A PRELIMINARY EXAMINATION OF RELIGION IN THE PERCEPTION OF THERAPISTS' HELPFULNESS

Except where reference is made to the work of others, the work described in this dissertation is my own or was done in collaboration with my advisory committee. This dissertation does not include proprietary or classified information.

_____
Crystal A. Bost Jackson

Certificate of Approval:

John C. Dagley Associate Professor Counselor Education, Counseling Psychology, and School Psychology	Renee A. Middleton, Chair Professor Counselor Education, Counseling Psychology, and School Psychology
Chippewa Thomas Assistant Professor Counselor Education, Counseling Psychology, and School Psychology	Stephen L. McFarland Dean Graduate School

A PRELIMINARY EXAMINATION OF RELIGION IN THE PERCEPTION OF THERAPISTS' HELPFULNESS

Crystal A. Bost Jackson

A Dissertation

Submitted to

the Graduate Faculty of

Auburn University

in Partial Fulfillment of the

Requirements for the

Degree of

Doctor of Philosophy

Auburn, Alabama
December 15, 2006

A PRELIMINARY EXAMINATION OF RELIGION IN THE PERCEPTION OF THERAPISTS' HELPFULNESS

Crystal A. Bost Jackson

_____
Signature of Author

December 15, 2006
Date of Graduation

DISSERTATION ABSTRACT

A PRELIMINARY EXAMINATION OF RELIGION IN THE PERCEPTION OF THERAPISTS' HELPFULNESS

Crystal A. Bost Jackson

Doctor of Philosophy, December 15, 2006
(B.A., Alabama Agricultural and Mechanical University, 2001)

107 Typed Pages

Directed by Dr. Renée A. Middleton

The current study aimed to assess religious clients' evaluation of therapists' helpfulness in psychotherapy. Participants (N = 35) were undergraduate and graduate students from 11 public institutions of higher learning within the United States of America. Participants were actual clients who had received or were currently receiving therapeutic services. These participants were also members of Christian, Jewish, or Muslim student organizations on their respective campus.

Level of helpfulness was measured using an one-item measure, which asked participants "How helpful was this therapist?," on a 4 point rating scale. Client satisfaction was measured by using Part Three of the Problem Resolution Outcome

Survey (PROS), which included three items that assessed the client's perceived effectiveness of resolution to his or her presenting problem. Each of the three items used a 6-point Likert scale. Participants were able to evaluate the level of helpfulness and satisfaction received from their first and/or most recent therapists. Participant strength of religiosity was also measured. Participants were asked to report on ecumenical behaviors displayed by therapists during their therapy sessions. The impact of therapists' ecumenical behavior and client strength of religiosity on client perception of therapists' helpfulness was also investigated.

Descriptive data analysis suggests the following: (1) As current and first therapists' ecumenical behaviors increased in frequency, the religious clients' level of perceived therapists' helpfulness increased; (2) The frequency of current and first therapists' ecumenical behaviors differed based on therapists' religious affiliation; (3) The perception of current and first therapists' helpfulness differed based on clients' religious affiliation; (4) Clients' strength of religiosity did alter client perception of current therapists' helpfulness, but not for first therapists' helpfulness ratings; and (5) A positive relationship exists between clients' satisfaction rating and clients' perceived level of helpfulness. Implications and limitations of the study are discussed.

ACKNOWLEDGMENTS

I would first like to thank my dissertation chair, Dr. Middleton and committee members, Dr. Dagley and Dr. Thomas for extending their divine support and time to helping me complete this research project. I thank Dr. Margaret Ross for serving as my outside reader and Mr. Asim Ali for his technical support. I also thank Drs. Liddle and Suh for their assistance during the beginning stages of my dissertation process. Dr. Deborah Shaw, you are thanked immensely for your consistent support, literally, since my very first day in Auburn, AL. Thank you for always opening up your heart and home to me.

Now, I must give thanks to my family. To my husband, Rashad L. Jackson, your melodious spirit inspires me. Thank you for being you and demonstrating agape love within our marriage and toward our gift from God that I am cradling in my womb. To my Mommy, Marta A. Scruggs, thank you for always believing in me and cheering me on, even when I may doubt myself. Your encouragement and sweet spirit fills my heart with great joy and brings me to tears. You are truly a Proverbs 31 woman. To my Father, Lawrence D. Bost, you are that challenging force that keeps me from being content and makes me push harder. Thank you for being my example of strong will and self-determination. To Rhonda R. Bost, my Stepmother, and Gerald L. Scruggs, my Stepfather, thank you both for your internal beauty and for being such wonderful parents.

Finally, I thank every family member and friend who has prayed for me and laughed with me. I believe it is because of all of you and God's grace that I am who I am.

Style manual or journal used: Publication Manual of the American Psychological Association, 5th Edition

Computer software used: Microsoft Word XP (2003), the Statistical Package for the Social Sciences (SPSS) 10.0 (2000).

TABLE OF CONTENTS

LIST OF TABLES xi

LIST OF FIGURES xii

I. INTRODUCTION 1

Historical Perspective on Religion and Psychology 1
Religion and Mental Health 4
Purpose of the Study 6
Research Questions 7
Significance of the Study 8
Glossary of Terms 9

II. LITERATURE REVIEW 11

Relationship Between Religion and Psychology: Past and Present 13
Clients and Psychologists: Comparative Perspectives of Religion in Psychology 16
Importance of Religious Dimensions in Therapy 21

Relationship Between Religion and Mental Health 21
Sensitivity to Religious Worldviews 25
Client-Therapist Match 26

Multicultural Counseling Perspective of Religion 28

Thoughts on Divergent Religious Groups 29

Ethical Considerations 32
Summary 36

III. METHOD 38

Participants 39
Survey Description 39
Procedure 44

IV. RESULTS 46

Prevalence Data 46
Analysis of Research Questions 47

Research Question 1 48
Research Question 2 50
Research Question 3 52
Research Question 4 53
Research Question 5 55

V. DISCUSSION 58

Summary of Findings 58
Limitations of Study 61
Future Research and Implications for Psychologists 63
Conclusion 67

REFERENCES 69

APPENDICES 84

Appendix A: Recruitment E-mail 85
Appendix B: Letter of Consent 87
Appendix C: Survey of Religious Clients' Perception of Therapists' Helpfulness 90

LIST OF TABLES

Table 1. Impact of Clients Religious Affiliation on Perceived Level of Helpfulness with Current Therapists 53

Table 2. Impact of Clients Religious Affiliation on Perceived Level of Helpfulness with First Therapists 53

LIST OF FIGURES

Figure 1. Relationship between Current Therapists' Ecumenical Behaviors and Perceived Level of Helpfulness 49

Figure 2. Relationship between First Therapists' Ecumenical Behaviors and Perceived Level of Helpfulness 49

Figure 3. Relationship between Current Therapists' Religious Affiliation and Ecumenical Characteristics 51

Figure 4. Relationship between First Therapists' Religious Affiliation and Ecumenical Characteristics 51

Figure 5. Impact of Clients Strength of Religiosity on Perceived Level of Current Therapist Helpfulness 54

Figure 6. Impact of Clients Strength of Religiosity on Perceived Level of First Therapist Helpfulness 55

Figure 7. Relationship between Clients' Satisfaction Rating and Perceived Level of Helpfulness of Current Therapist 56

Figure 8. Relationship between Clients' Satisfaction Rating and Perceived Level of Helpfulness of First Therapist 57

I. INTRODUCTION

Historical Perspective on Religion and Psychology

Toward the end of the twentieth century, mental health professionals were challenged to become knowledgeable about multicultural counseling and multicultural counseling competencies were developed (Sue, Arredondo, & McDavis, 1992). With the steady increase of multicultural diversity within the United States, psychologists were expected to accept this professional mandate. As a result, countless books, articles, training opportunities, committees, policy statements and guidelines have been created and promoted by the American Psychological Association and other professional organizations and professionals in the field of psychology on issues of diversity related to race, ethnicity, gender, sexual orientation, and socio-economic status (Ponterotto, Casas, Suzuki, & Alexander, 2001). While these are great strides that have been made, issues of religion continue to be neglected, treated negatively or as an afterthought in psychotherapy and counseling (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002; Jones, 1996; Myer 1988). Ellis (1980) contended that religiously devout and orthodox people are more emotionally disturbed than less religious persons. Even George Albee (2001), a past president of the American Psychological Association, implied that psychology must get rid of organized religion and asserted that "they are all patriarchal." Whereas almost all graduate training programs include coursework on ethnic and cultural

diversity topics, Shafranske and Malony (1990) found that only 5% of clinical psychologists reported any training in religious or spiritual matters during the course of graduate or postgraduate training. This percentage has not endured much change over the years. Thirteen years later in a 2003 article in the *Monitor on Psychology* by Kersting, it was reported that only 10% of psychologists reported even mild training on religious diversity or sensitivity. It was not until the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994) that a new section (V62.89) called Religious or Spiritual Problem was added in order to improve coverage of conditions that may need clinical attention to focus on religion or spirituality problems.

