transpersonal Gratitude Scales, which resulted in significant positive correlations (respectively *r*=0.476 and *r*=0.579 at *p*= 05). The item-total correlation and comparison of the upper 27% and lower 27% groups were examined for the item analysis of the scale; these have revealed the EGS to possess satisfactory discriminating power. As a result of the reliability analysis, Cronbach's alpha of internal consistency was calculated as .893. This study shows the EGS to be a valid and reliable tool useable in the context of Turkey for measuring individuals' existential gratitude levels. The EGS can be a valuable tool for practitioners in mental health settings in developing appropriate interventions for individuals' coping skills in celebrating adversity.
Keywords:
Gratitude • Existential gratitude • Scale adaptation • Reliability • Validity

Varoluşsal Şükür Ölçeği'nin Türkçe'ye Uyarlanması: Zor Zamanlarda Şükrün Ölçülmesi

Öz
Bu çalışmada, Jens-Beken ve Wong (2019) tarafından geliştiren Varoluşsal Şükür Ölçeği'nin Türk kültürüne uyarlanması amaçlanmıştır. Bu kapsamda, ölçeğin psikometrik özellikleri incelenmiştir. Çalışmada kolay örnekleme yöntemi uygulanmıştır. Çalışmanın örneklemini 212'si kadın (%74.1), 74'ü erkek (%25.9), yaşları 18 ile 53 arasında değişen 286 kişi oluşturmuştur. Yapı geçerliliği Doğrulayıcı Faktör Analizi (DFA) ile analiz edilmiştir. DFA sonuçları original ölçeğin tek faktörlü yapısını Türk örnekleminde doğrulamış ve iyi uyum değerleri göstermiştir (χ^2/df =2.784, *GFI*=0,936, *NFI*=0,930, *CFI*=0,954, *SRMR*=0,0420 ve *RMSEA*=0,079). Ölçeğin factor yükleri .46 ile .77 arasında değişmiştir. Ölçüt geçerliliği için ölçeğin Minnettarlık Gücenme ve Takdir Ölçeği Gözden Geçirilmiş Kısa Formu (K-MGTÖ) ve Manevi Şükür Ölçeği arasındaki Pearson Korelasyon Katsayısı hesaplanmış ve pozitif yönde anlamlı sonuçlar çıkmıştır (r=0,476, r=0,579, p= .05). Ölçeğin madde analizi için yapılan madde-toplam puan korelasyonu ve %27 alt-üst grup karşılaştırması sonucunda ölçeğin iyi bir ayırt edicilik düzeyine sahip olduğu görülmüştür. Güvenirlik analizi sonucuna göre, Cronbach iç tutarlık katsayısı .893 olarak hesaplanmıştır. Bu çalışma, Varoluşsal Şükür Ölçeği'nin Türkçe versiyonunun kişilerin varoluşsal şükür düzeyini ölçmede geçerli ve güvenilir bir ölçme aracı olduğunu göstermiştir. Bu ölçek, ruh sağlığı alanında çalışan uygulamacıların, kişilerin zorlukları daha iyi karşılamak için baş etme becerilerini geliştirecek uygun müdahaleler tasarlaması için değerli bir araç olabilir.
Anahtar Kelimeler:
Şükür • Varoluşsal şükür • Ölçek uyarlaması • Güvenirlik • Geçerlik

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Contrary to the problem-focused approach that has become dominant for years in psychology, positive psychology is a field that focuses on people's strengths (Hoy & Tarter, 2011) and encompasses individual experiences (e.g.,well-being) and positive personality traits (e.g., hope; Seligman & Csikszentmihalyi, 2014). Studies in positive psychology focus on understanding and explaining the constructs that play a role in individuals' flourishing such as optimism, hope, well-being, and love (Gable&Haidt,2005).Gratitudeis also a concept that has been a topic of studies in positive psychology. Despite having been studied in different fields such as theology and ethics, gratitudehas emerged as a concept which researchers have been interested in and studied extensively thanks to increasing studies in this field (Kardaş & Yalçın, 2019).

Gratitude is an important concept that has several positive associations with various constructs. Several experimental studies are found to have shown gratitude interventions to have a positive effect on psychological wellbeing (Bozkurt, 2019; Măirean et al., 2018; Uhder et al., 2017), subjective well-being (Megawati et al., 2019), school well-being (Jiang et al., 2015), and health (Millstein, 2016). Several studies have also shown gratitude to negatively correlate to depression (Sun et al., 2020; Tulbure, 2014; Wood et al., 2008) and anxiety (Gökşen, 2020; McCullough et al., 2002).

No one clear way is found for conceptualizing gratitude. Emmons and McCullough (2003, p. 377) defined gratitude as "an emotion, attitude, moral virtue, habit, personality trait, or coping response". Gratitude has also been defined as awareness and appreciation of positive aspects in the world (Wood et al., 2010) as well as appreciation of the things an individual finds valuable and meaningful or as a general state of thankfulness and discretion (Sansone & Sansone, 2010). Gratitude has been defined at both the interpersonal (McCullough et al., 2002) and transpersonal (Sansone & Sansone, 2010) levels and to include being thankful for nature or for God (Emmons & McCullough, 2003).

When examining the definition of gratitude in light of the literature, it has mostly been defined as an affective trait referred to as dispositional gratitude (McCullough et al., 2002; Watkins et al., 2003). McCulloughet al. (2002, p. 112) defined dispositional gratitude as a "generalized tendency to recognize and respond with grateful emotion to the roles of other people's benevolence in the positive experiences and outcomes one obtains"while mentioning four facets for this concept: intensity, frequency, span, and density. Intensity involves one feeling more gratitude toward a positive issue when their dispositional gratitude level is higher. The facet of frequency involves how often one feels grateful. This daily frequency may be higher for those with higher grateful dispositions. Span implies the number of areas for which one maybe grateful. A person who tends to feel more grateful is able to find more aspects for which to be grateful. Lastly, density points to the number of people toward whom one

feels grateful. One who is more disposed toward gratitude is able to find more people to be grateful toward regarding a particular event (McCullough et al., 2002).

With regard to focusing on the perspective of positive psychology perspective, gratitude has been examined as an emotional trait. However, taking gratitude into account only from this positive aspect may be insufficient (Jens-Beken& Wong, 2019). Positive psychology focuses on studying positive qualities, processes, and emotions (Lomas, 2016; Wong, 2019). Even though positive psychology also acknowledges the other side of the coin (e.g., adversity, pain, hardship; Gable & Haidt, 2005), its study area focuses on positive aspects such as happiness and success (Wong, 2016). Meanwhile, existential psychology deals with issues such as meaning in life, responsibility, choice, guilt, and death anxiety (McDougall, 1995). Existential positive psychology (EPP; Wong, 2009) has emerged as a new standpoint that creates good harmony between positive and existential psychology (Wong, 2010).

According to the EPP perspective, human behavior should be studied in terms of positive and negative. To study the positive side properly, the dark side of human experience should also be a target. This dialectical view becomes an important element in Second Wave Positive Psychology (SWPP; Wong, 2017). Second Wave Positive Psychology acts as an umbrella term for EPP. Wong (2016) used these two terms interchangeably at first, but then stated EPP to be a branch of SWPP (Wong, 2019). According to its assumptions, human well-being can be achieved by recognizing positive emotions and traits as well as the dark side of existence (Ivtzan et al., 2016). The dark side may refer to "hardships and heartbreaks, the existential abyss, and despairs" (p.6). Pain, adversity, and difficulty are inevitable parts of human life, and happiness cannot be achieved by ignoring these. Accepting pain and trying to balance the two sides can bring individuals authentic happiness (Wong, 2016; Wong, 2019).

Parallel to this dialectical view, existential gratitude refers to the tendency to be grateful in both good and difficult times and has a parallel meaning to dispositional gratitude. However, existential gratitude includes being grateful while also suffering (Jand-Beken & Wong, 2019). Jans-Beken and Wong's study showed existential gratitude to be a distinct construct of dispositional gratitude and emphasized being grateful from only a positive perspective while ignoring hard times may prevent one from seeing the whole picture and from making the necessary interventions in counseling or psychotherapy. Existential gratitude exercises can be a good example for understanding gratitude in adversity. In this exercise, people write about three points for which they are thankful. They can be grateful for breathing, for having supportive relatives, or for the beauty of nature. Contrary to the widely known gratitude exercise where people write about three good things, this exercise sees gratitude as an essential virtue by looking from a more meaningful and transpersonal view (Wong, 2016).

When examining the instruments that measure gratitude, the Gratitude Questionnaire (McCullough et al., 2002) and Gratitude Resentment and Appreciation Test (Watkins et al, 2003) are two widely used scales. Both of these scales take gratitude into account as an affective trait known as dispositional gratitude(Oğuz-Duran, 2017; Jans-Beken et al., 2015; Yüksel & Oğuz-Duran, 2012). The Gratitude Questionnaire (McCullough et al., 2002) is a three-factor, 7-point, Likert-type scale with six items. The Gratitude Resentment and Appreciation Test (GRAT; Watkins et al.,2003) is a three-factor, 9-point, Likert-type scale with 44 items,the S-GRAT (Thomas & Watkins, 2003) is its16-item short version. Different from the two instruments that measure gratitude from a dispositional perspective, the Transpersonal Gratitude Scale (Hlava et al., 2014) measures gratitude in a transpersonal sense.

To this point, none of the instruments described above have items that measure one's tendency to count one's blessings in difficult times. The Existential Gratitude Scale (EGS; Jans-Beken & Wong, 2019) is different from the other gratitude scales in that it aims to measure gratitude during both good and bad times, mostly focusing on times of suffering. Because no measurement tool is found in Turkey with this kind of focus, the current study's aim of adapting the Existential Gratitude Scale into Turkish would be a good contribution.

Method

Participants

The study uses the convenience sampling method was for measuring the psychometric properties of the scale. Convenience sampling is a non-probability sampling method in which participants who easily accessible are selected for the sample. This method provides researchers with several advantages, such as saving time and costs (Büyüköztürk et al., 2012). This study uses the convenience sampling method due to the conditions of the COVID-19 pandemic.The sample of the study consists of 286 participants. According to Child (2006), the sample size should be at least five times the number of items or variables being observed for the factor analysis. The sample size for the present study is appropriate for factor analysis in this respect. The participants consist of 212 women (74.1%) and 74 men (25.9%), and their ages range from 18 to 53 (M = 26.57; SD=8.21). Of the participants, two finished primary school (0.7%), 12 have high school diplomas(4.2%), eight have 2-year bachelor degrees (2.8%), 168 have bachelor degrees (58.7%), 72 have master's degrees (25.1%), and 24 have doctorates (8.4%).

Instruments

Existential Gratitude Scale (EGS)

The EGS was developed by Jans-Beken and Wong (2019)and aims to measure the tendency to be grateful in difficult times. It is a one-factor, 13-item, 7-point Likert-type scale whose answers range from strongly disagree (1) to completely agree (7). Items 3, 5, and 7 are negatively formulated and only used to check response bias (e.g., I am resentful that life has treated me unfairly). The scale is scored by calculating the mean total score of the items minus the three filler items (Items 3,5,7). Higher scores on the scale indicate a higher level of existential gratitude. One example item is “I am grateful that every crisis represents an opportunity for me to grow.”. The original factor loadings for the items range from 0.517 to 0.740, and the internal consistency was calculated as .87.

The Revised Short Gratitude Resentment and Appreciation Test (S-GRAT)

S-GRAT is a revised short version of GRAT (Watkins et al., 2003) and was developed by Thomas and Watkins (2003). Its Turkish adaptation study was made by Oğuz-Duran (2017) and is a 16 item, 9-point Likert-type scale with three factors aiming to measure dispositional gratitude. The sub-dimensions are lack of sense of deprivation (LOSD), simple appreciation (SA), and appreciation of others (AO). Items 3, 6, 10, 11, and 15 are negatively formulated items and reverse scored. The scores from each item on the scale are totaled to get the overall score, with higher scores indicating a higher level of dispositional gratitude. One example item is “Every autumnI really enjoy watching the leaves change color.”. Several studies have examined its validity and reliability. Cronbach’ salpha of reliability has been calculated as .92 for the original scale (Thomas & Watkins, 2003) and .77 for the Turkish version (Oğuz-Duran, 2017), which confirmed the three-factor structure of the original study ($\chi2/df$ = 265.15/ 101; *GFI* = .90; *CFI* = .92, *SRMR* = 0.07; *RMSA* = .07).

Transpersonal Gratitude Scale (TGS)

The TGS was developed by Hlava, Elfers, and Offringa (2014) and adapted to Turkish by Kaplaner and Ekşi (2020). It is a 16-item scale with 4 sub-dimensions and aims to measure transpersonal gratitude. The sub-dimensions are expression of gratitude, value of gratitude, transcendent gratitude, and spiritual connection. TGS is a 7-point Likert-type scale whose answers range from strongly disagree (1) to completely agree (7). Only Item 7 is reverse scored. The total score is calculated adding up the totals of the scores from the four sub-dimensions. A higher score indicates a higher level of transpersonal gratitude. One example item is “I am grateful for the opportunities I have had in my life”(Hlava et al.,2014). The original scale’s Cronbach’s alpha of reliability

was calculated as .88 and its factor loadings as ranging from .27 to .98 (Hlava et al., 2014). In the Turkish version, Cronbach's alpha was calculated as α=. 77, and its factor loadings range from .44 to .88 (Kaplaner & Ekşi, 2020).

Procedure

In the process of adapting the EGS to Turkish, permission to adapt was first obtained from Jans-Beken by e-mail. After permission was granted, the items from the English form were translated into Turkish by six people with advanced English levels. Once the translation process was complete, three experts in psychological counseling and guidance discussed the Turkish translation of the items using a panel study, and the Turkish form of the scale was created. After this forward translation process, the back translation of the Turkish form was made by an English teacher. When the back translation was compared with the original form, the items appeared very similar. Lastly, the finalized version of the scale was created.

To examine psychometric properties, the Turkish forms of the EGS, S-GRAT, and TGS were administered online to participants. After 50 participants completed the EGS, S-GRAT, and TGS, data collection continued by re-administering the Turkish form of the EGS. For ethical considerations, official permission was obtained from Marmara University, Education Sciences Institute Ethics Committee. The online form involved informed consent, which ensures that privacy and voluntary participation have been taken into consideration. After the participants read the information regarding the study's aim and scope in the online form, they gave their consent for participating.

Criterion validity and construct validity (confirmatory factor analysis) were examined for checking the validity of the scale. For reliability, Internal consistency was examined using Cronbach's alpha of reliability. A group comparison of the upper and lower 27% was done for analyzing the items on the scale.The data analysis was performed using the programs SPSS 26.0 and AMOS 26.0.

Results

Validity Study

Structural Validity

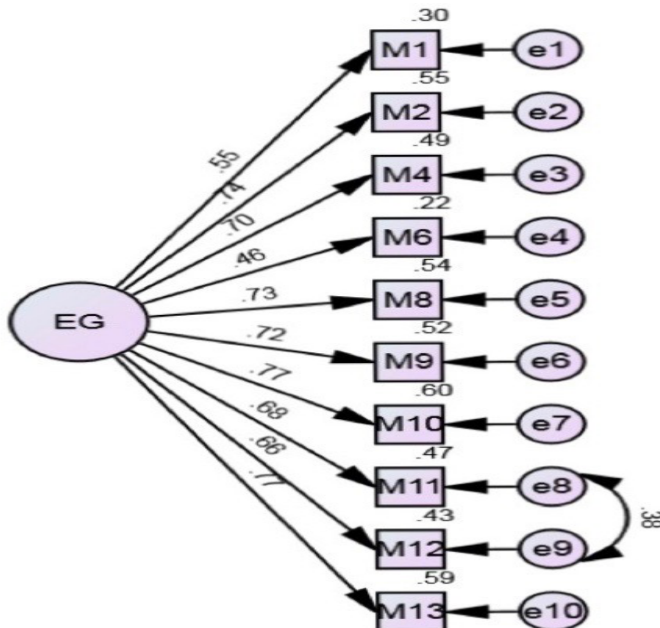
Confirmatory factor analysis (CFA) was conducted to evaluate whether the Turkish version of the EGS conforms to the structure of the original scale. In this respect, the ratio of the chi-square value to the degrees of freedom ($\chi 2/df$), goodness-of-fit index (*GFI*), normed fit index (*NFI*), and comparative fitindex (*CFI*), standardized root mean square residuals (*SRMR*), and root mean square error of approximation (*RMSEA*) were calculated. Table 1 shows the fit indices for the EGS.

Table 1.
Fit Indices for the EGS

Observed Fit Indices	Fit Indices Obtained for the EGS	Fit Indices Obtained for the Modified Version of the EGS
χ2/df	3.806	2.784
GFI	0.913	0.936
NFI	0.901	0.930
CFI	0.925	0.954
SRMR	0.581	0.042
RMSEA	0.990	0.079

The CFA results show the model to have acceptable fit indices. However, *RMSEA*=0.99 exceeded the acceptable value of 0.80 (Browne & Cudeck, 1993). At this point, modification suggestions were taken into account to obtain a better fit. Therefore, modification indices (*MI*) were evaluated. *MI* looks at the covariance between the observed and latent variables and suggests modifications for the model (Tortop, 2013). Upon evaluating the modification suggestions, the covariance value for Items 8 and 9 were found to contribute the most to the overall model fit. After combining these two items which have a theoretical connection, the model fit indices were re-evaluated. The new model showed good fit. The CFA results for the 10-item scale confirmed the one-factor structure of the original model over a Turkish sample. The scale's factor loadings range from .46 to .77 (see Figure 1).

Figure 1.
Modified one-factor model of the Existential Gratitude Scale.



Criterion-Related Validity

The EGS' criterion-related validity was examined by computing Pearson correlations with the Turkish version of the Short Gratitude Resentment and Appreciation Scale (S-GRAT) and with the Transpersonal Gratitude Scale (TGS). Moderate but significant and positive correlationswerefound between the EGS and TGS (r=.529, p<.05) and the EGS and S-GRAT (r=.476, p<.05). EGS scores also reveala significant and positive correlation with the TGS sub-dimensions ofvalue of gratitude (r=.320, p<.05), transcendent gratitude (r=.617, p<.01), and spiritual connection (r=.526, p <.05). In addition, EGS scores reveala significant correlation with S-GRAT's sub-dimensions ofsimple appreciation (r=.471, p<.05 and appreciation for others (r=.304, p<.05).

Item Analysis

Theitem-totalcorrelationsandupperandlower27%groupcomparisonwereexamined to evaluate EGS' item distinction. The independent samplest-test was calculated to determine the mean differencebetween theupper 27% and lower 27% groups in terms of item scores. Wiersma and Jurs (2001) suggested27%to bea good value in terms of the number of cases for analysis and item distinction level. The difference in means betweenthe upper and lower 27 percentile groupswascalculated,whichresulted in statistically significant t-values for all items (p<.01) and ranged from 10.12 to 18.35 (Table 2). Also, the item-total correlationsforthe scale wereexamined by calculating thePearson product-moment correlations. According to Stevens (2002), the cut-off value for item inclusion should exceed .30. EGS's item-total correlations range from .443 to .721, indicating all the itemshave acceptable values (Table 2).

Table 2.
Existential Gratitude Scale's Item Analysis Results

Item #	Item-Total Correlation	t Upper 27%-Lower 27%
EGS 1	.506	10.72*
EGS 2	.670	10.12*
EGS 4	.656	14.12*
EGS 6	.443	10.53*
EGS 8	.671	14.13*
EGS 9	.678	14.60*
EGS 10	.721	17.98*
EGS 11	.698	18.35*
EGS 12	.666	16.78*
EGS 13	.706	16.08*

*p<.01

Reliability Study

For the reliability analysis, Cronbach'salpha ofinternal consistency was calculatedas .893 for the overall EGS, indicating good reliability (Creswell,2003).

Discussion

This study has aimed to adapt the Existential Gratitude Scale developed by Jans-Beken and Wong (2019) to Turkish culture and to examine its psychometric properties. None of the analyses run for checking the instrument's validity and reliability contained the reverse-scored filler items 3, 5, or 7, as suggested in the original study (Jens-Beken & Wong, 2019). Because they create a different factor and negatively affect the analysis results, they were included in the final version of the scale only to check for response bias.

Confirmatory factor analysis was run to examine the EGS' structural validity. CFA is "a type of structural equation modeling that deals specifically with measurement models" (Brown & Moore, 2012, p.361). It can be used for several reasons such as evaluating the psychometric properties of measurement tools (Brown & Moore, 2012). According to researchers, an $\chi 2/df < 5$ indicates acceptable fit (Marsh & Hocevar, 1985), and *GFI* and *CFI* > 0.90 indicate good fit (Arbuckle, 2014; Hoe, 2008). An *RMSEA* < 0.080 (Browne & Cudeck, 1993) or $0.05 < RSMEA < 0.08$ (Arbuckle,2014) indicates acceptable fit. An *SRMR* 0.80 shows acceptable fit (Hu & Bentler, 1999). As such, the EGS can be said to have acceptable and good fit indices and the original one-factor structure of the scale to have been confirmed.The factor loading values being between .46 and.77 also show similar results to the values in the original study (i.e., between .52 and.74; Jens-Beken & Wong, 2019).

Upon examining the criterion-related validity, the EGS' relationships with the Turkish version of the TGS (Kaplaner & Ekşi, 2020) and S-GRAT (Oğuz-Duran, 2017) resulted in significant positive relationships. Moreover, the item-total correlations and group comparisons of the upper and lower 27 percentiles were examined for analyzing the EGS' items. According to Tavşancıl (2006), item-total correlation values greater than .40 indicate very good item values. Each item can be said to have good consistency with the overall scale. Also, the item distinction test for the upper and lower 27 percentile groups' mean differences resulted in significant t values ($p < .01$). Thus, the EGS can also be concluded to have satisfactory distinction power.