A complex relationship has always existed between religion and psychology. When conceived in the 16th century, Western psychology was linked with a religious worldview (Vande Kemp, 1996). It began with pnuematology, the study of spiritual being. Pnuematology consisted of three realms: the study of God, the study of intermediary spirits such as angels and demons, and the study of the human spirit. The term anthropologia was used later in that century to mean the science of persons (Vande Kemp, 1996). This designation "was divided further into psychologia," the doctrine of the human mind, and 'somatologia,' the doctrine of the human body" (Vande Kemp, 1982, p.108). However, in 1524, the Latin term, psychologia, was first used to refer to the division of pnuematology concerned with the human spirit (Vande Kemp, 1996). This is how psychology and religion were connected-psychology emerged as the study of the human mind, soul, and spirit. During this time, distinctions were not made between pneuma, the spiritual aspect of a person, and psyche, the soul or mind of the person.

The emergence of modern science in the 17th century and the Enlightenment period of the 18th century brought forth the Age of Reason and shifted the Age of Faith (Kurtz, 1999). The division of religion and psychology continued to widen during the 19th and early 20th centuries. Pioneers in the field of psychology, such as Sigmund Freud, John B. Watson, Edward L. Thorndike, and B. F. Skinner, established themselves with the scientific worldview and, as a result, gained credibility and respectability for their theories (Richards & Bergin, 1997). Science (or psychology) was said to be "grounded in empirical facts that are uninterpreted, indubitable, and fixed in meaning; that theories are derived from these facts by induction or deduction and are retained or rejected solely on the basis of their ability to survive experimental tests; and that science progresses by the gradual accumulation of facts" (Mahoney 1976, p. 130). In contrast, religion was focused on "the realms of significance, meaning, values, ultimacy, and ethics; these are regarded as making no factual claims on human reality" (Jones, 1996, p. 117). Thus, psychology and religion were assumed to be incompatible because psychology was based on fact and scientific hypotheses that could be proven, while religion was based on faith and subjective speculations.

In recent years, however, the postmodern, constructionist perspective has challenged the separation of psychology and religion. There has been an increase of interest in religion, as evident by the growing number of articles and books published by the American Psychological Association (e.g., Jones, 1996; Miller, 1999; Richards & Bergin, 1997, 2000, 2004; Shafranske & Malony, 1996), by journals being solely dedicated to religion and psychology (e.g., Journal of Psychology and Theology, Pastoral Psychology), and by professional organizations that focus on religion and psychology

(e.g., American Psychological Association Division 36: Psychology of Religion, Christian Association for Psychological Studies, American Counseling Association Division: *Association for Spiritual, Ethical, and Religious Values in Counseling*). Despite these developments, however, there remains a lack of discussion and incorporation of religious issues and interventions in the therapeutic process. This area of lack remains despite the fact that clients and potential clients need to trust that psychologists will demonstrate knowledge, skill, openness and sensitivity in responding to their religious concerns and worldview (King, 1978; Morrow, Worthington, & McCullough, 1993; Rose, Westefeld, & Ansley, 2001).

Religion and Mental Health

Empirical evidence suggests that religion and faith contribute positively to mental health (Batson, Schoenrode, & Ventis, 1993; Bergin, 1993; Gartner, 1996; Gartner, Larson, & Allen 1991; Levin & Vanderpool, 1987). Thus, both psychotherapy and religion offer ways of managing life's difficulties. Moreover, the religious dimensions of clients' lives may be additional tools in the therapeutic endeavor. Knowing that psychology values empirical evidence, these findings support the proposition that religion can be an integral component to the psychotherapeutic enterprise (Pate & Bondi, 1992; Richards & Bergin, 2000).

Religious commitment is noted as an important characteristic of a person and is a form of diversity (Pate & Bondi, 1992; Richards & Bergin, 2000). Richards and Bergin reported that religiously committed persons tend to report greater life satisfaction, less suicidal impulses, less depression, and less anxiety. In addition, persons who engaged in

religious coping (e.g., prayer, reading sacred writings, seeking support from religious community) were reported to adjust better to crises. Although the predominant organized religious group in the United States is Christian (85%), 2% are Jewish, and Muslims represent 1% of the American population (Gallup Foundation, 1996). Among other reasons for adopting a religious faith, many use it as a source of strength and guidance in their lives. Fifty-eight percent of those surveyed in the recent Gallup Polls (1996) identified religion as "very important" and nearly nine in ten surveyed reported praying to God at least occasionally to thank God for blessings, talk to God, ask for sins to be forgiven, or ask for guidance. With these data, psychologists can expect to counsel clients who have a religious faith and identify with an organized religion. Given that a source of strength is one of the ways religiously committed persons utilize their religious beliefs, psychologists should not only be prepared to counsel religious persons, but also be open to inquiring about the role religious faith plays in the lives of their clients.

The current study investigated the helpfulness of therapists, as perceived by clients expressing a religious faith. Research has indicated that 63% of clients believe it is appropriate to discuss religious issues (e.g., value conflicts, moral concerns, feelings of conviction, and other dilemmas which stem from a client's religious belief system) in therapy and 55% desire to discuss religious and spiritual issues in counseling (Morrow, Worthington, & McCullough, 1993; Rose, Westefeld, & Ansley, 2001). Shafranske and Malony (1996) and others (Lovinger, 1984, 1990; Miller, 1988, 1999) argue for the inclusion of religion and spirituality into treatment. In a national study of mental health providers, Bergin and Jensen (1990) found that only 29% believed clients' religious and spiritual issues were appropriate to be addressed in therapy. Ten years later, Shafranske

(2000) found that 50% of psychologists acknowledged the importance of assessing a client's religious background. It remains unclear; however, what may influence psychologists' usage of religious interventions in the therapeutic process with clients who are religious.

Research has shown that therapists are not well informed regarding the benefits of integrating aspects of a client's religious faith in therapeutic treatment, nor are they effectively trained to respond to issues of client religiosity in therapy (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002; Zeiger & Lewis, 1998). Lack of preparation or discomfort in discussing religious issues with the client may be one reason why the majority of mental health providers do not believe it is appropriate to address religious issues in therapy. The way in which a counselor responds to a client's religious faith may affect the client's perception and trustworthiness of the counselor (Morrow, Worthington, & McCullough, 1993). In a review of the empirical research on religion and psychotherapy, Worthington, Kurusu, McCullough, and Sandage (1996) report that studies in this area have generally used "potential" clients, instead of "actual" clients, contending that "research on actual clients should be a priority" (p. 451).

Purpose of Study

This present study was designed to contribute to the knowledge about real clients' expectations and experiences in therapy with regard to mental health practitioner's attention and sensitivity to their religious faith and beliefs. Specifically, the purpose of this study was to examine how clients expressing a religious faith perceive therapists helpfulness in therapy, as it relates to the therapist's attention to and respect for the

clients' religious beliefs. This study also attempted to determine whether or not the strength of a client's religiosity impacts the client's perception of what is deemed or viewed as helpful. Analyses were conducted to determine if demographic variables of the client and therapist would impact the degree of perceived helpfulness. It was expected that the more a therapist gives consideration to a client's religious beliefs the more helpful the client would perceive the therapist to be. It was also expected that the greater the client's religiosity, the stronger the correlation would be between perceived helpfulness and perceived consideration to the client's religious beliefs.

Research Questions

The research questions posed for this study are as follows/

1. Does a relationship exist between therapists' display of ecumenical behaviors and clients' perception of therapists' helpfulness?
2. Does the religious affiliation of the therapists' relate to therapists' ecumenical characteristics and ethical practices toward religious clients and their concerns?
3. Does the perception of therapists' helpfulness differ based on the religious affiliation of the client?
4. Does the perception of therapists' helpfulness differ based on the clients' strength of religiosity?
5. Does the effectiveness of individual therapist ecumenical behaviors relate to client satisfaction ratings?

Significance of the Study

The results of the current study may provide some preliminary guidance on practices therapists should consider when working with clients who identify with a religion. Psychologists can more effectively serve religious clients if they are able to sensitively address the concerns of such clients (King, 1978; Koenig, 1998). This study was also designed to provide supportive data on how therapist behavior and therapeutic approaches relate to religious clients' satisfaction with therapy. Literature that has focused on issues of psychology and religion has included comments on the neglect of our profession to study the psychotherapeutic experiences of a broad range of faith groups (Morrow, Worthington, & McCullough, 1993; Worthington, 1988). The present study therefore targeted participants of three religions: Christianity, Judaism, and Islam. The information gathered in this study has the potential to benefit the clinical treatment of clients who identify with a religious belief system.

On an individual level, this information can provide insight to the psychologist. It can help psychologists to become aware of how their response to religious issues in therapy may hinder or help religious clients. On a group level, this information can provide insight to the field of psychology. Research has already shown that educational training is needed to better equip psychologists to work with clients expressing a religious faith with religious issues in therapy (Holden, Watts, & Brookshire, 1991; Shafranske & Malony, 1990). The current research will help inform the content of that training by providing information about therapists' helpfulness and client satisfaction with therapeutic services, as reported by clients expressing a religious faith.

Glossary of Terms

Christian: A person who practices Christianity, within an organized Christian denomination.

Christianity: A *monotheistic religion* centered on the life and teachings of *Jesus of Nazareth* (Frankiel, 1993).

Islam: A way of life and refers to the comprehensive and inclusive nature of the Islamic ideals (Al-Faruqi, 1984).

Jew: A person who is a member of a religious group that practices the religion of *Judaism*: the religious beliefs and practices and the way of life of the *Jews* (Morrison & Brown, 1991).

Multicultural counseling: Preparation and practices that integrate multicultural and culture-specific awareness, knowledge and skills into counseling interactions (Arredondo et al., 1996).

Muslim: A person who practices Islam as a religion. "A Muslim recognizes that there is only one God, that Muhammad is his last Prophet, and that the Koran is the last holy book revealed to humankind" (Hedayat-Diba, 2000, p. 290).

Religion: A structured system of traditions and rituals that are designed to nurture a spiritual life that includes a relationship with a deity.

Religious client: A client whose beliefs and values are in agreement with some organized religion (i.e., expresses or identifies with a religious faith) and are held to be true concerning religion or religious spirituality (Worthington, Kurusu, McCullough, & Sandage, 1996).

Religious intervention: Practices of a religion that promote healing and wholeness/soundness of the mind, body, and spirit.

Secular Psychologist: A psychologist who has been trained in traditional counseling and clinical psychology programs that for the most part excluded training in religious dimensions (Ellis, 1980; Lovinger, 1984).

Spirituality: Spiritual experiences within an organized religious framework.

II. LITERATURE REVIEW

Since the emergence of the scientific (critical thinking) movement, the realms of science and religion continue to be in conflict. More recently, however, there has been a push in the field of psychology for clinicians to give more consideration to religious dimensions (Rose, Westefeld, & Ansley, 2001). In addition, an effort has been made by some professionals to identify and utilize religious accommodative methods in the clinical practice of psychotherapy (McCullough, 1999). Given the steady increase of religious diversity in the United States, consideration to religious faith may be vital to the effective treatment of religious clients by therapists.

> American Psychological Association Ethical Standard 2.01b (2002) clearly states
>
> Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with ... religion ... is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals.

It is important for psychologists to treat religious clients with religious concerns in a culturally sensitive and ethical manner. If psychologists are unable to sensitively address religious issues in therapy, then they cannot competently offer services to religious clients; to do so would be a violation of the American Psychological Association Ethical

Standard 2.01b. Competence to treat this population ethically is imperative. Psychologists should be aware of how religious faith affects a person's world view and mental health. Religious values, beliefs, attitudes, and practices impact interpersonal relationships, coping responses, self-esteem, etc.

Research has indicated that there is a significant difference of religious belief between the general population and psychologists. Psychologists have been surveyed and were found to be less religious than the general population and tend to identify themselves as spiritually oriented, outside of organized religion (Bergin & Jensen, 1990; Shafranske & Gorsuch, 1984). Literature has also shown that psychologists receive little to no training in the area of religion, in relationship to how it may impact delivery of therapeutic services (Shafranske & Gorsuch, 1984; Shafranske & Malony, 1990). These points lead to the primary research question of the present study: how helpful are therapists, as perceived by clients expressing a religious faith, given that fewer psychologists are adherents of religious systems and receive scarce clinical training on aspects of religion.

The information below is intended to provide an overview of the following: (a) the relationship between religion and psychology, (b) the importance of religious dimensions in therapy, as it relates to sensitivity to worldviews, multicultural counseling, and ethical implications and (c) religious beliefs-statistics, client-therapist match, and difference among religions.

Relationship between Religion and Psychology: Past and Present

When the word psychology is broken down into its language of origin (Greek), psyche and logos, meaning soul and study, respectively, we see that psychology means "the study of the soul." The word psychopathology means "the suffering of the soul." These meanings are said to be the roots of the term psychology (Elkins, 1995). Initially, in psychology's effort to distinguish itself from philosophy, but as a non-materialistic science, psychologists in the field used religious sentiment and jargon in their writings (O'Donnell, 1985). O'Donnell (1985) implied that psychologists had to convince the American people, that psychology, independent of philosophy, was a legitimate science that was not a threat to the spiritual well-being of those who were in their care. Founder of the American Psychological Association, G. Stanley Hall (1901), described psychology as a "microscope for the soul," while stating that "the brain is the mouthpiece of God" (p. 731).

Overtime, the foundations of religious views were questioned by evolutionary theory, German Higher Criticism, and an emerging consumer culture. As a result, there was an increase in scientism (Croce, 1995). Post (1993) noted that as the scientific framework developed, a seed of suspicion was planted in scientists toward religious persons. Post (1993) stated that a "strong scientific ideology and worldview" (p. 364) may contribute to the negligence of some clinicians to give serious consideration to the religious dimensions of clients.

Perhaps the past influence of Freud, Ellis, and Skinner continue to impact the present view of religion. Freud's attitude was that all religious belief was neurotic in nature and linked with obsessional character defenses (Freud, 1927/1968, 1930/1961).

During Seymour Sarason's 1992 centennial address at the American Psychological Association annual convention he summarized the general attitude about religion by professional psychology:

> I think I am safe in assuming that the bulk of the membership of the American Psychological Association would, if asked, describe themselves as agnostic or atheistic. I am also sage in assuming that any one or all of the ingredients of the religious worldview are neither personal nor professional interest to most psychologists…. Indeed, if we learn that someone is devoutly religious, or even tends in that direction, we look upon that person with puzzlement, often concluding the psychologist obviously had or has personal problems. (Sarason, 1992)

More recently, however, there has been a renewal of interest in religion in psychology, as noticed in the organizational structure within the field of psychology, such as Division 36 (Psychology of Religion) in the American Psychological Association. Initially established as the American Catholic Psychological Association, it was reorganized in 1971 as an ecumenical group, Psychologists Interested in Religious Issues (PIRI). PIRI became affiliated with the APA in 1975, and changed its name to Psychology of Religion in 1993. It now includes about 1,100 members, most of whom are clinical or counseling psychologists (APA, 2003). Despite being the primary organization of psychologists who study religion, its membership is small when compared to the 90,221 who comprise the APA, not including student affiliates (2005). It nevertheless provides an important forum for the discussion of religion and psychology. Other groups exist for psychologists interested in religion as well, such as American

Counseling Association Division: Association for Spiritual, Ethical, and Religious Values in Counseling. Among the more prominent of these is the Association for Transpersonal Psychology, which focuses on matters of altered states of consciousness and spirituality rather than on organized religion. It also has its publishes its own journal, *Transpersonal Psychology, which* offers an outlet for theory and research relevant to religious experience, particularly if the research uses methods outside the bounds of traditional empirical psychology.

In addition, there are several organizations that promote psychology and specific religious traditions such as Christianity or Judaism, as well as groups of what are known as pastoral psychologists. These organizations tend to focus most strongly on the application of psychology to mental health issues in a religious setting. The American Association of Pastoral Psychologists is one such group; another is the Christian Association for Psychological Science, which serves the evangelical Protestant community. Finally, there are interdisciplinary organizations such as the Society for the Scientific Study of Religion and the Religious Research Association. Psychologists involved in research on religion often use these organizations' journals as publication vehicles, and much of the work published in these journals is very fine in quality.

This resurgence of interest on religion in psychology has also led to entire psychological journals being dedicated to the topic of religion and a great many articles, and numerous textbooks on the subject matter (e.g., Plante & Sherman 2001; Richards & Bergin 2000, 2004; Edwards, Lim, McMinn, & Dominguez, 1999; Shafranske, 1996; Spilka, Hood & Gorsuch, 1985; Wulff, 1997). For example, religion was the cover story of the August 1996 *APA Monitor*, the monthly news organ of the American

Psychological Association. The APA also has published several books that address the role of religion in counseling or clinical psychological practice. Among these books is one by Richards and Bergin (1997) who suggest not only that therapy is more effective when it respectfully addresses clients' religious beliefs, but also that it is possible to have a "theistic" psychology that includes God, which was among APA's best-selling books in the year following its publication, suggests that individual psychologists are grappling with religion in their professional practices. A more encyclopedic view of religion in clinical psychology in the USA is found in Shafranske's (1996) book, which offers several different perspectives — all basically favorable — on the relevance of religion to therapy. Favorably inclined to empirical studies of religion, the *Journal for the Scientific Study of Religion*, *Review of Religious Research*, and *The International Journal for the Psychology of Religion*, as well as other similar outlets, have enabled psychologists to publish research focusing on aspects of religious belief and behavior, furnishing a venue that is valued by other psychologists. A total of 591 articles emerged from a subject keyword search of "psychology and religion" dating from 1896 to 2006, using PsycINFO database (2006). More than half of those articles (280) were published within the last ten years, from 1996 to 2006.