For the scale's reliability analyses, Cronbach's alpha was computed as .893, which is very similar to that from the original study ($\alpha = .87$). A Cronbach's alpha greater than .70 generally indicates an acceptable value (Kaplan & Saccuzzo, 1982; Nunnally, 1978). According to George and Mallery (2012), a Cronbach alpha greater than .90 shows excellent internal consistency, whereas .80 shows good, .70 shows acceptable, .60 shows questionable, .50 shows poor, and less than .50 shows unacceptable internal consistency. The EGS can therefore be concluded as having a good level of internal consistency.

The current study has several strengths and limitations. Firstly, the EGS is different from other gratitude scales in the sense that it aims to measure the tendency of being

thankful in difficult times. Jens-Beken and Wood (2019) showed existential gratitude to be a construct distinct from dispositional gratitude. Therefore, researchers and practitioners in mental health settings may benefit from using the EGS in addition to scales measuring gratitude from a dispositional perspective such as S-GRAT. In this way, they can obtain a more encompassing picture by taking gratitude as a coping mechanism and making appropriate interventions for different groups. Based on the existential positive psychology perspective (Wong, 2016), further studies can focus on developing interventions or activities that aim to increase gratitude in hardship or painful times, such as the existential gratitude exercise Wong (2016) proposed. As studies have examined positive gratitude interventions' effect on individuals (Drążkowski et al., 2017; Killen & Macaskill, 2015; Parnell et al., 2020), future research can investigate existential gratitude exercises' effects.

Another point regarding the study is that EGS is a short scale easy to administer and score. Also, the sample of the study consists of a wide age range (18 to 53). Moreover, one limitation of the study is its use of the convenience sampling method, which could create sample bias. The probability sampling method can be used in future studies. Additional validity and reliability studies such as convergent-divergent validity or test-retest reliability may also be conducted on more diverse groups to strengthen the results' generalizability and consistency.

To conclude, the Existential Gratitude Scale isa one-dimensional scale with 13 items and is a valid and reliable instrument usable in the context of Turkey. This scale can be a valuable tool for psychological counselors in assessing gratitude in painful times and making appropriate interventions to develop coping mechanisms with which people may celebrate adversity.

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Compliance with Ethical Standards

The authors of this study obtained official permission from the Marmara University, Education Sciences Institution Ethics Committee (Permission No.8-17 dated September 2021). All the steps in the study were conducted according to the ethical standards of research and publication. Informed consent was obtained from the participants in the data collection process, and their voluntary participation was taken into consideration.

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Appendix A

Varoluşsal Şükür Ölçeği Türkçe Formu

Bu ölçek var oluşsal şükür düzeyini ölçmek için geliştirilmiştir. Lütfen her cümleyi okuyun ve sizin hayatınızı ne derece ifade ettiğini belirtiniz. Aşağıda yer alan derecelendirmeye göre, uygun seçeneği işaretleyerek cevabınızı veriniz.

1) Kesinlikle katılmıyorum
2) Katılmıyorum
3) Kısmen katılmıyorum
4) Kararsızım
5) Kısmen katılıyorum
6) Katılıyorum
7) Tamamen katılıyorum

1. Hayatım zorluk ve acılarla dolu fakat yine de şükredebiliyorum.
2. Acı çektiğim zamanlarda bile yaşadığım hayat için şükrediyorum.
3. Hayat bana adil davranmadığı için dargınım.
4. Zorlukların üstesinden gelmemin bir sonucu olarak iç kaynaklarımın artmasından dolayı şükrediyorum.
5. Keşke bu hayata gelmeseydim
6. Yaşamımdaki insanlara, bana çok fazla acı yaşatmış olanlara dahi, minnettarım.
7. Başıma gelen tüm kötü deneyimler için hala acı hissediyorum.
8. Hayat benim için çok zor olsa da, yaşamak için sahip olduğum şeylerden dolayı şükrediyorum.
9. Her krizin gelişimim için bir fırsat sunmasından ötürü minnettarım.
10. Hiç bir şey yolunda gitmese bile her günün sonunda şükrediyorum.
11. Acı çekerek şükretmenin önemini öğrendim
12. Acı çekmenin inancımı ve karakterimi güçlendirmesinden ötürü minnettarım.
13. Çaresiz zamanlarda, üstesinden geleceğime olan inancım için “şükrediyorum

Madde 3,5 ve 7 katılımcıların cevaplarındaki tutarlılığı kontrol etmeyi amaçlayan maddelerdir. Toplam varoluşsal şükür düzeyini belirlemek için geri kalan 10 maddeden alınan puan ortalaması belirlenmelidir.

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Research Article

The Relationship between Spiritual Well-Being and Fear of COVID-19 in Individuals with Chronic Disease during COVID-19 Outbreak

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Abstract

The aim of this research is to determine the relationship between the spiritual well-being levels of individuals with chronic diseases and their fear levels of COVID-19 during the COVID-19 pandemic. The study was designed and conducted as cross-sectional and correlational research. The research was conducted with 323 individuals with chronic diseases living in Iğdır city located in the Eastern Anatolia Region of Turkey between the dates 05th of June of 22nd of June of 2020. Data were collected using a personal information form, Spiritual Well-Being Scale (FACIT-Sp), and Coronavirus Fear Scale (C19P-S). Mean, percentile distributions, and Pearson Correlation Analysis were used to analyze the data. It was determined that total score average of the participants on the FACIT-Sp was 28.94±5.61, and it was 59.43±16.71 for the C19P-S. It was determined that individuals' spiritual well-being and fear of COVID-19 mean scores were moderate, while meaning, peace, and faith sub-dimension domains were above the moderate level. In addition, it was indicated that the psychological and social fear levels of were above the average, and their somatic and economic fear levels were below the average.A negative significant relationship was found between the levels of meaning, faith and peace in the spirituality sub-dimensions of individuals with chronic diseases and the fear of coronavirus. It was observed that as individuals' spirituality increased, their fear of coronavirus decreased.It was recommended to provide telephone consultation service to individuals with chronic diseases during the pandemic to reduce their fear levels and inform them using mass communication methods.

Keywords:
COVID-19 • Fear • Chronic Disease • Spiritual Well-Being.

COVID-19 Salgın Sürecinde Kronik Hastalığı Olan Bireylerde Manevi İyi Oluş ile COVID-19 Korkusu Arasındaki İlişki

Öz

Bu araştırmanın amacı, COVID-19 salgını sürecinde kronik hastalığı olan bireylerin manevi iyi oluş düzeyleri ile COVID-19 korku düzeyleri arasındaki ilişkiyi belirlemektir. Araştırma tanımlayıcı ve kesitsel türde yapıldı. Araştırma 05-27.06.2021 tarihleri arasında Türkiye'nin Doğu Anadolu Bölgesinde yer alan bir şehirde yaşayan kronik hastalığı olan 323 birey ile yürütüldü. Veriler kişisel bilgi formu, Manevi İyi Oluş Ölçeği (FACIT-Sp) ve Koronavirüs Korku Ölçeği (C19P-S) kullanılarak toplandı. Verilerin değerlendirilmesinde; ortalama, yüzdelik dağılımlar ve Pearson Korelasyon analizleri kullanıldı. Katılımcıların manevi iyi oluş ölçeği toplam puan ortalamasının 28.94±5.61, koronavirüs korku ölçeği puan ortalamasının 59.43±16.71 olduğu belirlendi. Bireylerin manevi iyi oluş ile COVID-19 korku puan ortalamalarının orta seviyede olduğu, anlam, barış ve inanç alt boyut puan ortalamalarının ise, orta seviyenin üstünde olduğu belirlendi. Kronik hastalığı olan bireylerin psikolojik ve sosyal korku düzeyleri ortalamanın üstünde, somatik ve ekonomik korku düzeyleri ortalamanın altında olduğu saptandı. Kronik hastalığı olan bireylerin maneviyat alt boyutlarında yer alan anlam, inanç ve barış düzeyleri ile koronavirüs korku düzeyleri arasında negatif yönlü anlamlı bir ilişki bulundu. Bireylerin maneviyatları arttıkça koronavirüs korku düzeylerinin azaldığı görüldü. Pandemi döneminde kronik hastalıkları olan bireylere korku düzeylerini azaltmada kitle iletişim yöntemleriyle bilgilendirme ile telefonla danışmanlık hizmeti verilmesi önerilebilir.

Anahtar Kelimeler:
COVID-19 • Korku • Kronik Hastalık • Manevi iyi oluş.

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Coronavirus (COVID-19) is an infectious disease that has become an important public health problem in many countries around the world, including Turkey. Starting from Wuhan, China, in early December 2019, COVID-19 spread to the whole world in a short span of time (Zhaoet al., 2020; Arslan et al., 2020). Not only did COVID-19 pose serious threats to physical health, but many factors such as the uncertainty of the disease, social distancing, self-isolation, and quarantine began to affect the psychological and mental health of people (Cao et al., 2020; Chen et al., 2020; Yıldırım&Solmaz, 2020). Studies show that the COVID-19 pandemic has serious consequences, especially on people with chronic diseases (Büssing et al., 2020; Guan et al., 2020; Huang et al., 2020). "Chronic diseases are long-term diseases that progress slowly, last for three months or longer, are caused by more than one risk factor, usually have a complicated course, have no definitive treatment, and affect the quality of life of the person" (World Health Organization, 2020). The Centers for Disease Control and Prevention (CDC) analyzed a group of patients hospitalized with the diagnosis of COVID-19 in 14 states in March 2020, and many patients were found to have serious underlying health problems. It was determined that 89% of patients had at least one chronic disease, and this rate increased to 94% for patients 65 years and older (Centers for Disease Control and Prevention, 2019). In another study conducted in Wuhan, mortality was reported as 61.5% in 52 intensive care unit patients infected with SARS-CoV-2 (Yang et al., 2020).

During the COVID-19 pandemic, health personnel who are not experts in the field of chronic diseases were assigned to the COVID-19 clinics. This has jeopardized the treatment and care of oncology patients, the elderly, and people with chronic conditions (Wang & Tang, 2020). It is stated that some elderly patients, especially with chronic diseases, begin to experience widespread anxiety about discontinuation or termination of treatment due to sudden separation from their loved ones, lack of livelihood, loss of freedom, and uncertainty of the status of the disease (Brooks et al., 2020). Different quarantine policies have been implemented in different countries to contain the coronavirus (COVID-19) pandemic in a timely manner. In this case, it was stated that patients with chronic diseasessuch as cardiovascular diseases, cancer, diabetes, etc. begin to experience emotional discomfort, depression, anxiety, anger, and fear (Wang et al., 2020; Zhang & Song, 2020; Ing et al., 2020). Individuals' reactions to a chronic illness are usually in the form of feelings of tension and anxiety. These emotional states can occur in the form of indifference towards behaviors and the environment and excessive fear of many things (Baldacchino, 2006).

It is indicated that due to emotional changes such as depression, anxiety, and fear experienced during the chronic disease process, patients are in search of spirituality to cope with these problems (Balboni et al., 2013). Although a single, all-encompassing, definition is not available, spirituality can be described as "the aspect of humanity that

refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred," (Puchalski et al., 2014) Religion is a related concept that can be described as a group of beliefs about the transcendent that are shared by a community (Balboni et al., 2010). Koeing et al. (2004) stated in their study that spiritual attitudes and experiences are more common in hospitalized patients. It is emphasized that spiritual attitudes are associated with improved social support, psychological and physical health, and spiritual attitudes reduce the number and duration of hospitalizations (Koeing et al., 2004). Studies show that spiritual well-being reduces the level of anxiety and fear in chronic diseases, plays an important role in the fight against the disease, helps patients adapt to the disease, improves and develops mental health, and increases the quality of life (Davison & Jhangri, 2010; Hosseini et al.., 2013; Momeni et al., 2013; FaezehTorabi et al., 2017). Moreover, studies have also shown that spirituality is a factor that has a positive effect on mental health, especially in cancer patients (Boscaglia et al., 2005; Choumanova et al., 2006; Narayanasamy, 2003; Albayrak et al., 2019). Spirituality comes to the forefront especially in difficult times when a person's values and beliefs such as emotional stress, physical illness and death are threatened or when an individual is in an existential crisis and trying to find answers about life and eternity, and failing to reach the meaning of life, hope, power, and resources of connection (Arslan & KonukŞener, 2009; Chatrung et al., 2015).

It is stated that the spiritual needs of individuals have increased during the COVID-19 process and the importance of spirituality has become more prominent (González-Sanguino et al., 2020). In the religious coping theory developed by Pargament, it is stated that individuals with stronger religious orientation benefit from more spiritual coping practices. It is reported that spirituality has an important place in people's lives, helping individuals to make sense of, maintain and transform their lives. It is emphasized that spiritual coping fulfills five main functions such as discovering meaning, gaining control, gaining comfort through proximity to the Creator, reaching closeness with others, and transforming life. Spirituality generally functions as a protective force in the coping process. Spirituality is said to help preserve feelings of meaning, mastery, and spiritual connection during a life crisis, while religious coping is increasingly protecting people from the harms of stress. At the same time, it is stated that spiritual coping practices are very effective in reducing stress, no matter how intense the stress is (Pargament et al., 2004; Xu, 2016). It is emphasized that spirituality is an important tool to cope with the problems experienced by individuals with chronic diseases during the COVID-19 pandemic, and it positively affects the treatment received by the patient (Wu & McGoogan, 2020). More studies on mental health and spirituality are expected to be conducted during COVID-19 pandemic (Simon et al., 2020). When the literature is examined, it is seen that individuals with chronic diseases cannot benefit enough from spiritual care services during the

COVID-19 process due to lack of time, professional training and lack of awareness. It also shows that individuals cannot reach spiritual care services adequately due to cultural differences among healthcare professionals, patients and their families, and individual, institutional, and cultural barriers. Spiritual care practices should be considered as an indicator of the quality level of the provided services, as in some developed countries. This study was conducted to determine the relationship between the spiritual well-being levels of individuals with chronic diseases and their COVID-19 fear levels.In addition, this study will help determine the relationship between concepts and attach more importance to spiritual care practices.

Research Questions

• Is there a relationship between the spiritual well-being levels of individuals with chronic diseases during the COVID-19 epidemic and their COVID-19 fear levels?

• What are the spiritual well-being levels and COVID-19 fear levels of individuals with chronic diseases during the COVID-19 epidemic?

METHOD

The study was conducted as cross-sectional and correlational research. The research was conducted with 323 individuals with chronic diseases living in Iğdır city located in the Eastern Anatolia Region of Turkey between 05-27 June 2020.

Study Group

This study used snowball sampling.Snowball sampling technique is used when it is difficult to access individuals that make up the universe or when information about the universe is incomplete. This technique focuses on people and critical situations from which rich data can be obtained and reaches the universe by following these people and critical situations (Creswell, 2013). The universe of the study consisted of all individuals with chronic diseases who complied with the inclusion criteria (based on individual statements when meeting inclusion criteria) between the specified dates. This study was conducted with 323 Male (n=127, age=49.71±12.74), Female (n= 196, age=48.16±11.76) participants. The inclusion criteria for the present study are as follows: being 18 years old or older, not having a neurological disorder that would prevent the person to fill out the forms related to the study, not having a psychiatric diagnosis (depression, personality disorder, substance abuse, etc.), not having a communication problem, and being open to cooperation.

Data Collection Tools

Personal Information Form

The form was prepared by the researcher, and it consists of eight questions regarding the participants' age, gender, level of education received, employment status, occupation, perception of quality of life (self-report), marital status, and economic status (Bostan et al., 2020; Kasapoğlu, 2020; Ceyhan & Ünsal, 2018).

Spiritual Well-Being Scale (FACIT-Sp)

The original scale was developed by the Functional Assessment of Chronic Illness Therapy, Spiritual Well-Being Scale (FACIT–Sp). The scale was translated into Turkish, and validity and reliability were measured by Aktürk et al. (2017). It is a 12-item scale that evaluates spiritual well-being. The scale has three subscale domains: meaning, peace, and faith. The items are scored on a five-point Likert-type scale as "not at all" (0 point), "a little bit" (1 point), "somewhat" (2 points), "Quite a bit" (3 points), and "Very much" (4 points). The higher the scale score, the better the spiritual well-being (Aktürk et al., 2017). In this study, the Cronbach alpha internal consistency coefficient of the FACIT–Sp scale was found 0.82.

The COVID-19 Phobia Scale (C19P-S)

C19P-S is a 5-point Likert-type self-assessment scale developed by Arpacı et al. (2020) to measure phobia that may develop about the coronavirus. The items in the scale are rated on a 5-point scale from "Strongly Disagree" (1) to "Strongly Agree" (5). The scale consists of 20 questions and psychological, psycho-somatic, social, and economic subscales. The total C19P-S score is obtained by the sum of the subscale scores and ranges from 20 to 100 points. A higher score obtained from the scale indicates a greater phobia. In this study, the Cronbach alpha internal consistency coefficient of the C19P-S scale was found 0.78.

Data Collection

The questionnaires were prepared through Google Forms and the data were collected by sending the link to the individuals with chronic diseases via WhatsApp and Telegram. In data collection, "Questions Regarding Individuals' Socio-Demographical Characteristics", "Spiritual Well-Being Scale" and "COVID-19 Phobia Scale" were used.

Data Analysis

The data were analyzed with SPSS 25.0 statistical software. Descriptive features such as frequency, percentage, mean, and standard deviation were used to evaluate the

data in the study. The conformity of the data to the normal distribution was evaluated with skewness and kurtosis values. C19P-S (skewness: .080, kurtosis: -.786), and FACIT-Sp (skewness: -.066, kurtosis: .139) were found to show normal distribution. Pearson correlation analysis was used to examine the relationship between COVID-19 fear level and spiritual well-being level.

Ethical Aspect of the Study

Approval for the study was obtained from the Scientific Research and Publication Ethics Committee (number: 10879717-050.01.04). The consent of the participants was obtained online by giving information about the purpose and method of the study, the time they will allocate for the study, the fact that participating in the research would not cause any harm, and the participation was completely voluntary.

RESULTS

When the distribution of the demographic characteristics of the participants is examined, it was investigated that the average age of the participants is 48.86±21.98, 60.7% of the participants are female, 54.5% are primary school graduates, 60.1% are married, and it was determined that 44.3% responded to the question of regarding their perception of their mental health as moderate, while 45.8% responded to the question regarding their perception of their quality of life as moderate (Table 1).

Table 1.
Descriptive characteristics of Individuals

Variables	(n=323)	
	Number	**%**
Age		
18-35	105	32.5
36-53	64	19.8
54-61	42	13.0
62 and older	112	34.7
Gender		
Female	196	60.7
Male	127	39.3
Chronic disease		
Cardiac	71	22
Hypertension	80	25
Diabetes	45	14
Other	127	39
Education		
Primary School	176	54.5
Secondary School	52	16.1
Certificate	83	25.7
Graduate and Postgraduate	12	3.7
Marital Status		
Married	194	60.1

Single	129	39.9
Assessment of mental health		
Poor	36	11.1
Moderate	143	44.3
Good	104	32.2
Very good	40	12.4
Perception of quality of life		
Poor	24	7.4
Moderate	148	45.8
Good	121	37.5
Very good	30	9.3

The mean scores of the subscales of the COVID-19 phobia scale are as follows: psychological factors 20.68±5.80 (above the average), psycho-somatic factors 12.16±4.47 (below the average), social factors 15.76±5.22 (above the average), economic factors 10.81±3.57 (below the average), and in total 59.43±16.71 (moderate). The mean scores of the subscales of the spiritual well-being scale are as follows: meaning 9.11±2.26 (above the moderate), peace 8.08±2.50 (above the moderate), faith 11.73±2.90 (above the moderate), and in total 28.94±5.61 (moderate) (Table 2).

Table 2.
Minimum, maximum and mean scores distribution for FACIT-sp and C19P-S

Scale		Minimum	Maximum	Mean scores
Coronavirus Phobia Scale	Psychological	6.00	30.00	20.68±5.80
	Somatic	5.00	25.00	12.16±4.47
	Social	5.00	25.00	15.76±5.22
	Economic	4.00	20.00	10.81±3.57
	Total	20.00	97.00	59.43±16.71
Spiritual well-being scale	Meaning	0.00	16.00	9.11±2.26
	Peace	1.00	16.00	8.08±2.50
	Belief	2.00	16.00	11.73±2.90
	Total	13.00	44.00	28.94±5.61

When the relationship between individuals' spiritual well-being and coronavirus fear levels is examined (Table 3.), it is seen that there is no significant relationship between the average total score of spiritual well-being and the total score of the fear of coronavirus, and there is a negative relationship between the individuals' psychological fear level of coronavirus and peace & faith, which are the sub-dimensions of spiritual well-being ($p<.05$). It was investigated that there was a statistically significant negative correlation between the participants' psycho-somatic coronavirus fear levels and meaning & peace ($p<.05$). The results also revealed that there was a statistically significant negative correlation between the level of

coronavirus social fear and peace & belief ($p<.05$). It was determined that there was a statistically significant negative correlation between the total score of COVID-19 phobia scale and the peace sub-dimension ($p<.05$). This study explored that as the spiritual well-being levels of individuals with chro nic diseases increased, their somatic coronavirus fear levels decreased (r= -.173, p=.002), (Table 3).

Table 3.
The relationship between Individuals' Mean Scores of FACIT-sp and C19P-S

Spiritual Well-Being Scale					
		Meaning	Peace	Belief	Total
Coronavirus Phobia Scale	Psychological	r= -064 *p*=0.250	r= -.183* ***p*=0.001**	r= -.148* ***p*=0.008**	r= -.031 *p*=0.581
	Somatic	r= -.150* ***p*=0.007**	r= -.191* ***p*=0.001**	r= -.052 *p*=0.350	r= -.173* ***p*=0.002**
	Social	r= -.019 *p*=0.739	r=-.132* ***p*=0.018**	r= -.143* ***p*=0.010**	r= -.008 *p*=0.890
	Economic	r= -.072 *p*=0.196	r= -.107 *p*=0.054	r= -.087 *p*=0.117	r= -.032 *p*=0.569
	Total	r= -.084 *p*=0.133	r= -.179* ***p*=0.001**	r= -.101 *p*=0.070	r= -.061 *p*=0.271

*$p<0.05$ significant.

Discussion

It is stated that pandemic diseases cause serious negative and traumatic effects on people (Göksu & Kumcagiz, 2020). The COVID-19 pandemic also causes psychological problems such as panic disorder, fear, anxiety, and depression in individuals (Zhang et al., 2020; Wang et al., 2020; Takieddine & Tabbah, 2020). Individuals with high spirituality become more resilient in difficult and traumatic times such as the COVID-19 process and can adapt more easily to the new situation (Ing et al., 2020). Spiritual suffering during the COVID-19 pandemic can intensify the feeling of losing the meaning of life and even the loss of faith. The present study is important in terms of explaining the importance of spiritual well-being in individuals' tendency to struggle with life events. The information to be obtained regarding the pandemic might guide the prevention and intervention studies. The findings of this study, which was carried out to examine the relationship between the fear of coronavirus and the level of spiritual well-being of individuals with chronic diseases, were discussed in line with the literature. In this study, it was determined by the researchers that the coronavirus fear levels of individuals were moderate.

Researchers argued that diabetic patients are quite disturbed and worried due to the thought of being infected during the COVID-19 process (Joensen et al., 2020). It is emphasized that those with chronic diseases have more anxiety, fear, and stress symptoms towards coronavirus infection (Emami et al., 2020; Guoet al., 2020; Mazza et al., 2021; Özdin & Bayrak Özdin, 2020; Alacahan et al., 2021). Gyasi (2020) stated that the fear of individuals increased during the pandemic process and

their mental health was negatively affected. It was indicated by the researchers that cancer patients have a high level of fear of coronavirus (Erşen et al., 2020).Altundağ (2021), in his study to determine the fear of COVID-19 and psychological resilience during the pandemic period, explored that individuals with chronic diseases have higher coronavirus fear levels (Altundağ, 2021). In addition, in a study conducted in Israel, a positive relationship was found between fear of COVID-19 and having a chronic disease (Bitan et al., 2020). Doshi et al. (2020) reported in their study that individuals' coronavirus fear levels are below the average. The results of the present study differ from the results of Doshi et al.'s study. It is thought that this result is due to the low educational status of the individuals included in their study. Findings of some studies showed that educational level affects the level of fear (Celik & Edipoglu, 2018; Ruhaiyem et al., 2016). In the present study, it was investigated that the spiritual well-being levels of the individuals were above the medium level.

Increasing the level of spiritual well-being is accepted as a life-enhancing factor and coping resource that allows patients to cope with difficulties better (Heidari et al., 2019). Gürsu and Ay (2018) and Doğan (2018) conducted studies with elderly individuals living with their families, and it was found that the level of spiritual well-being of the individuals was above the medium level (Gürsu & Ay, 2018; Doğan, 2018). The fact that the individuals' spiritual well-being was above the medium level is thought to be caused by their spending more time with their families because of their anxiety and the quarantine process. In addition, it is thought that the spiritual needs of individuals arise from the fact that they are used more in crisis situations. Individuals feel happier and safer when they live with their relatives. It was argued that individuals who experience happiness in their spiritual world can overcome cognitive negativities by further strengthening their ties with life in an environment where they receive respect and love (Öz, 2001).

This study was conducted by the authors to better understand the relationship between spiritual well-being and fear of COVID-19. When the studies conducted in and out of Turkey are examined, it was noticed that, to the best knowledge of the authors, no study has been found that examines the relationship between fear of coronavirus and spiritual well-being in individuals with chronic diseases. For this reason, at the stage of discussing the findings we have obtained, it has been tried to reach a conclusion by comparing it with the results of the relevant literature, which is considered to contribute to the interpretation of similar study findings. In this study, a significant negative correlation was found between somatic fear and spiritual well-being. In the present study, the researchers stated that the increase in the level of spiritual well-being of individuals with chronic diseases will decrease their negative thoughts about the physiological problems. It is emphasized that mental changes in individuals can increase the fear of their bodies (Güner & Ural, 2017).

Gashi (2020) indicated that spiritual coping has contributed positively to the pandemic process. In addition, it was emphasized that spirituality makes positive contributions to people in the fight against coronavirus as well as in the face of similar disasters and crises. The findings of Gashi's study show similarity with the present paper. Researchers explored that a significant relationship was found between the fear of COVID-19 and spirituality (Hatun et al., 2020). However, there are only a few studies confirming this relationship during the COVID-19 pandemic. Among these few studies, Roberto et al. (2020) examined the relationship between COVID-19, spirituality, and resilience, and they investigated that spirituality also affects resilience in the context of COVID-19 (Roberto et al., 2020). Similarly, in the study conducted by Maraj et al. (2020), the relationship between resilience and hopelessness was investigated and it was stated that spirituality was effective in this relationship. Spirituality plays an important role in better coping with crises and traumas such as the COVID-19 pandemic (Baykal, 2020).

It was also argued that spiritual coping has a stress-relieving role among the American Jewish community dealing with the COVID-19 epidemic in the most affected region of the USA (Pirutinsky et al., 2020).

In this study, a negative significant relationship was found between the level of COVID-19 somatic fear and meaning & peace. It is thought that individuals can make sense of the fear that occurs, and that they make a spiritual effort to overcome it, and this allows them to think positively. Studies on spiritual meaning, which is one of the variables that give meaning to life, indicate that spiritual meaning is positively related to positive psychological health indicators and it helps to prevent psychological risk factors (Katsogianni & Kleftaras, 2015; Emmons, 2003). It is emphasized in the present paper that there is a negative significant relationship between the level of COVID-19 psychological fear and meaning & peace. It can be said that patients try to make positive sense of their psychological fears and to come to terms with this fear. In the study of Walsh (2020), the fact that this fear has not been experienced before during the pandemic process makes it difficult for the individual to understand this situation. It is also emphasized that individuals are making an effort to understand the consequences of COVID-19 and uncertainties about the disease (Walsh, 2020).

The emergence of mental problems also pushes people to different searches. These searches focus especially on understanding and making sense of events. It is stated that spirituality is the most sheltered place for human beings in terms of understanding and interpretation. Interventions and practices that will strengthen spirituality or a strong perception of spirituality reduce the fear that may occur in the individual (Gashi, 2020). In this study, the authors revealed that building better coping mechanisms and having resilience are possible with higher spiritual well-

being. Thus, both individuals and authorities can attach importance to the spiritual well-being of individuals and adopt a more holistic approach that includes both scientific and spiritual coping methods to combat the pandemic. The COVID-19 fear of people with chronic diseases is caused not only because they are in the risk group for COVID-19, but also the difficulties they experience in the management of their chronic diseases and their feeling of stigma. It is thought that the development of appropriate follow-up and treatment strategies for individuals with chronic diseases during the pandemic and the priority of risk groups in terms of psychological support for fear of COVID-19 will yield positive results.

Conclusion and Recommendations

In Turkey, no study has been found that examines the relationship between the spiritual well-being of people with chronic diseases during the COVID-19 process and the fear of COVID-19. It was determined that most of the participants could not perceive their quality of life and mental state appropriately. The findings of the study revealed that the spiritual well-being levels of individuals with chronic diseases were above the moderate level; similarly, the fear levels of COVID-19 were determined to be at a moderate level as well. The results also revealed that there was a statistically significant negative correlation between the level of coronavirus social fear and peace & belief. As the spiritual well-being levels of individuals with chronic diseases increase, the levels of COVID-19 fear decrease. Therapy applications to improve mental health can be offered online during the epidemic and similar periods. Therapeutic practices to improve mental health can be offered online during the pandemic. Close monitoring and control of chronic diseases will not only positively change the course of pandemic but will also enable the correct use of limited resources in the health sector.In such pandemic times, special online trainings aimed to increase awareness can be organized regarding meaning and purpose of life for people with different cultures, worldviews, and lifestyles. It may be recommended to carry out larger studies to determine the spiritual well-being levels of individuals with chronic diseases. It is thought that it would be beneficial to provide training on the methods of coping with the psychosocial and somatic fears experienced by individuals with chronic diseases during the epidemics. It is thought that it will be important to give more place to spiritual care in patient care in order to increase the level of spiritual well-being of patients.

Limitations of the Study

Since the research was conducted online, it was not possible to reach individuals with limited use of technology and it was not known whether they or the people they live with have caught the virus in this process.

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Conflict of interest

The authors declare no conflict of interest in this study.

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Research Article

Evaluation of Attitudes Towards Seeking Mental Health Services From a Cultural Perspective: Turkish Adaptation of Barriers to Seeking Mental Health Counseling Scale

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Abstract

The aim of this study is to adapt the Barriers to Seeking Mental Health Counseling Scale (BSMHCS) developed by Shea, Wong, Nguyen and Gonzalez (2019) to Turkish. Data were collected from 465 university students and 302 adults. The six-factor structure in the original form of the scale was tested with CFA in university students, and the six-factor model gave an acceptable fit. The factor loadings of the items in the scale varied between .45 and .91, and the item-total score correlation coefficients varied between .30 and .54. The Cronbach Alpha internal consistency coefficient was found as .870. Test-retest correlation coefficients for the total scale was calculated as .764. The Cronbach Alpha value was found as .843, and the item total correlations varied between .32 and .70 for the adult study group. As a result of CFA, it was found that the factor loadings varied between .31 and .93. The positive correlations between the BSMHS and the BSPHS revealed that the criterion-related validity of the scale was at an acceptable level. The results showed that the Turkish form of the BSMHCS is a valid and reliable measurement tool for both university students and adults and can be used in Turkish culture.

Keywords:
Barriers to seeking help • Mental health service • Psychological help • Reliability • Validity.

Ruh Sağlığı Hizmeti Aramaya Yönelik Tutumların Kültürel Açıdan Değerlendirilmesi: Ruh Sağlığı Danışmanlığı Aramanın Önündeki Engeller Ölçeği Türkçe Geçerlik ve Güvenirlik Çalışması

Öz

Bu çalışmanın amacı Shea, Wong, Nguyen ve Gonzalez (2019) tarafından geliştirilen Ruh Sağlığı Danışmanlığı Aramanın Önündeki Engeller Ölçeği'ni (RSDAÖEÖ) Türkçe'ye uyarlamaktır. Çalışma, üniversite öğrencileri ve yetişkinler olmak üzere iki grupta gerçekleştirilmiş, çalışma grubunu 465 üniversite öğrencisi ve 302 yetişkin birey oluşturmuştur. Dilsel eşdeğerlik çalışması Psikolojik Yardım Aramanın Önündeki Engeller Ölçeği (PYAÖEÖ) ile gerçekleştirilmiş ve iki ölçek arasındaki pozitif korelasyon, ölçeğin ölçüt geçerliliğinin kabul edilebilir düzeyde olduğunu ortaya koymuştur. Ölçeğin test-tekrar test korelasyon katsayıları .764 olarak hesaplanmıştır. Ölçeğin orijinal formundaki altı faktörlü yapı üniversite öğrencilerinde DFA ile test edilmiş ve altı faktörlü model kabul edilebilir bir uyum sağlamıştır. Üniversite öğrencileri çalışma grubunda ölçekte yer alan maddelerin faktör yükleri .45 ile .91 arasında, madde-toplam puan korelasyon katsayıları ise .30 ile .54 arasında değişmektedir. Ölçek fromunun Cronbach Alpha iç tutarlılık katsayısı .870 olarak bulunmuştur. Yetişkin çalışma grubu için Cronbach Alpha değeri .843 bulunmuş, madde toplam korelasyonları .32 ile .70 arasında değiştiği görülmüştür. Yapılan DFA sonucunda faktör yüklerinin .31 ile .93 arasında değiştiği bulunmuştur. Sonuçlar, RSDAÖEÖ'nün Türkçe formunun hem üniversite öğrencileri hem de yetişkinler için geçerli ve güvenilir bir ölçme aracı olduğunu ve Türk kültüründe kullanılabileceğini göstermiştir.

Anahtar Kelimeler:
Yardım aramanın önündeki engeller • Ruh sağlığı hizmeti • Psikolojik yardım • Güvenilirlik • Geçerlik.

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Seeking help to solve a problem is a natural process that many individuals engage in almost every day, and this help process covers a wide area from working on family issues to grief (Hinson & Swanson, 1993). Individuals can get help from informal sources such as friends and family to solve these problems, as well as from formal sources such as mental health professionals and teachers (Rickwood, Deane, Wilson, & Ciarrochi, 2005). Since many individuals see professional help as a last resort (Cramer, 1999), individuals prefer to refrain from seeking professional help for mental health problems or to delay receiving help (Clement et al., 2014). Andrews, Issakids and Carter (2011) stated that approximately 60% of individuals did not receive professional help during the year following the onset of the mental health problem and only 11% of individuals received direct assistance from a mental health professional. Arslantaş (2003), examined the attitudes of adults seeking professional psychological help and observed that individuals seek help from their families in the first place, rather than their friends and then professionals such as psychiatrists, counselors or psychologists.

There are several reasons why getting help directly from a mental health professional is one of the last choices and its low preference. Some individuals consider receiving help from experts as embarrassing, difficult and risky (Kushner & Sher, 1989), while others relate it to failure in daily life (Carnevale, 2001). Also, individuals may be reluctant to receive professional mental health services due to attitudinal and instrumental obstacles (Salaheddin & Mason, 2016). Problems such as lack of awareness about the problem, denial of the problem, not knowing the source to ask for help, lack of time, and having difficulty expressing emotion are among these obstacles (Gulliver, Griffiths & Christensen, 2012). In addition to these obstacles, variables that affect the attitudes and intentions of individuals in seeking / receiving psychological help in adult studies are gender (Mackenzie, Gekoski & Knox, 2006; Thao, 2004), social stigmatization and self-stigma (Barney, Griffiths, Jorm & Christensen, 2006), the fear of treatment (Skultety, 2003) and self-hiding (Serim and Cihangir-Çankaya, 2015). According toThompson, Brazile and Akbar (2004), besides stigmatization, variables such as lack of knowledge, lack of cultural understanding, and financial barriers are also affecting the decision of getting psychological help. Topkaya (2015) also concluded that individual, cultural and practical obstacles are factors that affect the preference of seeking psychological help. Bicil (2012) and Topkaya (2011) stated that social stigmatization negatively affects individuals' intention to seek psychological help.

University students also experience problems related to relationships, stress / anxiety, family problems, personality disorders, suicidal ideation, sexual abuse, depression, problems in academic and professional life, eating disorders, grief, alcohol and substance abuse, economic and emotional problems (Benton, Robertson,

Tseng, Newton & Benson, 2003; Topkaya & Meydan, 2013) and thus is one of the groups that needs professional psychological support. Yeşilyaprak (1986) stated that students who applied to the psychological counseling service have complaints such as distress, unhappiness, unwillingness, tension, and difficulty in controlling anger. They try to solve these problems on their own first and if they cannot, then they get help from their parents, friends, teachers and a mental health professional (Cramer, 1999; Özbay, Terzi, Erkan & Cihangir Çankaya, 2011). It was seen that their descending sort in seeking help for these problems would be their family, friends and finally to a mental health professional (Kıranşal, Biçer, Alkan & Akça, 2008; Koydemir & Demir, 2005; Topkaya & Meydan, 2013). In their study with university students, Vogel, Wade, Wester, Larson, and Hackler (2007) concluded that only 15% of students with mental health problems seek help. Harrar, Affsprung and Long (2010), mentioned that the studies that investigate the problems of university students, focus mostly on students who apply to university counseling centers yet there is less focus on students who need mental health counseling but do not apply to counseling centers, and there are also students who do not apply to counseling centers although they have psychological problems.

As in adults, there are barriers that prevent university students from seeking help. Similarly, barriers that affect the attitudes of seeking / receiving psychological help to solve the problems experienced by university students can be listed as stigmatization by society (Kavas, Topkaya & Gençoğlu, 2014; Shea & Yeh, 2008; Topkaya, 2011; Vogel, Wester & Boysen, 2005), self-stigmatization (Corrigan, 2004; Gürsoy and Gizir, 2018; Ina and Morita, 2015; Sezer and Gülleroğlu, 2016; Topkaya, 2014; Vogel, Wade and Hackler, 2007), self-hiding (Cramer, 1999; Liao, Rounds and Klein , 2005; Özbay, Terzi, Erkan and Cihangir Çankaya, 2011), gender (Erkan, Özbay, Cihangir-Çankaya and Terzi, 2012; Kalka and Odacı, 2005; Komiya, Good and Sherrod, 2000; Topkaya and Meydan, 2013; Türküm , 2000; Vogel, Wade, Wester, Larson & Hackler, 2007; Vogel, Wester, & Larson, 2007), fear of treatment (Carlson, 2001; Deane & Chamberlain, 1994; Kushner & Sher, 1989), culture (Yakunina and Weigold , 2011) and whether or not receiving psychological help before (Sezer & Gülleroğlu, 2016).

Since there are many factors affecting individuals' search for psychological support, there are many research and measurement tools in the current literature that examine individuals' attitudes and intentions to seek professional psychological help. While there are two measurement tools (Mansfield, Addis, and Courtenay, 2005; Shea, Wong, Nguyen, and Gonzalez, 2019) in the foreign literature for individuals' barriers to seeking psychological help, there is only one measurement tool in the Turkish literature (Topkaya, Şahin & Meydan, 2013). It is thought that the Barriers to Seeking Mental Health Counseling Scale developed by Shea, Wong, Nguyen and Gonzalez in 2019 differs from other scales with sub-dimensions such as lack of

access and cultural barriers, and the item designed just to receive information about cultural definitions of the individual. With this research, it was aimed to adapt the Barriers to Mental Health Consultancy Scale developed by Shea, Wong, Nguyen and Gonzalez in 2019 to Turkish culture and to examine its psychometric properties. The scale is thought to be useful for researchers and practitioners serving in the field of mental health.

Identifying common factors that prevent individuals from getting mental health counseling is of great importance for both individual and community mental health. By contributing to the identification of these obstacles, this measurement tool is expected to be beneficial to mental health counselors in studies to positively support the mental health of university students and adults, eliminate existing obstacles or take precautions. It is foreseen that it will contribute to the studies aiming to test whether the culture is effective in the formation or overcoming of the obstacles with the cultural barriers sub-dimension especially in the countries with different cultures. In addition, the validity and reliability study of the scale was made on both the university students and the adult sample, and this scale could be used in adults. For this reason, it is thought that the adaptation of the Barriers to Seeking Mental Health Counseling Scale to Turkish will have an important place in future studies.

METHOD

Research design

This research is a measurement tool adaptation study. In line with the purpose of the study, the Barriers to Seeking Mental Health Counseling Scale, developed by Shea, Wong, Nguyen and Gonzalez (2019) to determine the barriers to getting help for university students, was adapted to Turkish culture. After the scale was translated into Turkish by following the adaptation stages of a measurement tool, a linguistic equivalence study was carried out, and confirmatory factor analysis, criterion-related validity, internal consistency, test-retest study and item analysis were carried out within the scope of validity and reliability analysis. The ethical approval of the study is received from Marmara University Educational Sciences Ethics Commission with the approval code of 200223319.

Study group

The study group of the research consists of 465 students, studying at various universities in Istanbul in the spring semester of the 2019-2020 academic year. The ages of 155 male and 350 female university students participating in the study vary between 18-28. 110 of the participants had received psychological support before, 355 of them did not. While 402 participants stated that they would want to get

psychological support in case of need, 63 participants stated that they would not. In the adult study group, a total of 302 adult participants, 172 women and 130 men, were reached, observed that the age of the participants was between 22 and 59 and their mean age was 35. While 70 of the participants stated that they had received psychological help before, 232 people stated that they did not receive help. 206 of the participants stated that they would receive psychological help in case of need, and 94 people stated that they would not receive help. While 59 university students applied for the criterion-based validity study; test-retest study was conducted with 39 university students three weeks apart. The ages of 23 female and 16 male students in the test-retest study group ranged from 18 to 25, with an average age of 19.

Data collection tools

In the study, the "Barriers to Seeking Mental Health Counseling Scale (BMHCS)", the "Demographics Form" created by the researchers, and the "Barriers to Seeking Psychological Help Scale (BSPHS)" were used as data collection tools. Even though these two scales seem similar, BMHCS differs from BSPHS in analyzing the effect of cultural barriers and emotions.

Demographics: The form developed by the researchers consists of questions such as age, gender, whether they have received professional help before, and whether they want to receive professional help in need.

Barriers to Seeking Mental Health Counseling Scale (BMHCS): It was developed by Shea, Wong, Nguyen and Gonzalez in 2019 to determine the factors that prevent university students from receiving mental health counseling. The measurement tool consists of 27 items and 6 dimensions called Negative Perceived Value, Discomfort with Emotions, Ingroup Stigma, Lack of Knowledge, Lack of Access, and Cultural Barriers. Items are rated as 6-point Likert type, with options ranging from 1 (strongly disagree) to 6 (strongly agree). The total variance explained varies between .84 and .89. Internal consistency coefficients of the sub-dimensions of the scale are *Negative Perceived Value*.74, *Discomfort with Emotions* .88, *In-Group Stigma* .86, *Lack of Information* .88, *Lack of Access* .82 and *Cultural Barriers* .83.

Barriers to Seeking Psychological Help Scale (BSPHS): It was developed by Topkaya, Şahin and Meydan in 2017 to determine the barriers that affect university students' receiving psychological help. The measurement tool consists of 17 items in five sub-dimensions called Fear of Being Stigmatized by Society, Trust in The Mental Health Professional, Difficulties in Self Disclosure, Perceived Devaluation and Lack Of Knowledge. High scores reflect perceived higher levels of barriers in all dimensions. The scale items were rated in a 5-point Likert type, with answers between 1 (strongly disagree) and 5 (strongly agree). There is no reverse item in

the scale. The total Cronbach Alpha internal consistency coefficients of the scale obtained from different samples are above .70.