Clients and Psychologists: Comparative Perspectives of Religion in Psychology

Lehman and Witty (1931) identified 1189 scientists (men from different scientific fields) who state their religious affiliations in writing biographical sketches found in both Who's Who (1927) and American Men of Science (1927). Only 25 percent of those listed in the latter and 50 percent of those in the former reported their religious denomination,

despite the specific request to do so, under the heading of "religious denomination (if any)." Pphysicists and chemists head the list with reporting a religious affiliation, while psychologists were found to be at the bottom, suggesting that psychologists are not as religious as compared to natural scientists. The study reported that this was in great contrast to the well over 90 percent of the general population who claimed a religious affiliation. Leuba (1934) also found that psychologists were not as religious as compared to natural scientists. A questionnaire was sent to 1,000 scientists, selected randomly from the *American Men of Science* (AMS) to assess their religious beliefs. Leuba sought to understand the attitudes of these scientists toward a belief in a personal God and belief in immortality. He categorized the subjects into four groups of scientists; physicists, biologists, sociologists and psychologists. Leuba found that physicists had the greatest proportion of believers (38%) while psychologists had the smallest (10%). In an empirical study directed by Cross and Khan (1983), 56 psychiatrists, 173 psychologists, and 282 social workers were surveyed, concerning their values and religious beliefs. Results indicated that, psychologists tended to be less religious in comparison to social workers and psychiatrists. All 3 groups, however, were considerably less religious than the general public, as reported by Gallup Polls. Psychologists seem to express their spirituality outside of organized religion (Shafranske & Gorsuch, 1984; Shafranske & Malony, 1990). Shafranske and Gorsuch (1984) conducted a study of 272 clinical psychologists. The data were collected through a survey and were analyzed using multiple regression and chi square statistical procedures. The study investigated "psychologists perceptions of spirituality, religious affiliation, belief orientations, theoretical orientations, and educational and training experiences" to establish a

preliminary assessment of psychologists "preparedness to respond to the spiritual dimension or religiosity as experienced by clients" (p. 239). Results showed that 23% of a sample of psychologists identified with religious institutions, 13% identified themselves as atheistic, 11% revealed an agnostic stance, and 14% listed "other." The remaining 38% described an "existential" orientation rather than a religious orientation. The results of this study also indicated that psychologists receive little to no educational training regarding spiritual or religious issues.

Shafranske and Gorsuch (1984) noted that if spirituality is addressed in clinical practice, "the therapeutic perspective is based on the personal rather than the clinical orientation of the psychologist" (p. 239). This means that psychologists may use their private religious beliefs, values, and attitudes, instead of their clinical training, to inform their approach of addressing religious issues in therapy. This is not good practice for the competent psychologist, because this approach is very value laden. If a psychologist is not trained in a particular area of client concern, the use of personal subjectivity is not sufficient. For example, a former alcoholic cannot clinically treat a current alcoholic based on his or her personal experience with alcohol. Thus, psychologists must be trained in how to handle religious issues in therapy with religious clients (APA Ethical Standard 2.01 b, 2002). Shafranske and Malony (1990) found that the sense of competence psychologists held toward addressing clients' religious concerns in therapy was based on their personal religious orientation and not their clinical training.

Shafranske and Malony (1990) asked psychologists to indicate the religious interventions they used in therapy. They found that as actual counseling interventions became more "explicitly religious and participatory in nature" the clinicians attitudes

became “less favorable” (p. 75). Clinicians seemed to be more willing to inquire about the clients’ religion (91%) and less willing to use or recommend religious or spiritual books (32%) and 68% agreed that it was inappropriate for a psychologist to pray with a client. This is noteworthy considering that clients appear to consider religious issues as appropriate topics to discuss in therapy and should be incorporated (Hoge, 1996; Rose, Westefeld, & Ansley, 2001).

In particular, Rose, Westefeld, and Ansley (2001) assessed religious (60%) and non-religious (40%) clients’ beliefs about the appropriateness of and preference for discussing religious and spiritual issues in therapy. Results indicated that 63% of all clients sampled believe it is appropriate to discuss religious issues in therapy and 55% desire to discuss religious and spiritual issues in counseling. Shafranske (2000) found that 51% of psychologists reported that religion was not very important to them, in comparison to only 11% of the general population. As stated earlier, Shafranske also found, however, that 50% of psychologists believed it was important to assess clients’ religious history.

Morrow, Worthington, and McCullough (1993) surveyed the perceptions of college students who were Christian toward a counselor’s treatment of a religious issue. The participants in this study were divided into three different groups. A video, which displayed a counselor addressing a religious issue with a female client, was shown to each group. The video either supported, ignored, or challenged the client’s religious belief. Results indicated that regardless of the strength of the participants’ Christian beliefs, participants rated the counselor differently depending on how the therapist responded to the client’s religious faith. “The participants predicted that the client would

improve more seeing the counselor who supported her religious values than seeing the counselor who challenged those values" (p. 455). The study revealed that participants "would be less likely to return to the challenging counselor than to either of the other two" (p. 455). The counselor who ignored the client's religious values was viewed as more persuasive than the one who supported the client's religious beliefs. Morrow, Worthington, and McCullough (1993) cited the work of Pecnik and Epperson (1985) and Strong (1968), as they suggested that a possible explanation of this finding is that participants view counselors who focus more on religious content as less of an expert compared to those who focus on psychological factors, which is more in line with their expectations of therapy.

A study conducted by Wikler (1989) revealed that 45% of clients preferred a therapist with similar values because of (a) greater expectations of trust, (b) ability to relate to therapist with same values, (c) fear of conflict with a therapist with different values, and (d) some level of religious authority to reduce anxiety related to religious questioning. In the same study, 20% preferred to work with therapists who held different religious beliefs because of decreased expectations of being judged negatively by a therapist with similar values for not upholding religious standards. This is understandable given that some religious groups may convey expectations of living a life in strict adherence to their belief system and may condemn those who do not.

Importance of Religious Dimensions in Therapy

Relationship Between Religion and Mental Health

In contrast to some psychologists' negative views about religion, recent research has recognized a positive relationship between religious faith and mental health. Gartner (1996) performed a literature review on the subject matter (of approximately 200 studies) and found positive correlations between religious commitment and mental health. Measures of religious commitment were different across the studies. These included comparing members of religious organizations to nonmembers, measuring frequency of church attendance, measuring attitudes toward the importance of religious experience, and measuring belief in traditional religious creeds. Using each study's definition of religious commitment, the literature revealed lower rates of mortality, suicide, drug and alcohol use and abuse, delinquency, and criminal behavior, divorce, and depression, as well as higher rates of well-being and marital satisfaction among those who were more religiously committed.

Boyd-Franklin (1989) suggested that in times of crisis, the religious institutions attended by religious clients can be utilized as a support system and psychologists should be trained to use them for assistance. These institutions can be used to assist individuals through a mental breakdown, a financial crisis, child care, and the fulfillment of educational goals. Ministers and church members are often adopted as an extended part of the family of client who identify with a religion and can serve to encourage clients to continue in treatment (Boyd-Franklin, 1989). Researchers have also associated religiousness (defined as intrinsic religious motivation, attendance at religious worship, receiving support from one's religious congregation, and positive religious attributions

for life events) with less anxiety and higher self-esteem, life satisfaction and ability to cope with illnesses and stressors (Koenig, 1998; Pargament, 1997).

The literature reports forgiveness as restoring relationships and healing emotional wounds (Lauritzen, 1987; Worthington & DiBlasio, 1990). Forgiveness has been described as "a key part of psychological healing" (Hope, 1987, p. 240), and "a powerful therapeutic intervention" (Fitzgibbons, 1986, p. 630). Forgiveness has also been reported as highly beneficial for problems involving anger and depression (Fitzgibbons, 1986), family issues (Hope, 1987), and personality disorders (Fisher, 1985).

Miller (2001) discussed the impact of religious faith (the belief that God will take care of and protect those who believe in God) on happiness. Faith was related to greater ability to handle crisis and well-being. The social support and sense of community within religious organizations were said to be contributing factors. In addition, prayer and meditation has been found to yield beneficial results in terms of psychological and physical health. Specifically, Dossey (1993) reviewed medical studies (such as those concerning patients who had undergone cardiac surgery) on the efficacy of prayer and found that those who prayed "Thy [God] will be done prayers," triggered emotions (e.g., optimism and calmness) that, in turn, positively impact the immune and cardiovascular systems, thereby improving health. Although reasons for the protective effects of religious affiliation are not completely understood (Miller & Thoresen, 1999), Worthington et al. (1996) proposes that religion may encourage a healthy lifestyle, give people a sense of control by a benevolent God, provide a social network, and offer meaning, hope and optimism.

On the other hand, some studies have submitted neutral or negative findings on the relationship between religion and mental health. Larson, Sherrill, Lyons, Craigie, Thielman, Greenwold, and Larson (1992) reviewed the literature published in the American Journal of Psychiatry and Archives of General Psychiatry from 1978 to 1989, assessed all reported measures of religious commitment and examined the percentage of studies that reported positive, neutral, and negative relationships between religious commitment and mental health. Out of the 50 studies that indicated a relationship between religious involvement and mental health, six revealed a neutral relationship, eight revealed a negative relationship, and 36 revealed a positive relationship. Richards (1991) found that religiously devout persons did not significantly differ from those who were less devout and those who rejected organized religion on measures of depression, shame or existential well-being.

In a meta-analysis study on religious-accommodative counseling (therapy that identify and integrate aspects of a client's religious beliefs to the treatment process) McCullough (1999) reviewed data from five studies. One study compared the efficacy of Christian and secular rational-emotive therapy (RET) with Christian clients and another explored brief Christian and non-Christian RET with depressed Christian clients. One study compared secular and religious versions of cognitive therapy with depressed Christian college students, while another compared the efficacy of religious and non-religious cognitive-behavioral therapy on the treatment of depression in religious individuals. Finally, another study compared the efficacy of religious and non-religious imagery on the treatment of mildly depressed religious persons. McCullough (1999) found that religion-accommodative approaches are no more or less effective than

standard approaches and that the use of religious-accommodative approaches may be more a matter of client preference than of greater treatment efficacy. Suggestions were made, however, that for devout Christian clients, religious approaches may, literally, be the treatment of choice.