Procedure

As the first step, the researchers who developed the original scale were contacted in order to adapt the Barriers to Seeking Mental Health Counseling Scale to Turkish, and the permission to adapt the scale was received. During the adaptation of the scale to Turkish, the scale was translated into Turkish by five experts with sufficient language levels. In line with these translations, Turkish items that express the original items of the scale closest were selected and a temporary Turkish form was created. The created Turkish form was back-translated into English by an expert, apart from the experts involved in the first translation process. Another Turkish form was created by comparing the back translated version with the original form. The English form and the Turkish form of the scale were presented to the opinion of a competent English and Turkish speaking expert, and the final version of the Turkish form was prepared by taking the expert's opinion into consideration. A linguistic equivalence study was carried out by applying the English and Turkish forms of the scale to a group of 36 people who have sufficient knowledge of both languages with an interval of two weeks between two applications.

Structural validity and criterion validity studies were conducted for the validity studies of the Scale of Obstacles for Mental Health Counseling. Chi-Square Fit Test, Approximate Root Mean Square Errors (RMSEA), Comparative Fit Index (CFI), Root Mean Square Errors (RMR), Standardized Root of Mean Errors (SRMR), Normed Fit Index (NFI), Non-Normed Fit Index (NNFI), Akaike Criterion (AIC) and Expected Cross Validity Index (ECVI) were used. For the criterion-related validity study, the relationship between the scale and Barriers to Seeking Psychological Help Scale for College Students was examined. Barriers to Seeking Psychological Help Scle for College Students was chosen because it measures similar characteristics with the original form of the scale. Correlation analysis was performed for the relationship between scales and their sub-dimensions. Cronbach Alpha internal consistency and test-retest analysis were performed for the reliability study of the total and sub-dimensions of the scale.

RESULTS

Linguistic Equivalence

The original scale and Turkish form were applied to 36 participants who are fluently speaking English and Turkish with an interval of two weeks. It has been observed that there are no outliers and the data meet the assumption of normality. The relationship between two forms is given in Table 1.

Table 1.
Findings for the Linguistic Equivalence of BMHC

Dimensions	r
Negative Perceived Value (NPV)	.963*
Discomfort with Emotions (DWE)	.977*
In-Group Stigma (IGS)	.935*
Lack of Knowledge (LK)	.959*
Lack of Access (LA)	.951*
Cultural Barriers (CB)	.988*
Total	.984*

**p<0.01*

As seen in Table 1, the correlation coefficients between the subscales of the original and Turkish forms vary between .935 and .988 (p<.01). The correlation coefficient between the total scores of the scale found as .984 (p<.01). The positive and high correlation coefficients between the original and Turkish form reveals that linguistic equivalence is achieved.

3.2 | Item Analysis

In order to examine discriminative and predictive power of items for total score on BHMC, after normality of distribution was determined, item analysis was conducted. Findings of corrected item total correlation are presented in Table 2.

Table 2.
Corrected Item-Total Correlation Analyses

Item	*Corrected item total correlation analysis*
1	.191
2	.438*
3	.448*
4	.397*
5	420*
6	.433*
7	.385*
8	.403*
9	.419*
10	.322*
11	.503*
12	.450*
13	.386*
14	.505*
15	.400*
16	.431*
17	.444*
18	.484*
19	.499*
20	.306*
21	.465*
22	.417*
23	.356*
24	.480*
25	.463*
26	.370*
27	.541*

**p<0.01*

As observed in Table 2, it was determined that the corrected item total test correlations of all items except the first item ranged from .30 to .54. ($p<.01$). It can be seen that the correlation coefficient of the first item is found as .19. Since item total correlation coefficient above .30 are considered as good discrimination (Büyüköztürk, 2014), it can be said that all items except the first one have good discrimination.

When the first item was excluded, it was seen that the explained variance and Cronbach Alpha value would increase. For the purpose of examining the possible effect of removing the first item on the factor structure, exploratory factor analysis was conducted. It was observed that the first item did not enter the six-factor structure, but formed a different sub-dimension on its own. In this context, it was found that the first item, "I don't think talking with a mental health counselor would be helpful", did not work in Turkish culture and therefore this item was removed.

After testing the normality of distributions in the adult group and excluding outliers, corrected item correlations were found and presented in Table 3.

Table 3.
Corrected Item Total Correlation Results

Item No	Corrected Item Total Correlation
1	,274
2	,707*
3	,682*
4	,681*
5	,680*
6	,666*
7	,595*
8	,631*
9	,638*
10	,540*
11	,739*
12	,688*
13	,662*
14	,660*
15	,397*
16	,636*
17	,592*
18	,656*
19	,526*
20	,326*
21	,504*
22	,489*
23	,517*
24	,692*
25	,636*
26	,461*
27	,658*

$p<0.01$

As can be seen Table 3 was examined, it was found out that all items had a correlation coefficient above .30, and correlation coefficient of the first item was. 27 as in the university students. In this regard, it was decided to remove the first item for the adult population also.

Construct Validity

In order to examine the structure of the original scale consisting of six dimensions and 27 items, confirmatory factor analysis was conducted. Before CFA, sub-dimension and total scores of the scale were found to meet the normality assumptions by examining the normality of distributions, skewness kurtosis values and Kolmogorov Smirnov test (p> .05).

In order to evaluate fit between theoretical model and data, model fit indices was analyzed and presented in Table 4.

Table 4.
Indices for university students of BMHC

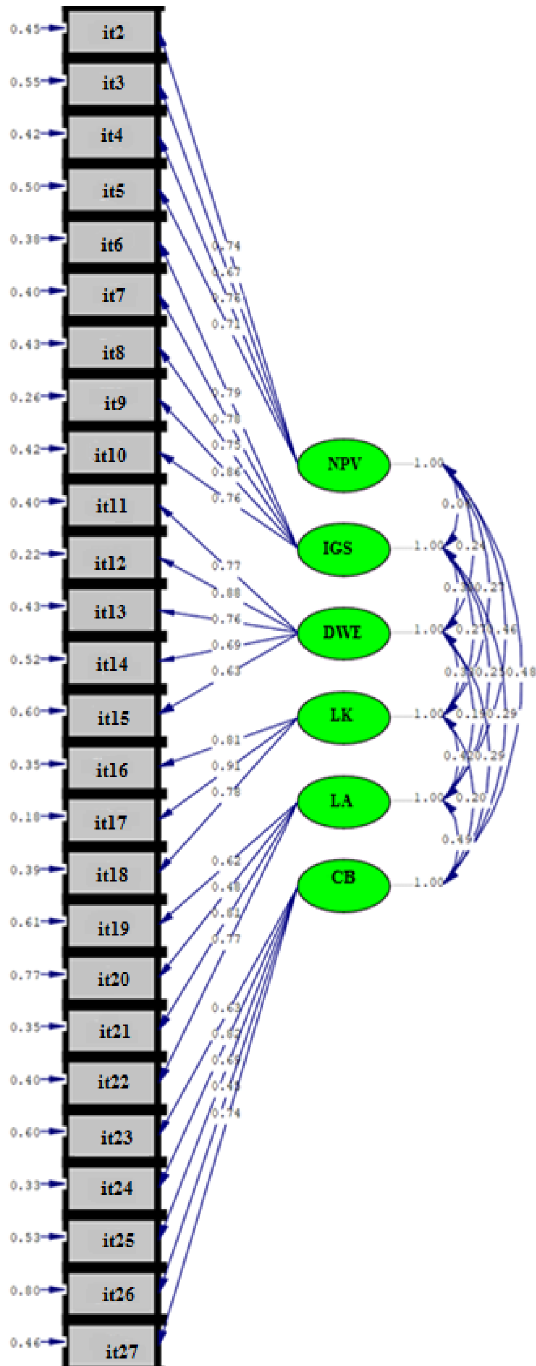
Goodness of fit	Model	Perfect Goodness of Fit	Acceptable Goodness of Fit
$\chi 2$	845,52		
sd	284		
$\chi 2$/sd	2.97	≤3	3< $\chi 2$/sd ≤5
RMSEA	.06	≤.05	.05<RMSEA≤.08
CFI	.95	≥.95	.90≤CFI<.95
SRMR	.06	≤.05	.05<SRMR≤.08
NFI	.92	≥.95	.90≤NFI<.95
NNFI	.94	≥.97	.95≤NNFI<.97

90% Probability Confidence Interval for RMSEA (0.062; 0.072)

As presented in Table 4, as a result of factor analysis, it reveals that values of models have perfect and acceptable goodness of fit. Values of RMSEA, RMR, SRMR, NFI and NNFI indicate acceptable goodness of fit and values of $\chi 2$/sd and CFI points out perfect goodness of fit (Çokluk, Şekercioğlu ve Büyüköztürk, 2012). The factor analysis showed that the six-factor structure of the scale was significant at. 05 level (t>1.96, p<.05) and error variances were different from zero. The six-factor structure and factor-loads of the scale are shown in Figure 1.

Figure 1.

Path diagram factor loadings six-factor structure of BMHC for university students



As seen in figure 1, relationship between latent variables and observed variables ranged from .67 to .76 for NPV, .75 to .86 for IGS, .75 to .86 for DWE, .63 to .88 for LK, from .48 to .81 for LA and from .45 to .82 for CB. It was observed that the factor loads of items varied between .45 and .91.

Since the original form of the scale was conducted on a sample of university students, the construct validity of the scale in the adult sample was examined with the CFI through the data collected from 302 adults. A modification was made between item 19 and item 20 and between item 23 and item 25 in line with the modification suggestions of analysis. Fit indices of final model are given in Table 5.

Table 5.
Indices for adults of BMHC

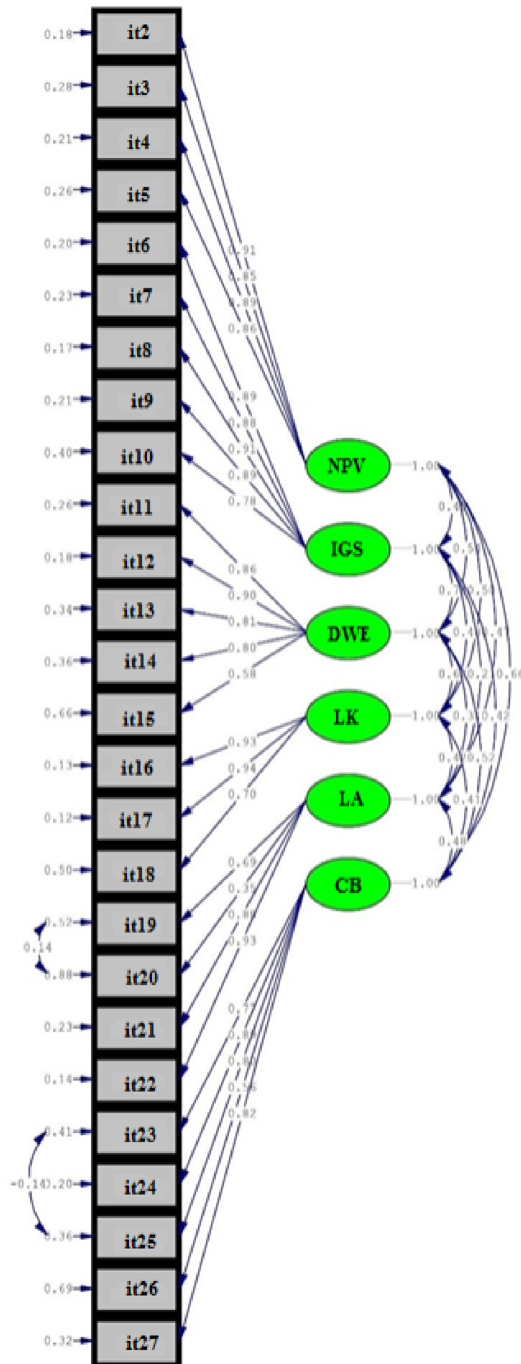
Goodness of fit	Model	Perfect Goodness of Fit	Acceptable Goodness of Fit
$\chi2$	790,59		
sd	282		
$\chi2$/sd	3.01	≤3	$3<X^2/sd \leq 5$
RMSEA	.07	≤.05	.05<RMSEA≤.08
CFI	.97	≥.95	.90≤CFI<.95
SRMR	.06	≤.05	.05<SRMR≤.08
NFI	.95	≥.95	.90≤NFI<.95
NNFI	.96	≥.97	.95≤NNFI<.97

90% Probability Confidence Interval for RMSEA = (0.072; 0.080)

As can be observed in Figure 2, relationships between latent variables and observed variables were between .85 and .91 for the NPV, .70 and .93 for the IGS, .58 and .90 for the DWE, .70 and .93 for the LK, .35 and .93 for LA, .56 and .82 for the CB. As a result, in the version of the scale applied to adults, the factor loadings varied between .35 and .93.

Figure 2.

Path diagram factor loadings six-factor structure of BMHC for adults



Criterion-Related Validity

For the purpose of examining criterion-related validity of BMHC, Barriers to Seeking Psychological Help Scale were applied to 59 university students and correlation analysis conducted between them. Correlation coefficient of scales and factors are presented in Table 6.

Table 6.
Correlation coefficient between BMHC and BSPHS

Factors	NPV	DWE	IGS	LK	LA	CB	BMHC
Fear of Being Stigmatized by Society	,292*	,410**	,535**	,391**	,232	,395**	,481**
Trust in The Mental Health Professional	,752**	,720**	,586**	,769**	,474**	,583**	,877**
Difficulties in Self Disclosure	,313*	,626**	,456**	,285*	,193	,302*	,461**
Perceived Devaluation	,350**	,477**	,488**	,378**	,280*	,462**	,530**
Lack of Knowledge	,658**	,381**	,374**	,651**	,581**	,670**	,781**
(BSPHS)	,509**	,642**	,585**	,561**	,416**	,627**	,738**

**p<0.05*
***p<0.01*
According to Table 6, a significant positive correlation was found between the total score of BHMC and SSRPH (r = .738, p <.01).

Reliability

Internal consistency coefficients and test-retest reliability coefficients were calculated to determine the reliability of the Turkish form of the scale, and the Cronbach Alpha internal consistency coefficients for scores of factors and whole scale are presented in Table 7.

Table 7.
Reliability Analysis Findings for Internal Consistency of BMHC for university students

Factors	Number of items	Cronbach α
NPV	4	.734
DWE	5	.872
IGS	5	.855
LK	3	.850
LA	4	.735
CB	5	.758
Total	27	.870

As seen in Table 7, the Cronbach Alpha internal consistency coefficient was found to be .870 for the total score. It was calculated as .734 for the negative perceived value, .855 for ingroup stigma, .872 for discomfort with emotions, .850 for the lack of knowledge, .735 for the lack of access and .758 for cultural barriers.

Table 8.
Reliability Analysis Findings for Internal Consistency of BMHC adults

Factors	Number of items	Cronbach α
NPV	4	.751
DWE	5	.758
IGS	5	.745
LK	3	.766
LA	4	.771
CB	5	.751
Total	27	.843

As examined in table 8, Cronbach Alpha internal consistency for the whole score was found as .843. It was calculated as .751 for the negative perceived value, .745 for ingroup stigma, .758 for discomfort with emotions, .766 for the lack of knowledge, .771 for the lack of access and .751 for cultural barriers.

Test-retest study was also conducted to test the reliability of the scale. The test-retest study was carried out with 39 university students in three weeks. Findings are presented in Table 9.

Table 9.
Test-retest reliability results

Factors	NPV	DWE	IGS	LK	LA	CB	Total of post-tests
NPV	.756 *						
DWE		.942*					
IGS			.822*				
LK				.756*			
LA					.775*		
CB						.687*	
Total of pretest							.764*

**p<0.01*

As seen in Table 9, the test-retest correlation coefficient of the scale was .764 for the total score. It was found as .756 for the negative perceived value, .822 for the ingroup stigma,.942 for discomfort with emotions, .756 for lack of knowledge, .775 for lack of access and .687 for cultural barriers. In the light of these results, it can be said that there is consistent between results of two applications and the second reliability condition is provided.

Discussion

The aim of this study is to adapt the Barriers to Seeking Mental Health Counseling Scale developed by Shea, Wong, Nguyen and Gonzalez (2019) to Turkish culture and to make validity and reliability analyzes. The Turkish translation of the scale was made by five experts with sufficient English and Turkish levels, and field of knowledge. Later, the scale was translated back into English by an expert different from the five experts involved in the first translation phase. By comparing the translations by the researchers, a draft Turkish form was created by selecting the translated items that give the closest meaning to the English items. The opinion of an expert who is competent in both languages was taken, and the final version of the form was formed by making necessary arrangements in line with the expert opinion. In the linguistic equivalence study conducted in line with the adaptation process of the scale, the relationship between the original form of the scale and the Turkish form was examined. The analysis revealed that all items of the scale provide linguistic equivalence.

In the construct validity study, the six-factor structure of the scale was tested by making confirmatory factor analysis. As a result of the analysis, it was seen that the six-factor structure was valid and the fit indices were at acceptable values. Item analysis of the Scale of Barriers for Mental Health Counseling was examined with corrected item total correlations. In the literature, items with item total correlation coefficient above .30 are considered as items with good discrimination (Büyüköztürk, 2014). Based on the analysis, it can be stated that the discrimination power of the items except the first item is sufficient. It was observed that the first item of the scale was lower than the accepted values and in the exploratory factor analysis, it was not included in the six-factor structure of the original scale and formed a sub-dimension on its own.

Two experts who are competent in both two languages were interviewed in order to discuss the reason for the low correlation coefficient of the item and the reason it creates a different factor. In the English version of the item, the negativity of the sentence can be given with "I don't think…" at the beginning of the sentence, but when this item is translated to Turkish it could be confusing since words with positive and negative meanings are at the end of the sentence. While in English, negative meaning can be given at the beginning of the sentence, in Turkish it is given with negative particle at the end of the sentence (İlhan, 2005). Thus, it is thought that the unexpected confusion is experienced in the Turkish version of the item because of the place of negative meaning in the sentence. This item was excluded from the analysis because the other items were also collecting information about opinions of the individual on receiving psychological help. However, in future studies, it is suggested that the Turkish version of this item could be written and after being discussed with the authors of the scale, can be added to the Turkish version of the scale and re-analyzed. In this context, it was deemed appropriate to remove the scale from the Turkish form because the first item did not give appropriate statistical results and the item did not function well in the Turkish cultural structure, and the psychometric qualities of the scale increased when this item was removed.

In the criterion validity study, the relationship between the Barriers to Mental Health Counseling Scale and the Barriers to Seeking Psychological Help Scale was examined. The analysis revealed that there is a significant relationship between the total score and sub-dimensions of the Barriers to Mental Health Counseling Scale, and the total score and sub-dimensions of the Barriers toSeeking Psychological Help Scale.

Cronbach Alpha internal consistency coefficient and test-retest reliability coefficient were calculated to determine the reliability of the scale. The threshold accepted in the literature for the Cronbach Alpha internal consistency coefficient is specified as .70 (Özgüven, 1994). It has been observed that the internal consistency coefficients of the total and sub-dimensions of the scale are above the acceptable

threshold in the literature. By applying the scale to the same group every three weeks, the relationship between the two applications was examined. The findings obtained show that the reliability of the whole scale and its sub-dimensions is sufficient.

The fact that it is not common to benefit from mental health services among adults as well as university students makes it necessary to understand the factors that prevent adult individuals from receiving mental health services. Accordingly, the scale was applied to individuals between the ages of 22-59 and the six-factor structure of the scale was examined with confirmatory factor analysis. As a result of the findings, it is seen that the six-factor structure of the scale tested in the sample of university students is also valid in the sample of adults and the fit indices are at acceptable levels.

As a result, the Turkish form of the Barriers to Mental Health Counseling Scale is a measuring instrument consisting of six sub-dimensions and 26 items. It is evaluated in 6-point Likert type which is answered between “1- Strongly disagree” and “6- Strongly agree”. There are 3 reverse items in the scale. The findings obtained as a result of the validity and reliability analysis reveal that the scale is a valid and reliable measurement tool. It is thought that the validity and reliability analysis of the scale in different sample groups will contribute to the future studies to be conducted. Data was collected in COVID-19 pandemic, which affected people’s perspectives about mental health counseling services, thus it is believed that later studies conducted after pandemics would contribute to the literature in seeing the differences in perspectives of people during and after pandemics.

This study has several limitations. An important limitation of the study is that the first item in the original form of the scale was removed from the Turkish form because the item discrimination was not sufficient. Another limitation is that the study is only for university students and adults. It is thought that it will be useful to examine the psychometric properties of the scale by applying it to different study groups in future studies. The low number of male participants in the sample of university students constitutes a limitation of the study. Studies with a more balanced participant profile can be carried out in the future. In addition, test-retest reliability analysis was not performed in the sample of adult individuals of the scale.

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Research Article

Spirituality-Based Addiction Counseling Model Proposal: Theory and Practice

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Abstract

This study aims to develop, implement, and test the effectiveness of a model prepared with a cross-disciplinary approach, which includes religious and spiritual elements that could be applied in the treatment of alcohol and substance addiction, especially in the rehabilitation process. The study adopts a mixed method research design. In the qualitative part, phenomenological analysis was used. In the quantitative section, scales were used to measure the participants' dependence. The study group included alcohol and substance addicts who were in the rehabilitation process at the Green Crescent Consultancy Center (YEDAM) and aged between 24and 56. Initially, the participants were given Addiction Profile Index (BAPI) to determine their demographic information, addiction level, and clinical chart, which is followed by Addiction Outcome Assessment Index (AOAI) during the interview process. Within the scope of the Spirituality-Based Addiction Counseling (MTBD) model, eight different interview sessions were held with each participant for an average of 45 minutes. Then, the data were discussed and evaluated in the light of the relevant literature. Quantitative findings indicated a slow but steady improvement in the participants, with slight fluctuations, from the pre-interview to the final interview (altruism) in MTBD Model. With regard to qualitative findings, the data showed that during the first steps of the model, the participants developed an awareness of how addiction affected them psycho-socially and spiritually, and during the following steps, this awareness was significantly effective in transforming their lives. It could be claimed that the model is a motivational element that reinforces the basic treatment and rehabilitation processes in the struggle to get rid of addiction and adds religious and spiritual meaning to this process.

Keywords:
Psychology of Religion • Addiction • Alcohol and Substance Addiction • Spirituality • Spirituality-Based Counseling • MTBD Model

Maneviyat Temelli Bağımlılık Danışmanlığı Model Önerisi: Kuram ve Uygulama

Öz

Bu araştırmada alkol ve madde bağımlılığının tedavisinde, özellikle rehabilitasyon sürecinde uygulanabilecek dini ve manevi unsurları içeren disiplinler arası yaklaşımla hazırlanmış bir modelin geliştirilmesi, uygulanması ve etkililiğinin sınanması amaçlanmıştır. Çalışmada karma yöntem kullanılmıştır. Nitel kısımda fenomenolojik analiz, nicel kısımda ise katılımcıların bağımlılığını ve bağımlılık seyrini değerlendirmek üzere ölçekler kullanılmıştır. Çalışma grubu, Yeşilay Danışmanlık Merkezi'nde (YEDAM) rehabilitasyon sürecinde bulunan ve yaşları 24-56 aralığında değişen 10 alkol ve madde bağımlısı ile gerçekleştirilmiştir. Başlangıçta katılımcılara demografik bilgilerini, bağımlılık düzeyini ve bağımlılık klinik tablosunu belirlemek üzere Bağımlılık Profil İndeksi (BAPİ-K), görüşmeler sürecinde ise Bağımlılık Seyir İndeksi (BASİ) uygulanmıştır. Maneviyat Temelli Bağımlılık Danışmanlığı modelinin adımları kapsamında katılımcıların her biri ile ortalama 45 dakikalık 8 görüşme gerçekleştirilmiştir. Elde edilen veriler ilgili literatür eşliğinde tartışılıp değerlendirilmiştir. Nicel bulgular, Maneviyat Temelli Bağımlılık Danışmanlığı (MTBD) ön görüşme adımından son görüşme adımına kadar geçen süre içerisinde hafif dalgalanmalarla beraber katılımcılarda yavaş yavaş ancak istikrarlı şekilde ilerleyen bir iyileşmenin gerçekleştiğini ortaya koymuştur. Nitel bulgularda ise, modelin ilk adımlarında katılımcıların bağımlılığın kendilerini psiko-sosyal ve manevi anlamda nasıl etkilediğine dair bir farkındalık geliştirdikleri ve sonraki adımlarda bu farkındalığın yaşamlarında dönüşüm yapmalarında hissedilir oranda etkili olduğu görülmüştür. Modelin, bağımlılıktan kurtulma mücadelesinde temel tedavi ve rehabilitasyon süreçlerini pekiştiren ve bu sürece dini ve manevi anlam katan bir motivasyon unsuru olduğu anlaşılmaktadır.

Anahtar Kelimeler:
Din Psikolojisi • Bağımlılık • Alkol ve Madde Bağımlılığı • Maneviyat • Maneviyat Temelli Danışmanlık • MTBD Modeli

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The link between addictive substances and humanity goes historically far back (Babaoğlu, 1997). It is even claimed that homo sapiens and psychoactive substances mutually affect each other's evolution (Mutlu, 2018). People use these substances for different purposes such as therapeutic purposes, for entertainment, and for religious purposes. While the history of addictive substances is as old as the history of humanity, the history of the treatment of addictions that develop with the use of addictive substances does not go back to such ancient times. Historical and scientific records indicate that addiction evolved throughout a very longtime period when it was described as a moral problem to a new period when it was explained with the concept of disease.

Addiction was seen as a moral problem and weakness of willpower until the beginning of the 20th century. Addicts were marginalized, severely punished, and demonized while the treatment of addiction was not even in question in this long historical period (Krushner, 2006, s. 131). Over the years, this unfavorable understanding has left its place to the *disease* approach. Benjamin Rush, known as the Father of Psychiatry in America, claimed that there was no difference between the mental and the physical, and he shared his observations and views on alcoholism as a disease in his work titled *An Inquiry of the Effects of Ardent Spirits Upon the Human Body and Mind* (Rush, 1823). With this study, alcohol addiction was first suggested as a disease. The most obvious point in Rush's definition of drunkenness was the "addictive" connection between the drinker and the drink. Rush suggested that the disease developed gradually, and as this process progressed, the person lost control over his or her drinking behavior (Schneider, 1978). In 1849, the Swedish doctor Magnus Huss took these steps further and named this disease as *alcoholism*. At the beginning of the 19th century, addiction was used (White, 2000a, p. 5). The backdrop for the ideas that addiction, which is defined as a brain disease today, is a disease was formed during this time. However, it took more than a century for this view to be accepted.

In the 1930s, addicts were gradually accepted in hospitals as patients rather than as corrupt people. By 1956, the American Medical Association declared in its annual report that it accepted alcoholism as a disease (AMA, 1956). Subsequently, with Jellinek's publication, *The Disease Concept of Alcoholism in 1960,* acceptance of the disease classification of alcoholism became widespread (Morgan, 1999). As addiction began to be explained physiologically with the "disease model", similar processes began to take place in the treatment process of addiction disease. Thus, the difficult process of eliminating the intense desire and deprivation caused by substance abuse in the human body was accepted as a disease that could be treated with the support of the addict's relatives under the supervision of relevant specialists despite all their hardships (Küçükşen, et al., 2016). However, we cannot say that the academic data on the disease model has thoroughly convinced the public. It should be noted that the outdated perception still exists in the society and impedes the recovery process of addicts.

With the acceptance of addiction as a disease, various solutions to the problem of addiction have begun to emerge. In this context, there are two approaches to the treatment process of alcohol and substance addiction: medical treatment and psycho-social treatments. Although the starting point of the treatment of the addicted individual changes with the process of using the substance, it generally starts with medical treatment, but the experience gained over the years shows that sometimes medical treatment alone is not enough. In cases where medical treatment was insufficient, various psycho-social treatments were needed.Therefore, various professional and amateur treatment models such as individual interview, group therapy, cognitive behavioral therapy, self-help groups, behavioral approach, samba, and therapeutic communities emerged (Ögel, 2017).

The treatment-oriented transformation in religious circles, which traditionally regarded addiction as a moral problem rather than an "illness", first began in 1774 with the publication of a booklet by the reformist Anthony Benezet, who adopted Quaker spirituality and claimed the necessity of abstaining from alcoholic beverages (Kurtz & Kurtz, 1985, p. 121)Unfortunately, this first spiritually-oriented step towards alcohol addiction in the United States did not continue. Due to the acceleration of medical approaches, medicine-based studies came to the fore for a long time until the "Emmanuel Movement" in 1906.

In 1906, at the Emmanuel Church in Boston, USA, a multidisciplinary treatment team was formed under the leadership of Dr Elwood Worcester combining three different disciplines: medicine, psychology, and religion (White, 2000b). This program was calledas *Emmanuel Movement.* The founder of this movement*, Dr* Elwood Worcester acknowledged that all diseases, including alcoholism, had physical, mental, and spiritual components. Dr Worcester suggested that the physical desire of alcoholics for the substance could be eliminated with a spiritual lifestyle, and this approach found application with the Emmanuel Movement (McCarthy, 1984a). Thus, for the first time in American history, alcoholics received outpatient or inpatient treatment including psychotherapy which incorporated religious resources (McCarthy, 1984b).

Unfortunately, this paradigm, in which religious and spiritual resources were used simultaneously with the medical and psychological treatment of addictions, came to an end with the retirement of the founders of the Emmanuel Movement. The fate of the Emmanuel Movement was due to the reticent approach of positive sciences. Psychiatrists and psychologists who adopted the positive science paradigm had difficulty in understanding the role that religion and spirituality played in curing the addiction, and this distanced stance prevented the continuity of multidisciplinary studies that started with the Emmanuel Movement (Schultz & Schultz, 2007). In

the following years, the pairing of the concept of spirituality and addiction became more visible with the success of the Alcoholics Anonymous (AA, henceforth) doctrine. Such that, there were even those who talked about the effect of AA in the transformation of the conceptual content of spirituality (Pargament, 1999).

In this context, it would be appropriate to refer to the letter records in which Bill Wilson, who is one of the founders of AA and made spirituality visible in addiction treatment, talks about his own addiction story and Carl G. Jung's story of his patient (Rowland Hazard). In these records (Wilson & Jung, 1987), Wilson reports how Jung led Hazard, who was described as a desperate case, into the recovery process. Jung's advice to the patient, who apparently tried all medical and psychiatric treatment methods, to *place himself in a religious atmosphere and hope for the best,* was remarkable. It was reported that the patient joined a religious society called the Oxford Group and attained sobriety over time. Moreover, Jung - in his reply letter to Bill Wilson - emphasized that the craving for alcohol was equivalent to spiritual thirst and finalized the text with the words: *You see, the Latin "alcohol" is spiritus and the same word is for the highest religious experience as well as for the most indecent poison. Therefore, the useful formula is:spiritus contra spiritum*(spiritual versus alcohol). As understood, AA was built on the concept of spirituality and created awareness about the effectiveness of spirituality in the treatment of addictions. Through the studies of the Emmanuel Movement and AA, Gregoire (1995) argued that alcoholism was best understood as a problem that affects the body, mind, and spirit.

Combating addiction includes multidisciplinary efforts in which different disciplines act together to protect the health and peace of society and future generations. In alcohol and substance addiction, which has a complex construct, individual's needs could be different, and treatment methods might vary accordingly. In the treatment, it is emphasized to consider what works for whom (Ayten, 2020). Therefore, the complex structure of addiction increases the rate of achieving positive results with the complementary work of the multidisciplinary team in the prevention and treatment processes (Köknel, 1983). It is noteworthy that terminological differences make multidisciplinary treatment and research approaches increasingly important (Kranzler & Li, 2008). It is claimed that multidisciplinary approaches, in which the spiritual dimension is taken into account by supporting medical and psychological treatments, are more effective on this ground. Several studies confirm this claim (Carter, 1998; Sanchez & Nappo, 2008; Heinz, et al., 2010; Kelly, et al., 2011). Recent research findings show that there is an inverse relationship between spirituality-religion and addiction (Park, et al. , 2017).

DiLorenzo, Johnson, and Bussey (2001, p. 271) define addicts as *having entered a spiritual predicament—a spiritual void that contributes to the individual's risk of being*

completely lost. In this regard, it seems that the lack of values such as "existence of a transcendent power, meaning and purpose in life, and interpersonal relations" drags some individuals into a spiritual void, and they *attempt to fill this spiritual void with a chemical* reality (Forcehimes & Tonigan, 2009).Compensation of spiritual thirst with substance is an attractive option that brings the individual to the source of pleasure in a short time. Substance abuse can also be preferred as a short way to avoid anxiety (Geçtan, 2021). In fact, it is understood that in addition to painful physical conditions, mental problems are also tried to be met by material means (Dass & Gorman, 1985). Wurmser (1997, p. 101) explains this situation in these words: "*The high relaxation and pleasure sought with the help of chemical substance seems to be an ideal substitute for what would normally be provided by the inner sense of meaning, goal orientation and value orientation.*" In fact, this substitute value is a chemical mythology. Thus, the individual who avoids facing his problems gets away from his/her problems suddenly. However, s/he might not realize that s/he is not able to solve his/her problems,which drags a bigger problem to the center of his/her life. With substance abuse, the person is drawn into a paradoxical situation and is alienated from his/her own existence (Wiklund, 2008a). By developing awareness of the addicted individual's spiritual values and goalsand understanding that addiction constitutes an obstacle in reaching these values, the ability to develop appropriate behaviors can be improved (Treloar, Dubreuil, & Miranda, 2014). Besides, focusing on the patient's spirituality might reduce suffering and promote growth (Wiklund, 2008b). Spirituality-based practices and awareness programs could increase recovery, prevent relapse, and allow the person to discover their strengths in the long run (Carter, 1998).Therefore, strengthening spirituality plays a key role in finding one's meaning and purpose in order to overcome addiction (Forcehimes & Tonigan, 2009). In addition, it is underlined by some researchers that spiritual values in general and the lifestyles prescribed by religions in particular have a structure that prevents the paths to addiction and supports the healing process (Ayten, 2020). However, the point to be noted here is to consider the possibility that religion and spirituality might not be a viable option for all addicts sincethere is no one-size-fits-all method in addiction treatment.

Today, interdisciplinary models, in which the fields of psychiatry, psychology, and theology could work together against addiction, are on the agenda again and it is hoped that this approach might be more useful. As mentioned earlier, spiritual approaches in the struggle against addiction have a long history in the West. In our country, when the studies on alcohol and substance addiction are examined, it is seen that the literature has a rich content. However, it is observed that studies on the relationship between addiction and spirituality are still in their infancy and no systematic suggestions are offered in the fight against addiction, and spirituality-based approaches are mostly designed with traditional practices. There is a need for a systematic structure based on spirituality in the struggle against alcohol and substance addiction. In line with this need, Ögel, Ayten, İşbilen, Şimşekand Çetin-

Şeker (2018) developed a model called «Spiritual Based Addiction Counseling» (MTBD, henceforth) based on the spiritual dimension of the human being, and it is suitable for our culture with its religious and spiritual content. MTBD was prepared predicated on an interdisciplinary approach, and it includes religious and spiritual elements which could be applied in the treatment of alcohol and substance abuse, especially in the rehabilitation process. This counseling model aims to create an environment where the counselee feels himself/herself at home in terms of his/her spiritual values. Thus, bearing the awareness of religious and spiritual values in mind, we hope that the counselee will stay away from addictive substances permanently. In this study, the MTBD model was applied for the first time. Following sections reportthe implementation of the model and its effect on alcohol and substance addicts.

Method

Mixed method research design was adopted in order to benefit from the objectivity offered by quantitative research owing to statistical data and the opportunity of qualitative research to evaluate the social phenomenon in its environment (İslamoğlu & Alnıçık, 2016).The rationale behind this preference is to expect more effective result from the mixed method in understanding an individual or social problem. A long-term practice was carried out with addicts in order to understand alcohol and substance addicts and addiction and to fight against addiction. In-depth interview technique was used as it provides the opportunity to better evaluate the feelings, thoughts, and behaviors of alcohol or substance addicted individuals. Questionnaire technique was used to determine the trajectory of effectiveness of the spiritual counseling model applied on the participants. To reach the main objectives of our study, the interpretative phenomenological method was preferred among the qualitative research analysis techniques, and the survey technique was chosen in the quantitative section. In this context, our study, which includes theoretical, quantitative, and qualitative stages, provides triangulation. The data obtained from the study were discussed and evaluated in light of the relevant literature.

The Study Group

The study group was determined by criterion sampling, one of the purposive sampling methods that paves the way for in-depth examination of small groups. As it is well-known, in the criterion sampling method, the cases that meet the predetermined criteria are examined (Patton, 1987, s. 56). In this context, the criteria for inclusion in the study were characterized as (1)residing in Istanbul, (2) continuing alcohol and substance abuse treatment in any of the YEDAM branches in Istanbul, (3) having a spiritual sensitivity, (4)being over age 18, and finally (5) voluntary participation. The process of applying the MTBD model was carried out within the scope of permission,

inspection, and request of YEDAM officials. The interview process was initiated after the psychologists detected a spiritual predisposition in the counselee during the psychotherapy process. In this direction, the working group was selected among alcohol and substance addicts who requested the MTBD model program while continuing their addiction treatment at Başakşehir YEDAM, Cerrahpaşa YEDAM, and Üsküdar YEDAM branches in Istanbul between 2019 and 2021,and the study group was limited to 10 people. The descriptive characteristics of the study group are provided in Table 1.

Data Collection Tools

In the study, the Addiction Profile Index (API) and Addiction Progression Index (BASI) scales were used in order to obtain information about the socio-demographic characteristics, personal characteristics, and addictions of the participants as well as to determine the course of addiction. For qualitative data, a structured interview form and a structured evaluation form were used. Information on quantitative and qualitative measurement tools is given below.

Addiction Profile Index (API). TheAPI was developed by Ögel, Evren, Karadağ, and Gürol (2012) to evaluate different dimensions of addiction and measure addiction severity. The API consists of five subscales with 37 questions: socio-demographic questions including personal information such as date of birth, gender, marital status, and then *substance use characteristics, addiction diagnostic criteria, the effect of substance abuse on one's life, strong desire to substance abuse, and motivation to quit substance abuse.* Each subscale is scored in itself and the score of each subscale determines the overall total score of the scale. Answer options were prepared in a 5-point Likert type scored in the range of 0-4 points. In terms of internal consistency to measure the reliability of the scale, the Cronbach Alpha value (α) of the whole scale is 0.89 and the Cronbach Alpha values (α) of the sub-dimensions are in the range of 0.63-0.86.

Addiction Cruising Index (BASI). The BASI was developed by Şimşek, Dinç, and Ögel (2021) to measure the progress of treatment and the level of improvement in addiction in all areas. In BASI, factors are discussed in social and substance-related areas. Social factors include areas related to participation in life, mental state, family relationships, employment status, and physical condition. Factors related to the substance include the amount and the frequency of alcohol-substance abuse and the desire to use alcohol-substance. The scale measures psycho-social recovery as well as quitting substance abuse in recovery. The BASI is an 11-item Likert-type measurement tool that measures the treatment progress of addicts in social and substance-related areas, and the response options are scored in the range of 0-4 points. In addition, the highest score that can be obtained from the scale is 44. The Cronbach Alpha coefficient (α) of the scale was found to be 0.80.

Semi-Structured Interview Form. At least 8 in-depth spiritual counseling interview sessions were carried out with each of the participants in the study. In these interviews, in which the steps of the proposed model were covered, a semi-structured interview form was prepared separately for each step to be directed to the counselees. While creating the interview form, the relevant literature, especially the studies in the field of psychology of religion on alcohol and substance addicts, was examined. In particular, the twelve-step recovery program of AA was taken into account. Then, a pool of questions suitable for working with experts in the field of psychology of religion was created. The prepared questions were checked by a psychiatrist who is anexpert in the field of addiction, two clinical psychologists who are experts in the field of addiction, and three experts in the psychology of religion. In light of experts' opinions, evaluations, and suggestions, necessary revisions were made and the interview form was prepared. Pilot interviews were conducted with alcohol and substance addicts using this interview form. As a result of the pilot study, some questions were eliminated and some questions were shortened or modified. The final version of the questions was presented to the experts. As a result of their approval, the semi-structured interview form was finalized, and it was ready for the implementation phase of the model.

Evaluation Form. This form has been prepared in order to determine both the participants' views and suggestions regarding the MTBD Model and the changes experienced in the dimensions of emotion, thought, and behavior during the process. In-depth interviews were conducted with the participants. As such, questions about the general information about the model, the involvement of a counseling on spirituality and religion in the treatment process, the evaluation of the effect of spirituality on awareness, and change in the treatment process were explored.

Process

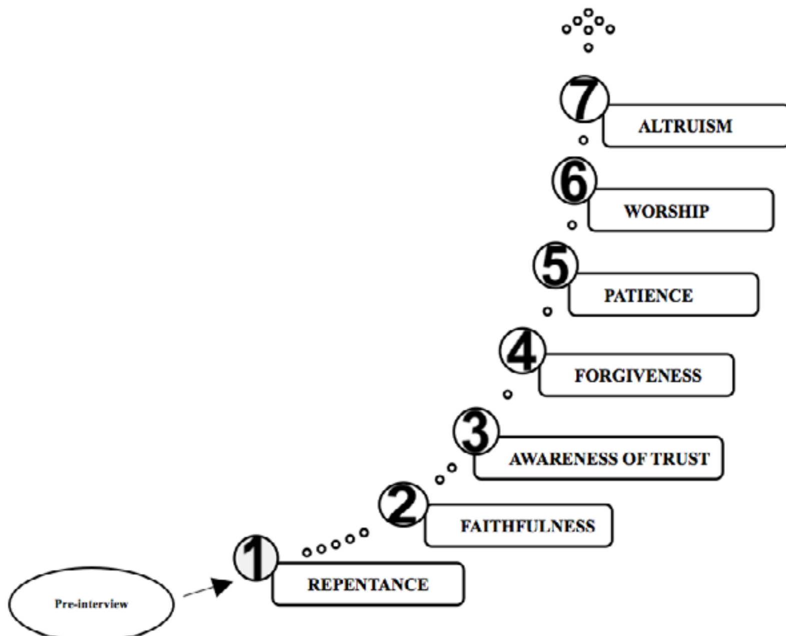
Preliminary Preparation. The steps of the MTBD Model were created by a team of 5 people, including the researcher, psychiatrists, psychologists, and psychology of religion experts. The content of the steps of the model was prepared by the researcher by examining the relevant literature and evaluated by the same team. The first version of the theoretical structure of the model was presented at the International Spiritual Counseling and Guidance Congress (Ögel, Ayten, İşbilen, Şimşek, & Çetin-Şeker, 2018; Ayten, 2020) held in Istanbul.This version of the model was restructured by the researcher, a pilot study was carried out, the content of the steps of the model was revised, and then the model was finalized.

Spirituality Based Addiction Counseling Model Interview Process and Evaluation. Each YEDAM counselee, who requested Spirituality-Based Addiction Counseling, were met in the prepared environment, namely in the meeting room

of YEDAM psychologists or social service professionals, through the YEDAM Public Relations specialist, on the day and time determined in accordance with the counselee and the spiritual counselor. The purpose of the meeting was explained to the counselee at the first meeting. Written informed consent was obtained by giving information about the nature of the interview sessions, how long they would last, the purpose of the audio recordings. Moreover, it was explained to the participants that the data obtained from the interview would remain confidential and that the interview sessions would continue as long as they volunteered to attend. In addition, the participants were informed that the voice recorder could be turned off at any time. First of all, a pre-interview session was carried out in order to determine why the client requested and what his expectations were for Spirituality-Based Addiction Counseling Model. Furthermore, information about the client's addiction history and religious and spiritual history was obtained.