To help readers understand the possible reason for the conflicting outcome studies on the relationship between religion and mental health, Bergin (1991) explained that studies on religiosity have used different dimensions, some have used intrinsic dimensions, while others have used extrinsic. Persons who are extrinsic use religion for the purpose of status. Persons who are intrinsic internalize religious beliefs and uphold them despite social pressure. When using Allport and Ross's (1967) intrinsic and extrinsic dimensions as a measure of religiosity, those who demonstrate more intrinsic dimensions demonstrate positive correlations with positive characteristics (e.g., responsibility, internal locus of control, intrinsic motives, high levels of self-control and life satisfaction, low degree of anxiety and emotional disturbances, etc.), while those who demonstrate more extrinsic dimensions show negative correlations with these characteristics. Allport and Ross's measure of religiosity supports the idea that there are different ways of being religious (intrinsic and extrinsic) and that these ways will correlate differently with independent mental health criteria. The use of different dimensions of being religious may explain why some religious studies report neutral or negative correlations between religious faith and pathology and others reveal a positive correlation. This finding was also noted by Hackney and Sanders (2003), who suggested that psychology needs to gain "an understanding of which aspects of religiosity are most conducive to psychological health ..." (p. 52).

In the meantime, attempts have been made to build a culturally sensitive diagnostic category in clinical diagnosis. The Diagnostic and Statistical Manual of Mental Disorders (fourth edition), included a diagnostic category entitled "Religious or Spiritual Problem" to assist psychologists with identifying problems of a religious nature that are not attributable to a mental disorder.

Sensitivity to Religious Worldviews

Based on a review of the literature, Johnson, Ridley, and Nielsen (2000) identified characteristics of religiously sensitive therapists. These characteristics include knowledge, awareness, and attitude toward religious cultures, as well as their personal beliefs, emotional disposition, cognitive abilities and perceptual skills relevant to religious cultures. Johnson, et al. also identified behavior of religiously sensitive clinicians. Their literature review highlighted that religiously sensitive therapists acknowledge clear differences in worldview and religious belief between themselves and their clients and demonstrate respect for the client's specific religious and spiritual beliefs and values. They also pursue specific knowledge of client religious faith and religious community, distinguish between client religious culture or belief and psychopathology in the assessment process, protect the self-determination and religious autonomy of the client by guarding against explicit or implicit dilution of the client's rational decision-making capacities, and consistently take the client's religious faith and culture into account in conducting psychotherapy. In addition, religiously sensitive therapists will use accommodative therapy, meaning to incorporate the client's religious faith into treatment.

The details of a person's religious commitment, beliefs, and concerns can attest to the qualities of his or her identity awareness and interpersonal relations (Lovinger, 1984).

For many clients, their religious identity is inseparable from their self-concept (Henning & Tirrell, 1982). In this view, the assessment of a clients' religious faith is essential to gain an adequate and complete psychological perception of the client for effective treatment. Through religious exploration, the therapist may recognize the need for the client to integrate religious aspects of himself or herself to achieve complete psychological health (Giglio, 1993; Spero, 1995). Thus, therapists must be open to discussing religious content when that may contribute to the psychological growth of the client.

Client-Therapist Match

Studies have shown that people who identify with a religious faith usually consult with friends, family, and clergy about their problems before entering into therapy as a last resort (Sell & Goldsmith, 1988). Many clients desire for therapists to address religious issues in therapy and prefer therapeutic treatment from those who hold religious beliefs, values, and views similar to theirs (Privette, Quackenbos, & Bundrick, 1994). The client may feel more comfortable in knowing that he or she will not have to explain or justify their cultural background, specifically, the importance of their religion, to someone who already understands the dimensions and facets of their religion. In a review of the literature, however, Beutler, Clarkin, Crago, and Bergan (1991) suggested that therapeutic improvement is enhanced by a complex relationship of the "similarity and dissimilarity between client and therapist belief and value system" (p. 701). Beutler et al. also assert that it is the therapist's acceptance of the religious views of a client and ability to communicate within the client's framework more than the clinician's religious views that contribute to client improvement.

Although it may be assumed that sharing the same religious faith as clients is advantageous, it is not necessarily required (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992). It is important, however, that psychologists understand and are sensitive to clients' belief systems. There is evidence that clients who express a religious faith actually respond better to therapy that is adapted to their religious concerns. Propst et al. conducted a comparative study of the efficacy of traditional cognitive-behavioral therapy (NRCT) and cognitive-behavioral therapy with religious content (RCT). Their study included 59 depressed religious clients. Results indicated that clients who received RCT reported significantly lower depression after treatment compared to those who received NRCT. Propst et al. (1992) also found that religious inclusion in the treatment approach was more important than the personal commitment of the therapist.

King (1978) surveyed conservative Christian clients about their counseling experiences and opinions. Of the 22 persons in the study who reported having emotional problems, 13 actually sought counseling. Twelve of the 13 participants reported that they did not find their Christian faith to be threatened, although nine of the 13 clients were treated by a pastoral counselor or a counselor who was Christian. The one client who found his Christian faith to be threatened received professional counseling by a psychiatrist. Eight of the 13 clients reported that their faith was supported or strengthened by counseling. The eight referred to here were treated by a professional counselor who was Christian. It is interesting to note here that the concern of the clients was not about the religious orientation of the counselors, but more on the therapist response to their religious beliefs.

Multicultural Counseling Perspective of Religion

The detachment of clients' religious beliefs and counseling is bewildering, especially in light of the recent emphasis in psychology to respect diversity (Ponterotto, Casas, Sue, Zane, & Young, 1994; Suzuki, & Alexander, 2001). There are many ethnic groups that have relied on and continue to rely on their religious faith as a source that provides them with the strength, hope, and sanity they need to live, especially those ethnic groups (e.g., African Americans and Jews) who have a history of being oppressed. In addition, faith provides some sort of peace as people deal with questions of death and suffering (Miller, 2001). It is believed that many people stay away from therapy because of the negative remarks made by psychotherapists about religious beliefs. This antipathy to religion has hurt the reputation of psychotherapy as a non-judgmental enterprise, respectful of diversity and client values and culture.

In the case of religiosity as an aspect of multicultural counseling, psychologists would be providing a sub-standard form of care to religious clients and their families if they ignore the positive role of religious institutions and the reliance on religion among the majority of the population (Georgia, 1994). A part of multicultural counseling is being open to understanding and appreciating the differences within cultural groups and not misdiagnosing a client or devaluing or demeaning the client because of biases, including biases against religious faith.

Ibrahim (1985) contends that psychologists and future clinicians should be taught to conduct a religious history of clients, just as they are taught to conduct a clinical interview, as this will help in the development of effective "cross-cultural counseling and psychotherapy" (p. 626). According to Miller (1999), "spirituality deserves neither more

nor less attention than other important aspects of human nature … to overlook or ignore is to miss an important aspect of human motivation that influences personality, development, relationships, and mental health" (p. 261).

Religion is often not viewed as an important aspect of diversity, despite the importance of religion in the majority of the population (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002; Jones, 1996; Myer 1988). Issues of gender, ethnicity and sexual orientation are more the focus of dialogue on diversity. The acknowledgement of religion as a part of diversity issues is often of secondary concern — that an ethnic minority happens to be religious — instead of a primary concern. This neglect exists even though the APA ethics code considers religion as an aspect of diversity that psychologists are to respect in their clinical work and research (APA, 2002).

Thoughts on Divergent Religious Groups

Although differences exist within religious groups, between group descriptors are the focus of this current study. With the increase of immigration and more conservative religious world views, psychologists will be faced with religiously committed people who distrust the secular therapeutic viewpoint. Research has suggested that many religiously devout people avoid psychotherapy and distrust the therapy provided because mental health professionals are perceived as promoting secular values and worldviews that are hostile to their beliefs (Richards & Bergin, 1997). As stated earlier, King (1978) surveyed conservative Christians on their experiences and opinions of counseling services. The total number included in the study was 122 layman and clergy. Twelve percent of laymen and 42% of clergy expressed their dissatisfaction with available counseling services. The main criticism (expressed by 89% of the total number dissatisfied) was concern that their

faith would "be misunderstood or unappreciated, perhaps even ridiculed or eroded by an agnostic or atheistic counselor" (p. 279). Despite predictions that religion would decline as scientific thought and mental health increase (Ellis, 1985; Freud, 1927/1968), religion is experiencing growth (Beyer, 1999; Wallis, 2002). The world is rapidly becoming more religiously diverse. Across the world, Christianity is growing at a 2.3% rate annually, while Islam is at 2.9% annually (Jay, 1997). In the United States, Islam is the fastest growing religion. Mosques in the U.S. increased 42% between 1990 and 2000 (Hartford Institute of Religion Research, 2001).

Muslims believe that people comprise a body and soul (the body deteriorates but the soul lives forever). They believe that the soul is responsible for behavior. The soul of a person is the spirit, heart, and intellect (Haque, 2004). Muslims consider the heart of a person the "cognitive faculty" (p. 48). For Muslims, mental health includes the presence of virtues (e.g., acts of worship to God, doing good to others, wearing appropriate Islamic attire, cleanliness, desire to seek knowledge of self and God through sincere contemplation, etc.) believed to lead a person into well-being. Several passages in the Qur'an mention how errors in a persons thinking can lead to illnesses.

Haque (2004) provides an enlightening list of possible stressors relevant to American Muslims. This list presents issues this group of people may deal with in therapy (e.g., the challenge to observe their religious rituals, especially within the work place; having a sense of alienation and identity crisis; dealing with misconceptions and negative views about the Islamic faith, especially in light of recent terrorist acts by persons who are Muslim; confronting issues of prejudice and discrimination; facing social issues related to family roles within Muslim households being in conflict with

typical European American family structure, etc.) For Muslims who originate from other countries, American laws may conflict with the principles and virtues of the Qur'an, which may invoke stress, depression, and insecurity within the people. Methods for preventing and coping with mental illness within the Islamic faith include having faith, prayer, hope, patience, taking responsibility and demonstrating self-control.

According to Hartsman (2002), the goal of Judaism is to facilitate holiness in the world by performing good deeds to others. From a Jewish perspective, this act creates a meaningful life and is following God's commandments. The role of choice is critical in Judaism. According to this faith, each person acts on their will and takes responsibility for their choices, regardless of life circumstances. Although God is considered all-knowing, a person's choice will affect his or her quality of life. In Judaism, a person in psychological distress signifies that something has gone wrong with their relationship with God or with other people. The process of healing consists of the person maintaining their dignity and self-sufficiency while exploring the nature of the person's suffering or pain, struggling with the pain, and discovering meaning in life. A strong and supportive therapeutic relationship is key in Judaism, as positive interpersonal relationships, in general, are what contribute to having a meaningful life (Hartsman, 2002). It is imperative for psychologists to understand the importance of how religious belief systems can impact all areas of a person's life.

Based on their comments, past and present, there is reason for religiously devout persons to mistrust the field of psychology or fear being misunderstood. Albert Ellis (1980) asserted religion to be a psychosis. He states, "The elegant therapeutic solution to emotional problems is quite unreligious.… The less religious [patients] are, the more

emotionally healthy they will tend to be" (p. 637). A more recent example is the comment made by George Albee, a past president of the American Psychological Association: He implies that psychology must get rid of organized religion. "It doesn't matter which religion," he states. "They are all patriarchal. And that is one of the major sources of social injustice in our society and the world" (Albee, 2001). Statements such as those above validate the fear of potential clients who identify with a religious group that their religious beliefs and values may not be respected or taken seriously.

Ethical Considerations

Shafranske and Malony (1996) contended that psychologists are ethically obligated to give consideration to clients' religious faith, as they would to race, ethnicity, or sexual orientation. Aspects of religion are mentioned throughout the American Psychological Association Ethical Principles of Psychologists (2002). However, because of the aspirational nature of the ethical principles, focus will be placed on the ethical standards of the code for the purpose of emphasizing psychologists' roles and obligations, specifically with the population of focus. Section 2.01 (b) "Boundaries of Competence" states:

> … where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the

> training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals… (p. 5)

In reference to "or they make appropriate referrals", psychologists are reminded to consider the needs of diverse populations and adapt their services and methods of assessment and intervention accordingly (APA Ethical Standards 9.02 a-c, 2002). Although the majority of psychologists have not been trained on how to handle religious issues with clients in therapy (Hawkins & Bullock, 1995; Shafranske & Malony, 1990; Kersting, 2003), this point is highlighted to discourage psychologists from having excuses as to why they cannot treat persons who differ from them culturally. If the majority of psychologists resorted to referring clients who identify with a religion, then they would do a disservice to this population of people.

Ethical Standard 3.01 states that in work-related activities, psychologists do not discriminate based on religion, among other things. The term discriminate mean: to distinguish. For example, studies have found that psychologists have unfairly diagnosed religious clients with more pathological mental disorders, while non-religious clients were diagnosed with less severe disorders, although they demonstrated the same symptomotology (Edwards, Lim, McMinn, & Dominguez, 1999; Houts & Graham, 1986). Ethical Standard 3.03 mentions that psychologists are not to demean "persons with whom they interact in their work based on factors such as those persons' … religion…." And yet statements demeaning people of faith have been made by men whom some may consider pioneers or highly esteemed individuals in our profession (e.g., Albee, 2001, Ellis, 1980; Freud, 1927/1968, 1930/1961).

Ethical Standard 3.09 insists that, "when indicated and professionally appropriate," psychologists cooperate with other professionals in order to serve their clients/patients effectively and appropriately. Literature suggests there are many benefits of collaborating with clergy and ministers inside a client's religious organization (Hood, Spilka, Hunsberger, & Gorsuch, 1996; Pargament, 1997). Johnson, Ridley, and Nielsen (2000), specifically state that collaboration between psychologists and clergy may reduce ethical violations with religious clients by providing an avenue to obtain more education on religious populations. Collaboration has the potential to increase understanding and sensitivity toward clients' religious beliefs, and decrease misconceptions that may lead to erroneous diagnoses and demeaning behavior toward clients of a religious faith, which can both induce harm. APA (2002) Ethical Standard 3.04 instructs psychologists to take steps to avoid harming clients.

It is necessary, however, for mental health professionals to set clear boundaries and clarify their roles. Psychologists are not to attempt to serve as religious leaders or perform acts they are not qualified to perform, such as offering religious blessings and making concrete declarations about religious doctrine (Chappelle, 2000). Chappelle offers "An Ethical Decision-making Template" for psychologists to use to stay within their boundaries as therapists, which include two stages, with 10 steps for the second stage.

Stage 1 includes three steps for psychologists to follow: (1) boundaries and responsibilities of the psychologists role should be clear, (2) determine the appropriateness of the use of spiritual interventions given the setting (public or private) in which therapy occurs, and (3) evaluate the relevance of religion to the clients presenting

concern. In stage 2 several steps are outlined. In step 4, "obtain informed consent" (p. 46), therapists are encouraged to seek permission from the client and his or her supervisor before using spiritual interventions. Step 5 emphasizes clinical competency. Therapists should have the necessary educational and training to incorporate a specific spiritual intervention. Maintaining "professional and scientific responsibility" (p. 46) in step 6 contends that the intervention used "must be applied in an empirical, ecumenical and denominationally specific" manner (p. 46). The term ecumenical, in this context, means:

> …the common ground that undergirds the spirituality of clients, an ecumenical approach will help therapists avoid getting tangled in the many theological conflicts that exist among divergent belief systems. Thus, an ecumenical approach will help therapists intervene sensitively and effectively in the religious and spiritual dimensions of their clients' lives regardless of their clients' religious affiliation and spiritual beliefs. (Richards & Bergin, 1997, p. 15)

Step 7 warns therapists against imposing their religious beliefs onto to the client by stating "respect the religious values of the client" (Chappelle, 2000, p. 46). Documentation of the use of spiritual interventions, along with the rationale and effectiveness of usage, is the focus of step 8. The focal point in step 9 is to "make appropriate arrangements regarding financial reimbursement" (p. 46). Finally, step 10 declares that psychologists are to "promote the welfare of the client" (p. 46).

Also, relevant to the topic of ethics and dealing with religiosity in therapy is the APA's Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (1993). This document states "Psychologists respect

clients' religious and or spiritual beliefs and values, including attributions and taboos since they affect worldview, psychological functions, and expression of distress."

Summary

Literature in psychology has demonstrated the growth and strides in our profession to give more consideration to issues of religion. Professional conferences and presentations have been held to promote greater knowledge and skills on how to deal with religious issues in therapy. The APA ethics code and the Diagnostic and Statistical Manual of Mental Disorders, have made it a point to consider the importance of religiosity on issues of diversity and outside the confines of mental illness.

On the other hand, research continues to reveal that there is a lack of integration of religious dimensions in therapy (Richards & Bergin, 2000). In addition, evidence suggests there is limited clinical training on competent responses to issues of religion in therapy in psychology programs (Kersting, 2003; Shafranske & Gorsuch, 1984; Shafranske & Malony, 1990). This neglect exists despite the high percentage of persons who identify with a religious group within the population and the desire of potential and actual clients to have religious issues addressed in therapy (Morrow, Worthington, & McCullough, 1993; Rose, Westefeld, & Ansley, 2001). Research has not, however, established documentation of the experiences of actual clients since the study by King (1978). The current study attempted to provide a more current account of the experiences of religious clients in therapy, by investigating the helpfulness of therapists as perceived by religious clients.

Although it has been stated earlier in this paper that the majority of persons expressing a religious faith prefer religion to play a larger part in psychotherapy and that religious clients generally prefer therapists with similar beliefs and values, Worthington, Kurusu, McCullough, and Sandage (1996) noted that most of these studies were conducted using Christians. Results may differ among clients identifying with other religious groups. The current study sought to broaden the research on client experiences, by including clients of Islamic and Jewish faiths.

III. METHODS

The purpose of this study was to conduct a preliminary assessment of therapists' helpfulness as perceived by clients expressing a religious faith. This study utilized survey research to address research questions. The independent variables included client and therapist religious affiliation, therapist gender, therapist ethnicity, client level of strength of religiosity, and therapist behaviors and practices displayed toward religious clients and their concerns. The dependent variable was client report of helpfulness of therapist. This study examined the following research questions:

1. Does a relationship exist between therapists' display of ecumenical behaviors and clients' perception of therapists' helpfulness?
2. Does the religious affiliation of the therapists' relate to therapists' ecumenical characteristics and ethical practices toward religious clients and their concerns?
3. Does the perception of therapists' helpfulness differ based on the religious affiliation of the client?
4. Does the perception of therapists' helpfulness differ based on the clients' strength of religiosity?
5. Does the effectiveness of individual therapist ecumenical behaviors relate to client satisfaction ratings?