The participants were informed that the interviews would be held weekly. As mentioned before, the MTBD model applied in the rehabilitation process of alcohol and substance addiction consists of 0+7 structured steps. These steps were carried out one-on-one by the researcher with each voluntary addict participating in the study, and an interview was held in the last session about the evaluation.

Figure 1.
Spirituality-Based Addiction Counseling Model



The Spirituality-Based Addiction Counseling (MTBD) Model. The model consists of 0+7 steps, and the progression of the steps consists of a sequence that will contribute to the rehabilitation process of the addicted individual. The steps of the model are interconnected and each step prepares the individual for the next step. The model includes a spiritual repair process that reaches altruism by starting the reconstructed life with repentance. At the first stage, the model constitutes the beginning of the journey to gain different perspectives by listening to the counselee's story effectively by the spiritual counselor as in all counseling processes. In the preliminary interview with the addicted individual, the spiritual counselor first introduces himself and obtains information about the addiction status of the addicted counselee. After the preliminary interview, the MTBD model includes a spiritual process that reaches altruism by starting the reconstructed life with repentance (step one). *Repentance* is the beginning of a spiritual process that begins when a counselee realizes that his relationship with Allah is about to deteriorate and that he accepts his mistake and confesses it to his Lord. The second step involves *honesty (*faithfulness*)* first to oneself, then to the creator, family, and the others. In the third step, the *sense of responsibility* and awareness of responsibility are reminded. The fourth step includes the process of *forgiving* the individual, his past, and reconciliation. The fifth step includes *patience* with the challenges of coping with addiction. In the sixth step, the individual learns to receive support from *prayer* and worship in the process. The seventh and final step is *altruism*. It is ensured that the individual gains awareness that he can do something for others. Each step has basic questions, similes, spiritual/moral stories, and religious text readings. This model is considered as a complementary supporting process to the psychological treatment that the individuals receive during the rehabilitation process.

Analysis of Data

Evaluation of Quantitative Data. The scales were applied in a test and re-test design. Thus, to understand what kind of change the participants experienced during the MTBD process, the quantitative data were analyzed in the SPSS program.

Evaluation of Qualitative Data. During the analysis of the data, the questions posed to the participants within the scope of the research and the steps of the model were taken into account. Thus, the upper and lower themes were determined by the phenomenological analysis method. The data analysis is as follows:i) the interviews on the voice recorder were deciphered without intervention and converted into written text;ii) A holistic evaluation of the participants' experiences was made and themes were organized,iii) In this direction, the processes of defining and interpreting the findings were carried out respectively. While performing data analysis, the conversations on the voice recorder were transcribed verbatim, and transcripts were carefully read from beginning to end, thereby making a holistic assessment of the participants' experiences. Themes were identified and the findings were interpreted.

Results

In this part of the study, the quantitative and qualitative findings obtained as a result of the analyses were included. In the quantitative part, first of all, the descriptive characteristics of the participants and their addiction trajectories during the Spirituality Based Addiction Counseling model interviews were presented in order to reveal the socio-demographic profile of the participants.

Quantitative Stage

Table 1.

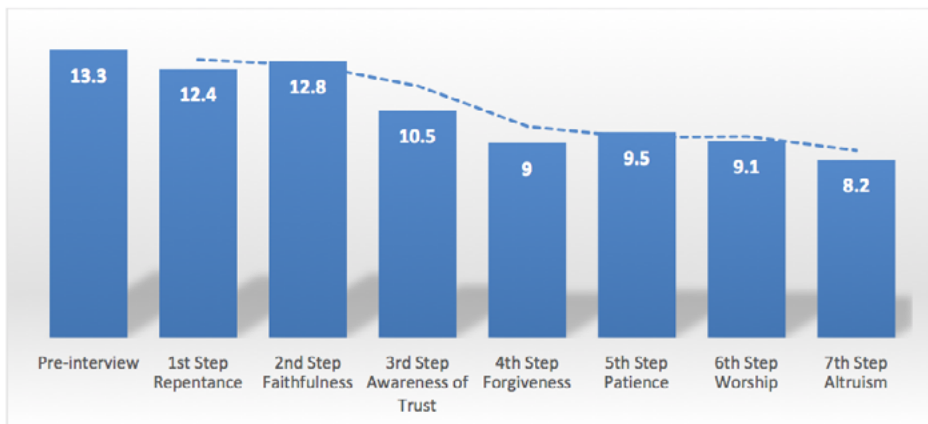
Socio-Demographic Profile of the Study Group

Nickname	Gender	Age	Marital Status	Education Level	Working Status	Economic-Situation	Substance Used
Umut	Male	27	Single	High-school	Has an irregular job	Middle	Cigarette, Alcohol, Synthetic Cannabinoid (Bonsai)
Salih	Male	48	Married	High-school	Has a regular job	Middle	Cigarette, Alcohol, Marijuana
Fuat	Male	33	Single	High-school	Has a regular job (family business)	High	Cigarette, Alcohol, Marijuana, Cocaine, Stone (Crack Cocaine)
Onur	Male	44	Single	High-school	Has an irregular job	High	Cigarette, Alcohol, Marijuana, Cocaine, Stone (Crack Cocaine)
Kerem	Male	39	Single	High-school	Has an irregular job	Middle	Cigarette, Alcohol, Marijuana
Selim	Male	52	Married	Middle -School	Has an irregular job	Middle	Cigarette, Alcohol
Tamer	Male	36	Married	High-school	Has a regular job (family business)	Middle	Cigarette, Alcohol, Marijuana, Synthetic Cannabinoid (Bonsai), Ecstacy (Ecstasy)
Özgür	Male	24	Single	Associate degree	Has a regular job (family business)	High	Cigarette, Alcohol, Synthetic Cannabinoid (Bonsai)
Arda	Male	56	Married	High-school	Retired	Middle	Cigarettes, Alcohol, Marijuana, Ecstasy
Barış	Male	27	Single	High-school dropout	Unemployed	Low	Cigarette, Alcohol, Synthetic Cannabinoid (Bonsai)

It could be seen that the entire study group was male, their age ranged from 24 to 56, and the majority of them were single. It was observed that one participant was an associate degree graduate, half of them were high school graduates, and the rest were secondary school graduates. The employment status of the participants was categorized in two groups as *irregular jobs*and *working in a family business.*Apart from one participant, the economic status of participants was average or above the average. When the distribution of the participants' substance preferences was examined, it was determined that one participant was addicted to alcohol, the other nine participants were addicted to drugs and at the same time consumed alcohol heavily. Except for three of the nine substance-addicted participants, the first substance they used was cannabis, with the exception of cigarettes and alcohol. In addition, it was determined that some participants used cocaine, ecstasy, and bonsai.

Chart 1.

Addiction Course of the Participants



When we examined the course of the participants' addiction in BASI, a slow but steady improvement was observed in the participants, with slight fluctuations in the period from the pre-interview step of the model to the last step. Given the findings obtained from the qualitative part, it was seen that the participants developed awareness of how their addictions affected them psycho-socially and spiritually during the basic steps of the model. In our study, it was witnessed that each participant had a unique addiction story, and each had their own strategies in coping with it. During the interview process, it was observed that religious and spiritual references somehow took place in these individual coping strategies, and the model we applied overlapped with the strategies of the participants. It was observed that the awareness that the participants developed during the steps of the model was significantly effective in transforming their lives. We also noticed that their awareness was a motivational element that reinforced the basic treatment and rehabilitation processes in the struggle to get rid of addiction and added religious and spiritual meaning to this process.

Qualitative Stage

Interview data were analyzed within the framework of the research problem, and the upper and lower themes were determined in parallel with the steps of the model and dealt with in a certain order.

In the preliminary interview, the spiritual counselor established a bond with the counselee and posed questions to the counseleein order to get to know the counselee. In this*pre-interview step*, in which the basis of the model's functioning was laid, the addiction history of the person was discussed in detail and the risks and opportunities in the person's fight against addiction were determined.

At this preliminary interview stage, questions were asked to the participants in order to determine the basic dynamics of the person's addiction. As a result of the first interviews, it was determined that the factors affecting the participants' initiation to alcohol or drugs were shaped around two themes: sociocultural factors and mental problems (Table2).

Table 2.
Factors Affecting the Addiction Process

Sociocultural Factors	So the circle of friends and the environment were bad. Our neighborhood was bad, the school was bad, it was filthy. There was a lot of alcohol. Back then, we had marijuana, we drank a lot of alcohol, we were skipping school. It started at that time, and I came to this situation by following the circle of friends. (Barış, 27) My girlfriend dumped me that day. I was depressed, I said to my friends'let's drink'with a depressed mood. We shouted. At the end, we got started. (Fuat, 33) There is no settled family structure. In other words, the relationship with the father, the relationship with the mother, unfortunately, does not exist. The lack of love has already caused me to shift outward to drug, to lead me to the drug in time, and lead me to different ways, unfortunately! (Salih, 48)
Spiritual Problems	My son died of blood cancer. A month later I went to the army. They didn't postpone my military service either. I mean, Iwas confused. During that military service, the first 5-6 months, I was in a very bad situation. I think I can't say that this is the reason. I mean, it's like I changed after that. (Onur, 44) "…I have bipolar disorder." (Fuat, 33)

The MTBD model is based on one's own spiritual approach. Therefore, the starting point of the model is the spiritual world of the counselee. Understanding whether and

Table 3.
Spirituality Story

Source of Spiritual and Religious Knowledge	Actually, I have taken these religious trainings since I was very young. My mother is actually very religious,youknow, pray five times, but my father has nothing to do with these things. They were sending me for the Quran study since I was a child, that's how I went. …Okay, we were learning the Quran, but when I couldn'tread I got a slap on the back of the neck, that wasn't pleasant anyway, it's like I'm a bit cold to religiondue to the events that I experienced with my father. (Umut,27) Our biggest dynamic is our grandfather. He always performs five daily prayers. He is a person who went on pilgrimage and fulfilled the conditions of belief in Islam. I mean, because we saw him, we always went that way keeping that awareness in mind. We lived downstairs, and my grandparents lived upstairs. He prays constantly. He constantly tells us about religious matters for the right path. (Onur, 44) …My family was not spiritual, but I always had it. For example, in the fifth grade, our class teacher would take us to Friday prayers. He used to make us fast during Ramadan, for example, for a month. I mean, we kept it not by force but due to our own free will. Every evening we would go to one of our house for iftar. We would break our fasts. Every evening, iftar was served somewhere. It has had an impact on me ever since. (Barış, 27)
Fate-Fatalism	There is a destiny drawn by Allah, you are in it. But, there, for example, you can do zigzags yourself. But, there is a certain thing. If he wanted to, he would. It is destiny, whatever it is. It is in human hands to change our destiny, but if only Allah wills or not…I'm praying and leave it to the God. For example, if God wants to test me with this thing again, he will. I will fight again. You have to look at the appraisal. (Özgür, 24) Let's call it a test. Everyone's challenge is different. I was disgusted with the substance, it was presented to me as beautiful (Özgür, 24) I will say that this is how it is. This is my own chosen path. You know, a bad way, a good way. We chose the bad path. But, I mean like this, I think like this. I say probably, Allah Almighty did not give up on this servant, but we suffered a calamity, we are trying to move forward on the right path (Selim,52)

how spiritual values and religious practices work in the addicted counselee's recovery from addiction (DiClemente, 2013) is the key element of our model. Breslin, Reed, and Malone (2003) explain the importance of gaining insight into the addict's spirituality in the addiction treatment process as follows: *Evaluating how spiritual orientation relates to one's substance abuse helps treatment providers understand how each individual views himself or herself in terms of individual worth.* From this point of view, questions were asked to determine the boundaries of the spiritual world as well as the substance abuse history in the pre-interview step. In this context, in each pre-interview, a spirituality story as an upper theme and the source of spiritual and religious knowledge and destiny-fatalism as sub-themes were determined (Table 3).

Finally, in the preliminary interview, the attitudes of the participants were tried to be determined in order to understand the effect of spirituality on quitting alcohol and drugs. Within the scope of this theme, two sub-themes (Table 4) emerged: *Remembering religious and spiritual values in alcohol or substance use,fear of death, and belief in the hereafter.*

Table 4.
The Effect of Spirituality on Alcohol and Substance Cessation

Remembering Religious and Spiritual Values in Alcohol or Substance Abse	For example, I would smoke marijuana and listened to Cübbeli. After that, we would open it, for example, some friends drank alcohol, okay? Someone used to say that I took the blame, he would listen(surah) Fussilet, there I used to read the subtitles. We would go into religious matters, so it was something different. So we have it inside. (Fuat, 33) I am truly afraid of God. But the drug abuse has become a habit. (Barış, 27) We were drinking alcohol, saying, "God forgive us." (Selim, 52)
Fear of Death and Belief in the Hereafter	Fear of death tickles me. What are you going to do on the other side, what the hell are you doing, how are you going to fix it?For those who are addicted like me, it is actually easy to get rid of addiction.A little fear (fear of the hereafter, heaven-hell) is enough for a person. Again, let me say for myself, we cannot generalize. When one is afraid, one can stay away from bad habits. But I can't stop smoking. (Selim,52) God knows the best of everything, but according to the prescription, this is the case. Now we have to follow that recipe in order to prepare for it. So this is what discouraged me. Okay, my soul will want it somehow, X and Y will want to go to the festival in the place, we will also want Burning Man or what we will want in friendships, but it was enough at one point, okay, we made those mistakes, they are in the past. Then to enjoy and savor a different life. It will be necessary to act with the thought of discovering the flavors there. That's what makes me. (Kerem, 39)

First Step: Repentance

In the MTBD model, the belief element is included in the act of quitting the addictive substance or substances with the step of *repentance.* An emotional dimension is added through faith, and the act of quitting is supported by sacred values to make it more effective and permanent.

Except for one (Barış, 27), the rest of the participants quit alcohol or drugs when they started the MTBD model interviews, but they did not know how to manage the

process. It was determined that some of the participants repented of the substance abuse (Salih, 48; Fuat, 33; Arda, 56); some of them (Onur, 44; Kerem,39; Selim, 52; Tamer,36; Özgür, 24) were open to repentance when the subject of *repentance* came to the fore with the step of repentance, and some of the others (Umut, 27; Barış, 27) did not feel ready to repent yet.

Table 5.
Repentance

Meaning Given to Repentance	I know very well what repentance is. But I don't feel ready right now. Why don't I feel ready now?Because I don't trust myself right now. My state and actions after repentance are very important, so I cannot trust myself. In many things, not just substance, but bad habits, bad words, something to fix myself. You know, I have something for all of them, but right now I'm a little scared. (Umut, 27) People say that since the door of repentance is open to everyone, you can do whatever you want. It introduces them to sin and also to goodness. It pushes him to sin, he says go, look, come back to me. I mean, he likes us to beg, I mean. He wants us to beg, he wants us to pray more. Repentance is very important. But I am not ready for repentance. I can't promise because I know I can't keep it. I don't feel ready. (Barış, 27) I heard about Nasuh repentance, but I could not learn it completely. Maybe because I was a little scared, I was afraid that I would break my repentance. I have never repented. But,I prayed a lot that God would not make me drink. I did not repent for fear of breaking my repentance. (Selim, 52)
Experience of Repentance	I performed salat, I prayed a prayer of repentance in my own way. After that, yes, my God, I repent, it was Friday, as if I would not drink again. I didn't think much of it on Saturday. It's weird, it's gone from my mind that I repented. The desire for substance overwhelmed me, I immediately talked to myself a little, I tried, I thought about the bad things he had done to me, I thought that I had repented, so I relaxed a little. Let's see how we will keep our repentance. Afterwards, I thought a lot, I wonder if I repented early, but when I thought very right what you said, I already said that I already repented like this by entering this path. (Umut, 27) May Allah accept it, I repented many times, but I hope Allah forgive me, the last job was 7 months ago. That day, with the support of my mother, I got up at night and prayed one or two rak'ahs. I read a verse from the Quran and prayed. Let's say my prayers have been answered. I haven't used it until now. (Onur, 44)
The Expectation of Miracle and Trouble	In fact, you are subconsciously waiting for a miracle. I also say that even if something happens, I start the prayer, let go of the substance. Or something will happen to us, then we will have to leave. We will either go to jail, or the police will catch us. (Tamer, 36) You know, I was walking on the wrong road so much that I always said: When are we going to be slapped? With street language, let's see when we will be in trouble, when we will get into trouble?Can we get up in the morning? But, get up and continue with the old system. As soon as I had this accident, I said,'oh thank God, the trouble I was waiting for finally came.'From now on, I have to be a man, a normal person. (Selim, 52)

Second Step: Faithfulness

Research studies indicate that addicts have a tendency to resort to "lie" in order to reach the substance because their relatives and society do not welcome them, and they use addictive substances that are prohibited by legal authorities (Mutlu, 2015). Coping with lies can sometimes spread throughout life. In this sense, an awareness-raising training has been carried out on how our work's faithfulness step and inability to be honest affects their lives in the long run. Within the framework of the faithfulness theme, three sub-themes were determined: (1) the meaning given to faithfulness,(2) the meaning given to lying, and (3) the experience of faithfulness (Table 6).

Table 6.
Faithfulness

Meaning Given to Faithfulness	If a person cannot control himself, he cannot control anyone else. If a person does not respect himself, he cannot have respect for anyone else. This is my view;faithfulness is a fundamental element in all relationships. So, I guess nothing would work without it. I can say that the key element is trust (Fuat, 33) …To build trust in people. (Tamer, 36)
The Meaning Given to Lying	Lying is not a good thing. There were times when I was not telling the truth because of what I did. For example, when I was using drugs with my friends, when they called me from home, I was lying that I was in a religious meeting. (Tamer, 36) Now let me tell you that there are processes in which every person is prone to mistakes. I had times like this when I was younger. First of all, you save the moment with family and relatives by filling up with lies, but after that, it comes back as restrictions. This time, you break the trust of the person in front of you and you inevitably enter a dead end. You are stuck at dead end road. (Fuat, 33)
Faithfulness Experience	We spend time together in the evenings. I do not have a problem with my family. They are relieved because they know that I am here, that is, they know that I am under the roof of YEDAM. There is no snooping anymore. But there is just one thing. For example, when I was leaving the house, my mother asks, "When will you come, son?" I say "I will come at this time". If I'm a little late, my father pouts and asks "Why are you late?", he becomes suspicious, however, there is nothing to be suspicious. (Onur, 44)

Third Step: Trust Consciousness

In this step, awareness of trust is the main theme. During this step, how an individual gain trust in their relationships is discussed with the participants. Trust consciousness was considered both as a religious dimension that includes the relationship between God and servant and a social dimension that includes human relations. For example, from this perspective, life, youth, and health (physical and mental) are a trust, and family and friends are also a trust. Within the framework of the upper theme of trust awareness, the meaning given to trust, health problems, and trust and trust experience sub-themes were created (Table7).

Table 7.
Trust Consciousness

Meaning Given to Trust	I've been observing myself for a while. Taking care of my physical health, for example. (Kerem, 39) When I think of trust, the first thing that comes to mind is to protect the next generation. (Salih, 48) Entrustment is very important to me, be it my own trust or the trusts of those around me. This is really a beautiful thing. We must explain the importance of this to our environment (Arda, 56)
Health problems	Having health problems makes me quit. Recently, sores started to appear on my body. It scared me too, at that time I wanted to go and quit. (Barış, 27) I mean, it has bad effects on my body. I realized that it harms my brain, it harms my body. When I use it, my heart aches, my chest is tight, I could not breathe. I mean, I've come to the extreme. Experiencing these also had an impact on me in terms of quitting the substance. (Özgür, 24)
Trust Awareness Experience	I'm making changes to my diet. It seems to me that when I eat too much, life becomes unproductive. I stopped eating cheese. Cheese is the hardest to digest dairy product, actually. (Kerem, 39) I lost my car. He put me in prison; the breaking point of my life. By the way, the car was entrusted to me from my father. Previously, when I was entrusted someone's car, I used to drive it fast as if it was my own. I did not know that entrustment is so much important then, but now I'm care about it. (Fuat, 33)

Fourth Step: Forgiveness

At this step, the concept of forgiveness is discussed in four different dimensions: forgiveness of self, forgiveness of others/interpersonal, forgiveness of situation/ event, andforgiveness of God. In this step, the relationship of the person with himself and others is examined. Therefore, it is a question of making peace with oneself and the others. The findings about *the meaning given to forgiveness,*and the sub-themes of *forgiveness* and *forgiveness experience* are given in Table 8.

Table 8.
Forgiveness

The Meaning Given to Forgiveness	Forgiveness is greatness. But it is also a little difficult to forgive everything. (Onur, 44) The greatest forgiver is Allah, after that our family. (Tamer, 36) Are we more powerful than our Almighty Lord? He forgives unimaginable things, but we do not forgive what He forgives.(Arda, 56)
Forgiveness or the Experience of Forgiveness	My family has forgiven me over and over again for my substance abuse. I need to be on the right track. According to them, if we go wrong, if we repeat them all the time, trouble will occur. (Tamer, 36) For years, I was very angry with a friend of mine. … I said myself that the same could happen to me… When I thought about this, my anger at my friend went away, I forgave him. (Umut, 27)

Fifth Step: Patience

Patience is one of the virtues that a person needs most in his journey to fight against addiction. In this sense, the step of patience involves increasing the counselee's resilience in the difficulties of the recovery process from addiction and the difficulties of craving for the substance. In addition, with this step, attention is drawn to the instructive and constructive aspect of the difficult and troublesome events encountered in life. Moreover, its contribution to the personal development and spiritual maturation of the human being is underlined. In this framework, the findings about the meta-theme of patience, the meaning given to patience, and the patience experience are given in Table 9.

Table 9.
Patience

The Meaning Given to Patience	Is it to put your trust in God and ask for help from the Almighty God in the face of existing bad events, in the face of what happened to me, and so on.? In the face of such difficult situations, people experience it in some way. I wonder if I misunderstood… (Kerem, 39) Patience is the reaction when the calamity first strikes... (Salih, 48)
Patience Experience	I have had a bit of a cigarette in the past few weeks. On the one hand, I am still patient with it. Something happened to drugs, too. I am trying to detect what triggered it. It could be the mood… But here I am patient. (Kerem,39) I got a big desire this week. For example, I stopped for the first time, like what is going on with me. I said to myself,I will delay it to the later; Let's go all the way home, let's see what is going to happen. Then it passed. I kept myself busy and persevered. (Umut, 27)

Sixth Step: Worship

In the step of repentance, the counselee makes a promise to his Lord by reviewing his relationship with Allah and embarks on a long journey. The step of *worship* is

a stage in this journey where a person reinforces the promise he has made at the beginning and takes his relationship with the Creator to a higher level. It is an important source of motivation for a person to feel the help of Allah when he is not with any of the family members or experts who support addicts to get rid of addiction. Thus, a person always remembers that he is under the "control and supervision" of Allah (Bayrakdar, 1987, s. 9-11). On the other hand, when it comes to alcohol and substance addiction, attention is drawn to the effectiveness of prayer, especially in preventing relapses (Sanchez & Nappo, 2008).

When religious rituals come to the fore with the step of worship, state of calmness, and lamentation was observed in almost all of the participants. During the interview, it was understood that this situation was due to the desire to perform the prayers but the lack of continuity in the prayers. In addition, each of our research participants reported that they cared about prayer. In this context, the meaning given to worship and prayer within the framework of the upper theme of worship and the findings regarding the sub-themes of worship, prayer, and dhikr experience are given in Table 10.

Table 10.
Worship

Meaning Given to Worship and Prayer,	To be in contact with God… Keeping the contact remains in contact. You continue that relationship and it strengthens you. One of the biggest factors for staying in a halal circle is prayer. Prayer is the pillar of religion. It is necessary to perform the prayer… (Salih, 48) It is a kind of relationship anyway, but it is not like talking to Mosesof course, but there is a connection, God says, "I will reciprocate." It means that you are already in contact with God in a way. I pay attention to things, for example, I pay attention to the feeling that comes to my heart, it is usually true. (Salih,48)
Worship, Prayer and Dhikr Experience	For example, when I do dhikr, it seems as if the Prophet was giving me advice. This is how I get inspiration…When I say salawat, when inspiration comes, I say, I guess this is an advice of our Prophet to me. They say that while praying, do not think about anything like that, they say only think about Allah. (Fuat, 33) I do not know how to say this, the only way to get rid of substance abuse or whatever, is worship. I mean, would you believe, I performed a prayer for eight months. Nothing came to mind. But, after that, I remembered that period. I stopped praying after eight months. Here I had a period of slipping. But, worship is the solution to everything. Due to my work, I can only go on Friday at the moment. But worship is the solution. (Onur, 44) I continue to use drugs two days a week. I went on Friday last week. The day I went to Friday, I did not use it that day to go to Friday prayer. (Barış, 27) I am very good today. In fact, during our session with the psychologist lady, she told me that I was very energetic today. And I said to her: Ms. Nihal told me a surah (Surah Inshirah). I was relieved to read it. Now, I am trying to memorize it. I also shared this with my mother. My mother did not know either, so she started memorizing. That is great, thank you really. You shared such a thing with me. I prayed for you that day and I still pray for you. Why? Because I have been very happy since the day you really told me that surah. My life has been different, it seems. (Onur, 44)

Seventh Step: Altruism

In altruism step, which is the last step of our model, the meaning of altruism was asked*(what does altruism mean to you?).*Almost all of the participants responded by squinting their eyes. It was observed that the participants were unfamiliar with

the concept of altruism, they wanted further explanation. The findings regarding the altruism step are given in Table 11.

Table 11.
Altruism

Meaning Given to Altruism	You said altruism, I have never heard of that phrase. (Salih, 48) People goes towards selfishness in the social life without being aware of it. To get out of this situation, I try to be altruistic as I witness it. That is, altruism is a virtue that protects people from being selfish. (Kerem, 39)
Experience of Altruism	I directly assist young people starting at the age I started. When I say advice, I reflect the things I experienced at that moment, and the things I experienced between the ages of 25 and 41. (Onur, 44) We can come across altruism in many things. A person should be altruistic to his closest environment at first. On the bus, when you get off the bus, in public transportation vehicles, there are many occasions at work, with the neighbor, at the grocery store, with an aunt in the queue. It is happening right now. (Kerem, 39)

Both at the end of the model's steps and at the conclusion of some interviews, open-ended questions were asked to the participants about the operation and effectiveness of the MTBD model.The opinions of some of the participants about the model and the interview process are presented in Table 12.

Table 12.
Evaluation

Opinions and Thoughts of the Participants on the Model	These conversations are helpful, obviously. I was really, really depressed when we took a break last week. As I talk to someone like you, who has learned this science, I can do things more regularly, I can think. I can even switch apps this way. When I was told about Spiritual Counseling, I wanted to see you right away. I thought you might understand me on many common points. It feels really good to talk to you. During this time, I try to think and understand them, etc. I am working or something. Then I come across things related to those issues. Do not think about them etc. It also provides an opportunity. It sounds good, I feel better, I really do feel better. As if something changed my life spiritually, etc. I can see it too. It has beautiful repercussions in my life. I pay attention to my prayers. If it was not working for me,I would leave it somewhere. (Kerem, 39) Sometimes, when I am very enthusiastic when I am at home, for example, I immediately think that I have entered a path. That I should never stray from this path, I repeat it over and over in my mind. Then, I immediately think of the day when we will meet with you… It is like I programmed myself like this; be patient until that day, Do you understand? That is how it occurred to me. You will have to wait until Thursday. I have been patient until Thursday, so after talking to you, I already feel relieved, I feel really good. This lasts me, for example, for three or four days, it is like I have always programmed myself like this (Umut, 27)
Evaluation of Participants' Achievements	I come here to talk to you, but it could go in one ear and out the other. But that is not how it ever happens. I remember a lot of things you said while driving in the car or at home. Gradually, the regret is overwhelming. It is oddly heavy. After our conversations with you, my thoughts about my father were reversed, why did I do this to this man. I have made people squint for other things that matter.(Umut, 27) One of the biggest pillars of my strength right now is that the door of repentance is open. We do not have many faces, but I repent and spiritually support my repentance. The more I take care of myself in a spiritual sense, the more they affect my life, and they affect me to become stronger. (Salih, 48) Our Lord is very merciful, I took refuge in him and repented. I believe that I have succeeded in quitting the substance with the help of Allah. (Özgür, 24)

Discussion

The present study attempted to develop, implement, and test the effectiveness of the MTBD model, which is predicated on an interdisciplinary approach that includes religious and spiritual elements that could be applied in the treatment of alcohol and substance addiction, especially in the rehabilitation process. In the qualitative part of our mixed method research, phenomenological analysis was used. In the quantitative part, scales were used to evaluate the addiction profile and addiction course of the participants. The total score of the API scale applied to the participants in order to evaluate the different dimensions of the participants' addictions and to determine the severity of addiction. The lowest score for the *severity of addiction* was 6.34, the highest score was 12.8, the arithmetic mean was 9.59, and the standard deviation was 1.84. According to the cut-off points of the scale, the addiction severity level of the study group was determined as medium addiction severity. When we examined the addiction courses of the participants in BASI starting from *the pre-interview* step of the *MTBD*model and throughout the basic steps of the model, it was seen that the level of improvement reached by the participants in the last interview (*Step 7 Altruism)* was better than the pre-interview steps. In this context, it is possible to claim a slow but steady improvement in the participants from the *pre-interview* step of the model to the *7th Step.*

How do they start?

Puberty and peer pressure. When the findings obtained from the interviews carried out with theparticipants of our study at the pre-interview step are interpreted as a whole, it is seen that almost all of the participants met with alcohol or drugs in the friendship environment during their early teenage years. It seems they tried the substance in a friendship environment where they felt comfortable and safe. Erikson (2014) states that the psycho-social crisis of adolescence is identity confusion. According to him, the influence of parents on the individual decreases while the influence of peer groups increases during this process. Therefore, to be part of the peer group,young person tends to adopt to the values of peer groups and fulfill those values both verbally and behaviorally.It appears that the participants entered the addiction process by making the mistake of trying or using the substance in order to get the approval of their peers.Therefore, "adolescence and peer influence", which was expressed as a result of many studies (Ögel, 2017, p. 35-36) and observations, was also confirmed in our study.

Another issue is that during adolescence, when young people try to find out who they are, they try to separate themselves from their parents, struggle to become independent, and identify with people or groups they feel close to. When this growing process cannot be managed well, the adolescents might be dragged into addiction

while seeking independence (Semerci, 2016, p. 35). Therefore, it appears that the participants did not manage their search for independence well in adolescence. Another characteristic of the adolescence period is that the brain has not yet completed its development (Eagleman, 2015). Studies have reported that the *prefrontal cortex*, which is responsible for skills such as decision making, reasoning, and evaluation, is underdeveloped in the adolescent brain, but the *limbic system, which* is the emotional center, develops very well (Spear, 2000). This situation causes young people to display risk-prone, impulsive, moody, and emotional behaviors (Plotnik, 2009, p. 411). In our study, it was determined that some of the participants (Umut, 27; Fuat, 33; Arda, 56; Barış, 27) preferred addictive substances as a coping tool when they could not face the problems they experienced. Studies indicate that the insufficient development of coping skills, especially in the young group, is considered as a risk factor for addiction. It has been reported that some individuals with insufficient coping skills take shelter in addictive substances and develop tolerance to addictive substances over time and become addicted (Russell, Skinner, Frone, & Mudar, 1992; Eftekharia, Turnera, & Larimer, 2004).

Family relations. Another notable factor that was found in our study is "family relations". Some of the participants (Umut, 27; Salih, 48; Tamer, 36; Arda, 56) who started addictive substances for the first time in a friend environment stated that the main reason for starting alcohol or substance abuse is family relations. In the literature, it is reported that friend influence and family problems are the leading factors in studies conducted to determine how and why addicts become addicted (Ögel& Tamar, 1996; Erdamar&Kurupınar, 2014; Yaman, 2014; Öz&Alkevli, 2018; Danışmaz-Sevin&Erbay, 2021; Karataş, 2021). The findings of our study are in line with the literature. It is possible to say that the studies conducted in this direction and the results of our research support each other.

How do they make sense of the addiction?

Determining how addicts make sense of their addiction situation is an important detail in terms of the function and success of the model, whether it contains religious and spiritual elements. It has been observed that the majority of the addicted individuals (Umut, 27; Fuat, 33; Onur, 44; Kerem, 39; Tamer, 36; Özgür, 24; Arda, 56) who participated in our research, had their religious knowledge from their family or close relatives like grandmother and grandfather. As seen on Table 3, all of the participants learned spiritual information more or less from their families or through other people. Therefore, it is understood that all of the participants who requested *The MTBD Model* had a spiritual background.

In the interviews with these participants, it was seen that some of the participants explained their addiction status with *fatalistic* approaches. For example, it is

observed that Özgür attributes his addiction to a superhuman factor with his fatalistic approach to addiction. Thus, it is understood that the participant tries to protect his/her self-efficacy by neutralizing himself, and this approach has turned into a defense mechanism tool. It is possible to say that the participants use the belief in fate as a defense mechanism to protect their own self-worth.

Religion, spirituality and coping with the addiction

Studies indicate that religious and spiritual values are the determining factors that shape people's daily life and affect their behaviors (Özbaydar, 1970, p. 5). Although the religious knowledge that the participants learned during their childhood and adolescence did not prevent them from using alcohol or drugs, it was stated by the participants that they did not let go of them during alcohol and substance abuse. It is understood that the participants developed an attitude towards things that religion did not tolerate in their childhood and especially in their youth, and when this attitude is challenged, they experience cognitive conflict. It is possible to evaluate this experienced cognitive contradiction as one of the factors that carry the person to the journey of getting rid of addiction and that this action is an effort for change. On the other hand, as can be seen from the statements of the participants (Selim, 52; Kerem, 39), they are not indifferent to the reality of death and the doctrine of the hereafter. The thought of death and belief in the hereafter could be considered as effective factors in quitting addictive substances and getting rid of addiction.

In our study, we explored to what extend participants' religious and spiritual values can play a coping and overcoming factor in drug and alcohol addiction through the steps of MTBD model.

Repentance

Some of the participants (Salih, 48; Fuat, 33; Arda, 56) experienced the act of repentance before, some (Onur, 44; Kerem, 39; Selim, 52; Tamer, 36; Özgür, 24) experienced repentance with the step of *repentance*, and the others (Umut, 27; Barış, 27) resisted to repent even though they quit the substance. However, it was observed that the resisting participants eventually adopted repentance in the process. When we consider the repentance experiences of the participants in general, it is understood that they are aware that they need to change their way of life through the act of repentance, but they cannot fully trust themselves in this regard.

It is seen that their views about repentance are shaped in two frameworks: repentance is something should be done *now* and something should be done in *the future*. It is understood that some of the participants developed an attitude of -all or nothing- to repentance. In other words, they attributed a meaning that repentance

should be done at a future time with the belief that it would be a behavior that could be realized with a radical change in the whole life style. This finding is in line with the finding of other studies. For example, in Yaman's (2018) study, it was reported that *Apache youth who want to get rid of addiction* interpreted repentance as an action that should be taken when the *time comes.*

One of the most significant finding in the step of repentance was related to the miraculous story of Bishr-i Hafi. His story of repenting to alcohol was shared with the participants. Bishr-i Hafi, an alcohol addict and tavern regular, once again goes to the tavern to drink alcohol, and on the way, he sees a piece of paper on which the word Allah is written. He picks it up from the ground and preserves it. Upon this occasion, he repented of drinking alcohol and would not drink alcohol again. In fact, throughout the rest of his life, he preached the religious truths to those who drank alcohol in taverns by making efforts to get rid of addiction to those who drank alcohol or to stopped drinking alcohol. During the interviews with the participants, it was understood that this story of Bishr-i Hafi made the participants expect miracles instead of motivating them and reinforced the existing miracle expectations of the participants, and it was seen that such a belief was a dominant theme among the participants.

This miracle expectation, which we label as "Bişr-i Hafi Syndrome" in addiction, sometimes appears as an unexpected "trouble". For instance, it was seen that Selim, one of our participants, always expected trouble during the addiction process, and eventually this expectation came true, and Selim interpreted his accident as a lesson given to him to get rid of addiction. It is possible to say that the participant explained this accident with "favorably interpretation", one of the positive religious coping mechanisms. Positive religious coping strategies can be instrumental in the beginning of the spiritual maturation process of the person or the development of the spiritual maturation process (Ayten, 2012). When Selim's interview progress was examined, it was observed that he reviewed his life after this accident and rearranged it according to religious and spiritual principles. Similar to Selim's *expectation of trouble is also found* in Yaman's (2018) research with Apache youth. In Yaman's study, it was reported that one of the participants (Kenan, 18, high school dropout, Diyarbakır) had an expectation of a great event that would take a lesson to perform the prayers.

Faithfullness

It has been observed that the participants gave shorter answers and changed the subject in the *Faithfulnessstep*, in which subjects such as lying, honesty, and loyalty were discussed. When we examine the participants in general, it is understood that the concept of *faithfulness is perceived something limited to*male-female relationsIn other words, theirperception of faithfulness does not cover all human affairs such as being honest, avoiding lies, sincerity, and beingfaithfulness to one's word. On the

other hand, it is possible to say that the participants did not want to talk much about this issue because they included lying as a solution in their lives while they were using drugs. When addicts start to use drugs, they try to hide it because the substance they use is not accepted and it is illegal. Lying behavior is especially common in addicts. In this sense, all of the participants of our study stated that they resorted to lying behavior, sometimes indirectly and sometimes directly while they were using drugs. In addition, it can be said that the participants hide the truth and resort to lies in order to mask the situations that they have difficulty in coping with as a result of using substances that are not morally welcome in the society and have some legal consequences. Report form other studies indicate to similar problems. For instance, in the study of Erükçü-Akbaş and Mutlu (2016) in which the treatment experiences of addicts receiving addiction treatment at AMATEM were discussed, it was determined that the participants did not resort to lying before using the substance, but they turned into a lying person to reach the substance. Again, it is reported that addicts who were treated for the second time at AMATEM to quit their substance lost the trust of their families because they told too many lies (Danışmaz-Sevin& Erbay, 2019).

Trust Consciousness

When we evaluate in general how the participants understand trust consciousness (Step 3), it is seen that they have some awareness about trust in terms of social or religious aspects. It seems that they are more sensitive to trust behavior in the context of social relations. On the other hand, some participants (Tamer, 36; Fuat, 33) emphasize that they are aware of the trust consciousness in their relationship with God. Experiencing health problems during the addiction process leads them to self-observation. Therefore, experiencing problems in one's health is an effective factor that leads the person to the process of change and transformation. Some of the participants (Özgür, 24; Barış, 27; Kerem, 39; Onur, 44) stated that they experienced health problems during their substance abuse and that their physical health improved after quitting. It is possible to say that the participants become aware of body safety only when they face health problems, and health problems are an important source of motivation for quitting addictive substances. It can be said that tangible things are sometimes more effective in decision making. Considering the trust experiences of the participants, it is understood that they make an effort to be more conscious. However, their awareness about the trust consciousness was not at the desired level. Therefore, during this step participants' awareness of mental and physical health as something entrusted from God is a key point to develop trust conciseness. It was observed that when "health concern" regarding the addiction was emphasized by spiritual reference,most of the participants were deeply affected. An awareness to a certain level was achieved.

Forgiveness

The participants put forward that forgiveness is a quality identified with Allah the most, and they also question their own forgiveness in comparison to Allah's forgiveness. In addition, they are aware of the importance of forgiveness, but they have difficulties in applying it. As the participants pointed out the difficulty of forgiveness in the sense they gave to forgiveness, only Salih and Umut gave examples of forgiving while only Tamer gave example of being forgiven.

It can sometimes be many years between the time addicts use addictive substances and the time they decide to recover from addiction. At the stage in which they struggle to get rid of addiction, the fights and inexcusable self-reliance of addicts are noticeable (Langman& Chung, 2013). Forgiveness can also set the stage for the emergence of hidden factors that sometimes affect the emergence of consultants' dependencies (Lin, et al., 2004). In this respect, the experience of not being able to forgive and not being able to forgive participants in order to get rid of the weight that impedes the process of recovering from addiction and occupying their minds has been addressed, and particularly their experiences of not being able to forgive.

For the sake of forgiveness, the addict was supported by religious and spiritual resources by taking lessons from the past but being able to look into the future safely without being stuck in the past. During the discussions, participants were observed to have made progress in forgiveness. For example, Umut said that he was beginning to understand his father and that he could forgive him. Some of the participants (Umut, 27; Salih, 48; Fuat, 33; Özgür, 24) forgave themselves.

Patience

The majority of our participants described patience (Step 5) as more endurance. As it can be understood from the statements of the participants, they tolerate difficulties and mark that this is patience. This approach, which pacifies the person, lays the groundwork for a fatalistic understanding. Thus, the person is freed from taking responsibility for what he did or did not do. It is possible to say that this attitude, which makes the individual feel good in the short run, harms himself and his environment indirectly in the long run. When we evaluate the meaning given to the patience by the participants in general, the picture that emerges is that the meaning of the concept of patience by the majority of the participants does not quite match the meaning in the religious literature. Similar results could be seen in the study of Karakaş (2016) in which he examined the effect of the patience attitude of municipal employees on the quality of life. In another study (Esen-Ateş& Kayıklık 2019) conducted with veteransandfamilies of martyrs, itwas reported that both patience and endurancewere encountered in veterans and their families, and patience was encountered in families of martyrs. These studies support our findings on how addicts understand the concept

of patience. It seems that the existence of the dynamic structure of the concept of patience that goes beyond the passive structure needed to be differentiated for the participants. In this direction, the participants were told what patience was and what it was not with examples from religious sources and the life of the Prophet, and it was brought to the agenda again in the process. It was observed that the participants made some progress, albeit partially, in displaying an attitude of patience in accordance with the religious literature.

We mentioned earlier that the participants were confused about the concept of patience. When we considered the concept of patience in practice, as could be seen from the examples of *patience* shown by the participants not to use addictive substances, the participants developed an awareness of the distinction between patience and endurance during the *MTBD Model* interviews and that they gradually incorporated patience into their lives primarily not to use addictive substances.

Worship

In the interviews carried out with the participants, it was determined that all of the participants had worship (Step 6) experiences. As stated before, all of the participants are male. It was understood that the obligation of Friday prayer in Islamic religious teachings was known by all of the participants, and it was determined that all of them had experienced Friday prayer more than once before starting the *MTBD Model.* Apart from this, it was determined that the vast majority of the participants (Salih, 48; Fuat, 33; Onur, 44; Kerem, 39; Tamer, 36; Özgür, 24; Arda, 56; Barış, 27) performed five daily prayers at least once in their lives. In addition, it was determined that almost all of the participants continued the Friday prayer from time to time during the interviews, and they tried to perform the daily prayers even if it was not performed five times a day. Some participants (Salih, 48; Fuat 33) regretted that they felt guilty because they could not perform the five daily prayers regularly and that they started to pray five times a day, but then they could not maintainthe practice.

Each of the participants of our study stated that they cared about prayer and that they had more or less prayer practices in every period of their lives. At the same time, in each step of the *MTBD Model,* various assignments such as prayer, dhikr, and worship were provided to the participants. It was understood from the statements of the participants that they paid special attention to prayer and took into account the assignments given. Another point is that the participants acknowledged that they stayed away from addictive substances with prayer and dhikr practices. The results of the study conducted by Johnsen (1993) on the participants of Alcoholics Anonymous' twelve-stage recovery program support our findings. In Johnsen's study, it was reported that participants who prayed more frequently than participants who had repeated relapses avoided using addictive substances. Another study supporting

our findings is Shuler, Gelberg, and Brown's (1994) study examining the relationship between spiritual/religious practices, mental health, and substance abuse. According to this research, the ritual of prayer was found to be associated with less alcohol or substance use and less anxiety and depressive symptoms.