Participants

Participants for this study (N = 35) were male (n = 14) and female (n = 21) college students (undergraduate and graduate) who had at least one personal psychotherapeutic experience. These participants also expressed a Christian, Jewish, or Islamic religious faith. Christians represented 54.29% of the sample, 34.29% were Jewish, and 11.42% were Muslims. These students ranged in age from 18 to 53 years (M = 25.40, SD = 6.65). The majority of participants identified as Caucasian/White (60%). African Americans/Blacks comprised 25.71% of the sample, 2.86% were Latino, 2.86% were East Indian, 5.71% were Asian/Asian American, and 2.86% did not report an ethnic group. These participants were recruited from 11 institutions of higher learning.

Survey Description

Participants completed a survey consisting of four sections (see Appendix C). First they completed a set of demographic questions. This section included open-ended questions that pertained to the age, gender and ethnicity of the client, and the religious affiliation of the client and therapist. Therapist religious affiliation was reported by the client. The next section asked participants to comment on the helpfulness of up to two therapists: their first and most recent. This section consisted of two different scales, which measured therapist helpfulness and client satisfaction. The first was a one-item rating adapted from Brooks (1981 via Liddle, 1996). Participants answered the question "How helpful was this therapist?" with one of four responses: (1) destructive, (2) not at all helpful, (3) fairly helpful, or (4) very helpful. This one-item measure showed adequate

concurrent validity (r = .84; Liddle, 1999) with a longer, well-validated measure of client satisfaction (Conte, Buckley, Picard, & Karasu, 1994).

The second measure used was a section of the Problem Resolution Outcome Survey (PROS) (Heppner, Cooper, Mulholland, and Wei, 2001). There were three parts of this survey. The first part assessed the perceived effectiveness of problem-solving strategies. The second part assessed the level of interference of clients' presenting problems across seven common problem domains: mood, thinking, self-esteem, relationships, school/work, spirituality, and legal issues. The current study adopted Part Three, which consisted of three items assessing the perceived effectiveness of any resolution of the client's problem by examining the client's general satisfaction with therapy (GST) after termination of counseling. The three items asked about satisfaction with outcome, probability of returning, and recommending this counseling service to others. Participants indicated their agreement or disagreement with each item using a 6-point Likert scale (1 = strongly agree; 6 = strongly disagree). According to Heppner et al. (2001) there is evidence of construct (convergent) validity for the PROS, specifically with the GST factor. Higher GST scores were associated with more positive Computerized Assessment System for Psychotherapy Evaluation and Research (CASPER) outcomes. CASPER is a computerized intake assessment and an individually tailored psychotherapy outcome measure. The correlations ranged from .57 to .66, indicating a moderate association between these two outcome measures but also suggesting distinctly different constructs.

GST was also correlated with the working alliance (one of the best predictors of psychotherapy outcome) and counselor credibility (found to relate to positive therapeutic

outcome) at statistically significant levels at termination, as well as at one-month and six-month follow-ups (Heppner et al., 2001). Thus, client problem resolution, as reflected by GST, is related to major counseling process measures that are associated with or predictive of therapeutic outcomes. In addition, the results indicated that the PROS is sensitive to assessing therapeutic change over time (Heppner et al., 2001). Factor analysis revealed internally consistent factors with good variability, reflecting different components of clients' problem resolution. More specific to the GST, all the factor loadings for the three items were statistically significant ($p < .001$). The GST alpha coefficient for both the exploratory factor analysis and confirmatory factor analysis data sets was .87 (Heppner et al., 2001).

The next section of the survey asked participants questions relevant to their religious concerns in therapy (items 14–17) and the responses and practices of their therapist toward their religious concerns (items 18–36). Items 14–17 are original in nature; however, items 18–36 were derived from a list of behaviors and practices proposed by Richards and Bergin (1997) as being effective, ecumenical, and ethical when working with religious clients.

The behaviors and practices reported in Richards and Bergin (1997) were rephrased to reflect therapist behavior, which could be observed and reported by the client. For example, the statement "Effective ecumenical therapists are capable of communicating interest, understanding, and respect to clients who have religious and spiritual worldviews, beliefs, and values that are different from the therapist" (Richards & Bergin, 1997, p.120), was reworded into the following item "My therapist communicated interest, understanding, and respect to my religious and spiritual worldviews, beliefs, and

values." Characteristics and practices that reflected therapist belief or internal thoughts were omitted because they could not be reported by clients. For example, the following statement was not included in the survey: "Effective ecumenical therapists are aware of their own religious and spiritual heritage, worldview assumptions, and values and are sensitive to how their own spiritual issues, values, and biases could affect their work with clients from different religious and spiritual traditions" (Richards & Bergin, 1997, p.120).

Statements that included several possible questions were modified into separate items/questions so respondents can report on each individually. For example, the statement: When value conflicts between therapists and clients arise during therapy, therapists should respectfully and explicitly (a) express their own values, (b) acknowledge the client's right to hold different values, (c) explore whether the value disagreement could undermine the success of therapy, and (d) decide whether referral to another therapist is indicated. Therapists should do their best in such situations to safeguard their clients' autonomy and welfare and to remain aware of their relatively more powerful position in the therapeutic relationship, a power that should not be abused (Richards & Bergin, 1997, p.158) was organized into the following separate items (a) "If value conflicts between my therapist and me arose during therapy, my therapist respectfully and explicitly expressed his or her own values *and* acknowledged my right to hold different values" (b) "If value conflicts between my therapist and me arose during therapy, my therapist explored whether the value disagreement could undermine the success of therapy, and referred me to another therapist if necessary" (c) "If value conflicts between my therapist and me arose during therapy, my therapist safeguarded my autonomy and welfare and did not abuse his or her power in the therapeutic relationship."

A team of judges discussed and came to a consensus on how best to represent Richards and Bergin's (2000) original criteria for characteristics of effective ecumenical psychotherapists and ethical practices in respecting clients' values in the form of a client report survey. The team of judges consisted of the primary investigator (a counseling psychology doctoral candidate) and two faculty members experienced in research design. The faculty members included a counseling psychologist and a counselor educator. Each item, adapted from Richards and Bergin (1997) was answered by the participants using a yes, no, or not relevant response to indicate whether the behavior or practice under consideration was displayed by the therapist being rated.

The final section of the survey used in the present study consisted of The Santa Clara Strength of Religious Faith (SCSORF) Questionnaire (Plante & Boccaccini, 1997). The SCSORF is a brief self-report questionnaire comprised of 10 items. This questionnaire was designed to provide a quick measure of strength of religious faith regardless of religious denomination or affiliation. Sample items include "I look to my faith as a source of inspiration" and "My faith impacts many of my decisions." The items use a 4-point Likert scale response format, ranging from (1) "Strongly Disagree" to (4) "Strongly Agree." Scores range between 10 and 40, with higher scores reflecting stronger levels of religious faith. The SCSORF shows good reliability and validity.

The validity of the measure had been supported by strong correlations between results of the SCSORF and other established measures of religiousness and religiosity, such as the Hoge (1972) Intrinsic Religious Motivation Scale (*r*s ranged from .69 to .82, $p < 0.5$) and the Koenig, Meador, and Parkerson (1997) Duke Religious Index (*r*s ranged from -.85 to -.71, $p < 0.5$), while there seemed to be a lack of correlation between the

SCSORF and instruments measuring self-righteousness, depression, and need for alliance (Plante, Yancey, Sherman, Guertin, & Partdini, 1999). The SCSORF has high internal reliability (Chronbach's Alpha = .93 in Lewis, Shevlin, McGuckin, & Navra`til, 2001 and .95 in Plante & Boccaccini, 1997) and high split-half reliability (r = .92; Plante & Boccaccini, 1997). The factor loadings for each item were high, ranging from 0.72 to 0.91, revealing "that each item is a good indicator of the general construct of strength of religious feeling" (Lewis et al., 2001).

Procedure

The present study was conducted by an on-line survey on a secure website hosted by Auburn University, designed not to capture identifiable information. The targeted populations were undergraduate and graduate students who reported adherence to Christian, Islamic, or Jewish faith. Phone calls were made and e-mails were sent to advisors of 198 Christian organizations, 37 Jewish organizations, and 26 Muslim organizations, within 27 institutions, to obtain their agreement to assist in notifying the organizational members of the current research project.

Once the advisors of the religious organizations agreed to notify the members within the organization a recruitment e-mail (see Appendix A) was sent by the principal investigator to the contact address for each organization. The e-mail explained the research project and included a web-link to the Letter of Consent (see Appendix B) and the on-line survey. The recipient of the e-mail was asked to forward the email to all of the members of the organization. If the e-mail was forwarded, then the individual members of the organization received the explanation of project and the link to the Letter of

Consent and the survey to fill out on-line. Of the 27 schools and 261 organizations contacted, 11 schools participated in the current study, comprising 17 Christian organizations, 8 Jewish organizations, and 4 Muslims organizations. Once participants completed the on-line survey, the website program stored and transmitted the data into an Excel file, which was later analyzed using the Statistical Package for the Social Sciences (SPSS).