Altruism

Although the participants initially exhibited a conceptual unfamiliarity with what *altruism* (Step 7) means, it was understood from the statements of all of them that they valued behaviors that could be considered within the scope of altruism such as helping, assisting, cooperating, and supporting.As it can be understood from the statements of the participants, it was seen that they were sensitive to attitudes and behaviors that might be evaluated within the scope of altruism in life. It can be said that the participants in the remission period have the potential to transfer their experience of getting rid of addiction to others. This method is carried out professionally in AA. In the context of the principle of universality, it is good for the addicts who are alone in the society to share about addiction in the group or with a person who is experiencing the addiction process (Yalom & Leszcz, 2018). It is possible to say that this method is one of the important factors that support the individual in the fight against addiction.

Conclusion

At the end of the steps, all of the participants expressed their satisfaction with the program and demonstrated the necessity to have a counseling program that integrated religious and spiritual resources. The participants stated that there were not many people around them to talk to about religious and spiritual issues, and thus they had difficulties in solving the problems they experienced on these issues. On the other hand, when they shared their views and thoughts on religious and spiritual issues, and they stated that they were not respected and even judged because of their addiction situation. For this reason, they stated that they could not talk about these issues with anyone, and therefore they were deprived of the support that religious and spiritual resources would provide them.

It is possible to interpret the participants' attendance to the program as the simplest indirect expression of both making a significant effort to get rid of addiction and thinking positively about the program. As seen above, some of the participants clearly stated that "I would have left it somewhere if it did not have effects" (Kerem, 39) and "I would not have come if it did not feel good"(Barış, 27). Therefore, it is possible to say that the fact that they completed the interviews gives an idea about the applicability and effectiveness of the model even though some of them sometimes skipped the interviews with or without informing.

One of the most important stages in the fight against addiction is the addict's recognition that addiction is a problematic behavior and acceptance of the situation. In this sense, it has been observed that all of the participants have an awareness of getting rid of addiction, and they are willing to make a transformation in their lives.

As a result, the quantitative findings revealed that the participants experienced a slow but steady improvement in the MTBD model with slight fluctuations during the period from the pre-interview step to the final interview altruism step. In the qualitative findings, it was seen that in the first steps of the model, the participants developed an awareness of how addiction affected them psycho-socially and spiritually. Moreover in the next steps, this awareness was significantly effective in transforming their lives. It has been understood that the model is a motivational element that reinforces the basic treatment and rehabilitation processes in the struggle to get rid of addiction and successfully adds religious and spiritual meaning to the recovery process.

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Compliance with Ethical Standards

The research was conducted with the permission of Marmara University, Institute of Social Sciences Ethics Committee, dated 20.10.2021 and numbered 2021-93. All the steps in the research were conducted according to the ethical standards.

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Book Review

A Spiritual Oriented Holistic Approach: The Connections Paradigm

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The Connections Paradigm: Ancient Jewish Wisdom for Modern Mental Health
By David H. Rosmarin
Templeton Press, 2021, pp. 268

Spirituality is seen as a significant resource in human wellbeing and functionality. It has deemed highly significant in research carried out in the domains of applied psychology. In addition to discerning the needs of the client throughout their psychology sessions, it is of importance that the overall intervention program provides attention to the client's priorities. When these factors are considered, it can be stated that spirituality has an undeniable supportive role in the psychology sessions and attention should be paid to the level of spirituality of the client and the manner in which spirituality can be incooperated into therapy. For this purpose, the priorities of the client as well as the competence of the menal health practitioner should be taken into account.

In recent years, it has become evident that holistic psychological counselling models incooperating spiritual orientation are required. David H. Rosmarin has developed a holistic counseling model with a spiritual orientation that "brought together approaches to cognitive behavioral therapy with the teaching of the Connections paradigm" in a way that can meet this need. He expresses that he has been using this model for many years hence has transferred his experiences into this book. The author has highlighted that there have been many

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positive and negative changes in our lives due to the development of technology. This has become increasingly evident in Western society in which social welfare has seen an incredible improvement whilst mental health has seen a major decline. Due to these reasons, Rosmarinstates that he set out to answer two questions: First of all, why is western society experiencing increasing psychological problems in terms of mental health? Secondly, what kind of measures we can take to reduce this tendency and to support people psychologically? As a result of long-term research and applications to find the answers to these questions, Rosmarin states that modern mental health experts cannot provide people with a satisfying sense of satisfcation as they focus on returning clients to their basic functionality. This is not effective in the satisfaction with life. In his counseling sessions, some of his clients showed courage by asking "Is getting rid of my psychological disorders completely the best thing I can hope for in life? Or am I missing out on a greater happiness that I can achieve?" After these experiences, Rosmarin expresses that he engaged in a deep search for the meaning behind the question "How to live a happy and fulfilling life?" Through this search, Rosmarin was able to utilise a spiritually oritented approach to modern therapy.

David H. Rosmarin, PhD, is director of the Spirituality and Mental Health Program at McLean Hospital and an assistant professor of psychology in the Department of Psychiatry at Harvard Medical School. Dr. Rosmarin is a clinical innovator whose work on integrating spirituality into cognitive behavioral therapy has wide acclaim. He is also a prolific researcher, having authored over 50 peer-reviewed scientific publications, numerous editorials/book chapters, and over 100 abstracts.Dr. Rosmarin clinical work and research have received media attention from ABC, NPR, Scientific American, the Boston Globe, the Wall Street Journal and the New York Times.

The book has three sections, each of which is consist of five chapters. These three main sections include these headings, respectively: "a) Inner Connection: (Body-Soul), b) Interpersonal Connection (Us and Others), c) Spiritual Connection: (Us and God)". In these sections, the concepts of the connections paradigm are explained in detail with examples and exercises. According to the connections paradigm, every human being at any given moment inhabits one of two worlds: the connected world and the disconnected world. While the world of connection, which is also expressed as the world of love, is defined with interdependence, compassion, generosity and courage; The world of disconnection, also called the world of fear, is defined by separation, fear, anxiety, isolation, anger. Our emotional states throughout all of our life experiences depend entirely on which world we choose to inhabit. The connection is explained by the union of two complementary and opposite entities in three basic areas. Disconnection causes separation and alienation of any of these components. These three domains are hierarchical: our relationship with God has bounded with our relationships with others, and our relationship with others with the degree to which

we maintain Inner-connection. Healthy interpersonal connections form on a bedrock of body-soul connection, and these two domains, in turn, provide a foundation for developing a relationship with God. By contrast, it is impossible to sustain a spiritual connection without interpersonal or inner connection. In each domain of connection, there is a giver and a receiver. Connection occurs when one entity provides for the other, which in turn accepts the contribution.

According to him, listening to the voice of the body and responding to its needs will also open the barriers to success (p.34). The body-soul connection is the basis of our communication with others and with God. Here, as a result of the establishment of the body and soul connection, an acceptance occurs under the guidance of the spirit (p.78). It can be said that this acceptance situation is similar to the acceptance that third wave therapies want to bring about in clients. Here, it can be stated that there is a comforting aspect of showing compassion to oneself and oneself say your goodbyes (Hayes, Strosahl, & Wilson, 1999). Rosmarin emphasizes that in order for the soul to maintain the inner connection, the unique features of the body should be approached with love and patience. We need to truly accept and love ourselves, even if we are sometimes inadequate. In summary, Rosmarin says that today's people neglect their physical needs along with many activities they perform. This highlights the importance of taking care of our various needs.

According to Rosmarin, an interpersonal connection is more complex than an inner connection. This is due to the existence of communication between two bodies and two souls (p.92). We are required to see the globe through the eyes of others, feel their joy, despair, and develop a pure empathy to recognize and meet their needs. To enter the world of another and remain at the level of interpersonal connection, we must also learn to give rather than receive. It is through this that the paradigm differs from meditation-oriented paradigms. Additionally, learning to tolerate and suffer the burden of relationships is considered a respectful preparation for spiritual connection with divinity as itteaches us to accept circumstances that are beyond our control (p.157). Through the Covid-19 process, we, as a collective, have experienced and acknowledged that making peace with uncertainties is one of the main criterias of being well (Sungur, 2020). With this, Rosmarin discusses various ways in which one can control and move away from negative emotions. However, instead of moving away from emotions, it may be more important to recognize the emotion, identify it, monitor it, focus on what it tells us and focus on its functional aspects. When we acknowledge the emotion, we can refocus on ourselves and our needs. Moving away from emotion may prevent us from acquiring the information we can learn from it. Therefore, following our emotions without escaping can be an advantage for our actions (Berking & Whitley, 2014; Leahy, 2015).

The concept of spiritual connection includes realizing the recognition of the will of God. It is also worth emphasizing that it is not necessary to be a member of a religious doctrine but to benefit from the spiritual connection. Nevertheless, individuals must be open to the possibility of a God's existence to develop their spiritual connection (p.159). Connection, both inner and interpersonal, weakens over time without a healthy relationship with God. Spiritual connection involves going beyond the physical limits of our inner and interpersonal worlds. The purpose of this step is to establish a uniquely close relationship with God by perceiving the presence of God every day and fulfilling the requirements of what we perceive (p.161). Spiritual connection focuses on recognizing order and design in the world, recognizing our own vulnerability, seeing the divine potential in each of us, making heroic efforts to reveal that potential. Rosamarin also expressed the following opinion as a result of his interview with a Muslim client: "During this session, I saw how consistent most of the Islamic concepts about the client's religious traditions and the nature of God were with the paradigm of connections." (p.168). Rosamarin at this point, he says that the model can also be applied to clients with different religious beliefs. The concept of spiritual connection is highly significant hence the emphasis on the concepts. Connecting with the God here; trusting Him, being glorification to Him and being grateful. In addition, it is also important to contemplate the order and design in everything created and to take actions in a way that the creator can tolerate. Itis emphasized that one cannot reach wholeness without the realization of spiritual connection. Considering these dimensions, the necessity for clients to be open to the existence of the God emerges. It can be said that this model is a study that can benefitthose who believe in the God or are open to the possibility of the God's existence. In this respect, I think that it is not possible for clients who do not have a God idea to carry out the work especially in the area spiritual connections section.

In my opinion, the teaching in question has aspects that overlap with other religious teachings. It shows that the basic assumptions presented by this teaching can also be used for other spiritually oriented approaches. The flexibility of the paradigm in this regard can provide convenience to professionals in the psychological counseling process. It also draws attention in terms of the importance given to relationships in the counseling process, the emphasis on context, and its approach to people with different beliefs. However, the author's the idea of being open to belief in God shows that there is a certain limitation in the approach. Here, the client's emphasis on the connection with God as the determinant of his relationship with himself and his environment is a sign of this. I think that this situation will be evaluated before the client begins the therapy. Therefore, it is considered important for clients who want to receive services in line with this approach to adopt a counseling model that gives priority to the spiritual field. In conclusion, the author states that many therapy approaches focus on only one of the assumptions predicted by the connections paradigm. He particularly emphasizes

that very few types of psychotherapy include spiritual connection. It is stated that the connections paradigm is unique in that it offers a multi-faceted view on the use of human resources. This statement of the author seems a little assertive. As logotherapy, Transpersonal Psychology, Positive Psychology, Acceptance Commitment Therapy (ACT), Mindfulness-Based Therapies, etc., all deal with the relationship of the person with himself, his environment and spirituality from different aspects. In addition to this, integrated therapy approaches such as spiritually oriented Psychodynamics, Cognitive Behavioral Therapy, ACT are also studied. In summary, it can be said that in today's world, there is a need for multidimensional therapy approaches. This paradigm can be evaluated with a holistic approach that considers the spiritual and psychological dimensions of human experience and development as separate dimensions and evaluates the priority and wishes of the client. At the point of spiritual and psychological development, taking into account the answers of the client, the arrangement of the counseling approach will determine how the process will proceed.

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Book Review

Indigenous Healing and Its Prescription for Contemporary Psychology

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Indigenous Healing Psychology: Honoring the Wisdom of the First Peoples
By Richard Katz
Rochester, VT: Healing Arts Press, 2017, pp. 480.

There is something peculiar about the almost obsessiveness with health and wellness in the present day to the point where what goes by the name of wellness is actually its antithesis. For example, the emergence of the health and wellness marketplace for mass consumption, while having some beneficial aspects of raising awareness, is not a sign of the attainment of health and wellness. On the contrary, it is a sign of their deficiency or absence, to the degree of illuminating the ascendency of the illness and dysfunction of this era. The rise of the global tourism industry, specifically the big business of what has become known as *spiritual tourism* or *psychedelic tourism*, often ends up commodifying the traditional wisdom and healing practices of the indigenous peoples, as if there could be a price tag or monetary value placed on such knowledge or healing practices. These phenomena are further indicators of the profound thirst for wholeness and transcendence and simultaneously the spiritual crisis of the modern world.

The quest for health and wellness outside of the conventional paradigm is in large part due to the intrinsic reductionism of modern science and its inability to confer what is beyond its scope of competence, principally the spiritual dimension. Mainstream psychology as a derivative of this materialistic science is in large

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part unable to provide authentic healing due to its inability to access realms that transcend the empirical order. Yet across the world since time immemorial, there have been and are modes of knowing and healing connected to the diverse religious and spiritual traditions of the world. Knowledge and science for the traditional peoples are inseparably connected to sacred science, metaphysics, and spiritual principles; however, this is not the case for modern science and its ways of knowing.

Seldom are alternatives known to the hegemony and colonialism of mainstream psychology. It is all too often assumed that modern Western psychology is the *only* psychology, when it is actually one among *many* psychologies. To be sure, there is nothing absolute or universal about modern psychology. It is often unknown that prior to the long historical trajectory of events that occurred in the modern West such as the Renaissance, Scientific Revolution, and European Enlightenment, there was a shared common or underlying metaphysics with the rest of the world's religions and spiritual traditions, and it was only in the post-medieval world of the West that this desacralized outlook atrophied and divorced itself from metaphysics. It is in the transcendent unity of religions that the perennial psychology, which recognizes that within each of the divinely revealed religions, including the religion of the First Peoples and their shamanic traditions, there exists a traditional psychology or "science of the soul" that can provide a multidimensional framework and pluralistic epistemology to understanding both the human psyche and its healing.

This book brings together Katz's work spanning over five decades within the discipline of psychology and with Indigenous Elders, healers, and knowledge keepers in Africa, India, the Pacific, and the Americas. He received his doctorate degree from Harvard University, where he taught for twenty years, and is professor emeritus at the First Nations University of Canada and an adjunct professor of psychology at the University of Saskatchewan. It contains a prologue, three sections, and eight chapters. *Chapter One: "If We Can't Measure It, Is It Real?": Entering the Profession of Psychology* provides an overview of the discipline of modern Western psychology as it is known through its "four forces," consisting of behaviorism, psychoanalysis, humanistic psychology, and transpersonal psychology to examine its limitations due to its reductionism. *Chapter Two: "We Try to Understand Our World—That's Just What We Do": Indigenous Elders as Our First Psychologists* presents the author's research in the field living among indigenous communities, the learning that transpired, and his exposure to ceremony, traditional knowledge, and healing. *Chapter Three: "We Respect What Remains a Mystery in Our Lives": The Enduring Foundation of Spirituality in Everyday Life* documents how the sacred pervades the whole of indigenous ways of life and is not limited to indigenous psychology and outlines how radically different mainstream psychology is in comparison due to being cut off from the spiritual dimension. *Chapter Four: "The Purpose of Life Is to Learn": Research*

as a Respectful Way of Experiencing and Knowing explores the distinction between the research methods of mainstream psychology focusing on prediction and control as an empirical science versus the differing ways of knowing of the indigenous peoples that are based on the principles of respect and exchange and how these sacred epistemologies can benefit scientific research. *Chapter Five: "All in the Circle of Our Lives Remains Valuable": Nourishing a Recurring Fullness throughout the Life Cycle* discusses human development over the lifespan as informed by indigenous ways, in contrast with the developmental paradigms of modern Western psychology. *Chapter Six: "Health Is More Than Not Being Sick": Balance and Exchange as Foundations of Well-Being* looks at the ways that healing is understood by indigenous psychology, which is not the same as obtaining a cure or the absence of symptoms as understood in modern psychology; health and well-being are not static, but require a way of life that is connected to the sacred. *Chapter Seven: "All My Relations": Honoring the Interconnections That Define Us* explores how indigenous peoples understand the notion of relationship as it extends throughout the entire web of life to include the human being with all sentient existence, including the unseen and sacred, and how this differs from the perspective of modern psychology and its notions of the separate self and individualism that separates itself from community or society. *Chapter Eight: "There Is No One Way, Only Right Ways": The Renewing Synergy of Multiple Psychologies* speaks to the diverse indigenous peoples and their distinct ways of knowing and healing modalities which inform their understanding of psychology.

Katz emphasizes that the book has been very effective as foundational reading to enhance work with indigenous individuals and communities in programs that train counselors and therapists, as well as in psychology courses. Contemporary psychology appears to be unaware of the fact that its presence within underrepresented and marginalized communities signifies the long-standing and continued process of a colonizing force and perhaps to its surprise is not perceived as a healing or liberating force to bring equity to all. The decolonization of psychology can allow it to become a psychology to benefit the well-being of all human beings to the degree that it is rooted in the sacred epistemologies of these diverse religious and spiritual traditions.

The discipline of psychology needs to be vigilant about continuing to be a vehicle of colonialism. Katz writes, "When racism and oppression and their consequent diminution of others infects mainstream psychology, its power becomes overpowering, denying diverse nonmainstream groups their rightful access to healing resources and social justice" (p. 5). To decolonize psychology is to restore it at its metaphysical roots so that it can once again become a true "science of the soul" as opposed to a *psychology without a soul*.

Conventional psychology's commitment to the biomedical or medical model that exclusively focuses on the somatic (including the neurological and genetic)

dimensions, which exclude the intermediary dimension of the human psyche and its connection to the Spirit, is not only symptomatic of its reductionism, but is at its core also an important facet of its colonializing force. Katz points out, “A biological, materialistic approach continues to dominate, promoted as ‘superior’” (p. 75). Across the diverse cultures of the world is the recognition of the tripartite constitution of the human being and that of the cosmos, of which the human being is a small mirror, which consists of Spirit, soul, and body or the spiritual, psychic, and corporeal states. The notion that modern Western psychology is universal and applicable to all peoples regardless of fundamental factors of human diversity, cultural distinctions, and religious and spiritual traditions is an immense overreach and is an assault on what it means to be truly human. Moreover, “the global adherence to the Western-sourced *Diagnostic Statistical Manual* (DSM) as *the* definitional authority for what is mental illness, is but one example of the continued exportation of a false universalism” (p. 79). It is *scientism* purporting to be science that is the problem, for when science claims a monopoly on the truth, it trespasses beyond its own domain of knowledge, namely the empirical order. Katz conveys the fallacy of scientific neutrality: “The very concept of *neutral* research or *neutral* science is problematic” (p. 216).

The author points out that “spiritual journeys are at the heart of a healing psychology” (p. 36). At the essence of every integral psychology or “science of the soul” is the recognition of psycho-spiritual transformation or *metanoia*, which is inseparable from the spiritual dimension. Katz speaks to this: “To heal, one must die and be reborn into an enhanced state of consciousness” (p. 100). Healing and transformation are then possible within the lived experience and adherence of one of the divinely revealed religious or spiritual traditions of the world, which remains outside the scope of secular or conventional psychology. Traditional healing can never be an object to be obtained once and for all, even if the symptoms are no longer found, as it requires living in a balanced manner by way of the sacred teachings and practices of a given religion or spiritual tradition. Even when the spiritual dimension is not pathologized and is introduced in a favorable manner, it is often done without clear criteria and in an *ad hoc* manner. Katz adds, “spirituality’s position in Western psychology is unclear. Largely misunderstood, ignored, and dismissed within mainstream approaches, spirituality is gaining a foothold among countercurrents within that mainstream—but even there, confusion and misdirection still prevail” (p. 201). The recovery of indigenous psychology and all authentic forms of the “science of the soul,” known as perennial psychology, as a distinct discipline from mainstream psychology, requires the restoration of its sacred foundations in the spiritual domain (Duran & Duran, 1995; Smith, 2021; Stewart et al., 2017).

Regarding the present-day phenomena of the spiritual marketplace attempting to sell indigenous knowledge and healing practices for mass consumption, let the buyers

beware. Indigenous elders, such as Ratu Civo speak in unison about the fact that "Our sacred teachings are never for sale" (p. 132). At the same time, they are never free as such. This is further explained by the Fijian healer Ratu Civo, "Freely given … yes. But not free. You do pay for these teachings. You pay in your struggle to understand them and even more in your struggle to apply them in your life" (p. 133).

This is an insightful and timely work that aims to establish a constructive comparison between modern Western psychology and indigenous psychology. Katz covers the essential elements in exposing the erroneous notion that mainstream psychology is universal and the standard or the only psychology, which it is definitively not. In fact, it could be said that as long as mainstream psychology disqualifies the intermediary realm of the human psyche, it is not a psychology or "science of the soul" at all. For the decolonization of psychology and psychotherapy to occur, its secular Eurocentric epistemology needs to be thoroughly examined and recognized. This work provides guidance to individuals or mental health professionals who wish to turn to indigenous psychology to understand the human psyche and its sacred knowledge and healing modalities. It is not about one psychology dominating all others, such as the ongoing hegemony of modern Western psychology, but the needed recognition that there are many psychologies that are to be found within the religious and spiritual traditions of the world. Through unlearning all that we thought we knew, we become capable of actually learning, so that a new path can emerge for us to comprehend integrative models that will support decolonizing therapies. It is through a life lived with intention and reliance on the Spirit that this path becomes discernable. As Danny Musqua, an Anishnabe Elder, instructs, "All ways of knowing, all teachings are connected. One thing leads to another, making it more clear" (p. xii).

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