IV. RESULTS

Prevalence Data

The following demographic information was reported by research participants about their current/most recent therapist: Male (n = 15), Female (n = 20). Six therapists were reported as Black/African American, 28 were identified as White/Caucasian, and 1 was not identified with an ethnic group. Seven therapists were identified as Christian, and five as Jewish. The religious affiliation of 23 therapists was not reported. A total of 86% of participants reported that there current/most recent therapeutic experience was in a secular setting, while 14 % reported that therapy took place in a religious setting. A total of 91% of participants agreed to strongly agreed that they were satisfied with how counseling helped them and would recommend "this counseling service to other people," while 6% disagreed to strongly disagreed. A total of 86% of participants agreed to strongly agreed that "if the need should arise [they] would seek counseling again, while 11% disagreed to moderately disagreed. With current/most recent therapist, 37 % of participants agreed to strongly agreed that their presenting issue in therapy was relevant to their religion, while 57% disagreed to strongly disagreed. A total of 63% of participants reported that there was discussion of their religious beliefs in therapy. Of that total, 82% of the participants said they initiated discussion of their religious beliefs, 18% reported that the therapist initiated the discussion (14% of participants said this

discussion occurred during the intake session, 45% said discussion took place during the course of therapy, and 41% said discussion transpired during the intake session and during the course of therapy).

The demographic information below was reported by research participants about their first therapist: Male (n = 10), Female (n = 15). Two therapists were reported as Black/African American, 20 were identified as White/Caucasian, one was reportedly Latina, one was identified as Asian American and 1 was not identified with an ethnic group. Seven therapists were identified as Christian, three as Jewish, and one as Muslim. The religious affiliation of 14 therapists was not reported. A total of 84% of participants reported that there first therapeutic experience was in a secular setting, while 16 % reported that therapy took place in a religious setting. A total of 60% of participants agreed to strongly agreed that they were satisfied with how counseling helped them and would recommend "this counseling service to other people," while 40% disagreed to strongly disagreed. A total of 68% of participants agreed to strongly agreed that "if the need should arise [they] would seek counseling again, while 32% disagreed to moderately disagreed. With first therapist, 32 % of participants agreed to strongly agreed that their presenting issue in therapy was relevant to their religion, while 64% disagreed to strongly disagreed. A total of 56% of participants reported that there was discussion of their religious beliefs in therapy. Of that total, 79% of the participants said they initiated discussion of their religious beliefs, 21% reported that the therapist initiated the discussion (21% of participants said this discussion occurred during the intake session, 36% said discussion took place during the course of therapy, and 43% said discussion transpired during the intake session and during the course of therapy).

Analyses of Research Questions

Research Question 1

The first research question queried the existence of a relationship between therapists' display of ecumenical behaviors and clients' perception of therapists' helpfulness. A correlation analysis was conducted to test this hypothesis. Exploratory findings showed a positive relationship was found between the number of ecumenical behaviors exhibited by therapists and the rate of helpfulness. This was found to be true with current therapists (n = 35) and first therapists (n = 25).

Results showed that when fewer ecumenical behaviors were displayed by therapists, clients' evaluation of therapists' helpfulness was lower (see Figures 1 and 2). For example, when therapists were labeled as "not at all helpful", the mean number of ecumenical behaviors demonstrated was 4.0 for both current and first therapists. Current therapists who were perceived as "fairly helpful" reportedly showed a mean number of 5.60 ecumenical behaviors, while first therapists showed a mean of 7.25. Therapists who were perceived as "very helpful" exhibited the highest mean of ecumenical behaviors (i.e., 9.65 for current therapists and 8.37 for first therapists).

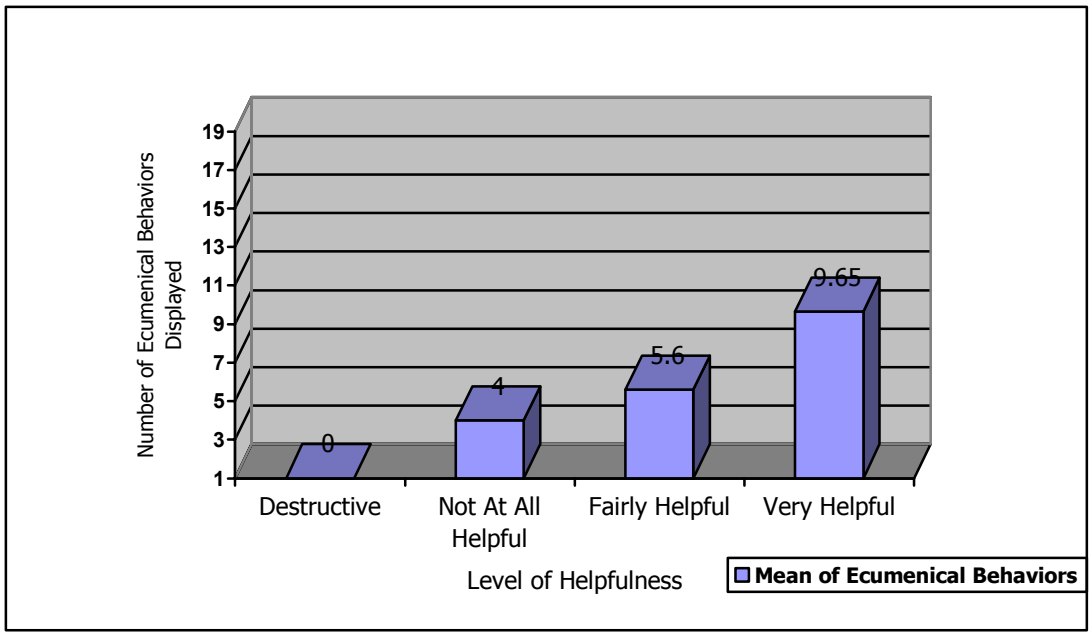

Figure 1. Relationship between Current Therapists' Ecumenical Behaviors and Perceived Level of Helpfulness

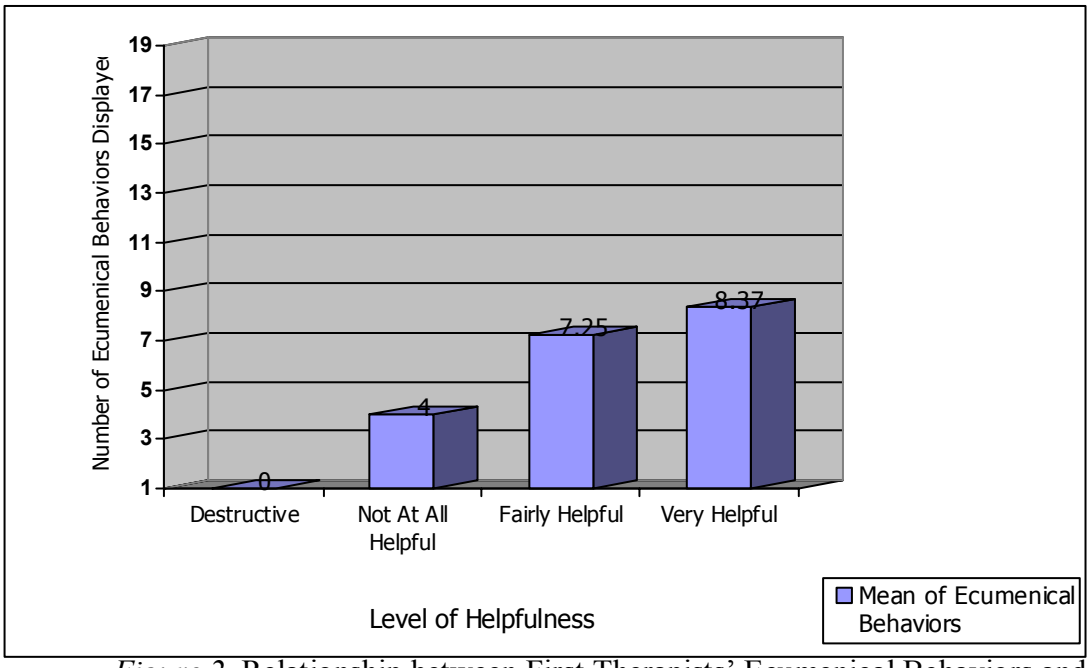

Figure 2. Relationship between First Therapists' Ecumenical Behaviors and Perceived Level of Helpfulness

Research Question 2

The second research question inquired whether or not therapists' religious affiliation would relate to therapists' ecumenical characteristics and ethical practices toward religious clients and their concerns. Descriptive analyses were conducted to assess if one religious group of therapists would display more ecumenical behaviors than the other two.

Preliminary descriptive data revealed that current therapists (see Figure 3) who were identified as Christians (n = 7) demonstrated the highest mean number (12.42) of ecumenical behaviors. Current Jewish therapists (n = 5) displayed the next highest mean of ecumenical behaviors, at 6.6, while current Muslim therapists were not identified by research participants. Among current therapists whose religious affiliation was not reported (n = 23), the mean number of ecumenical behaviors demonstrated was 6.56.

The order in which the highest number of ecumenical behaviors were displayed based on therapists' religious affiliation was the same for first therapists (see Figure 4) as it was for current therapists. First Christian therapists (n = 7) mean number of ecumenical behaviors was 10.70, followed by a mean number 5.0 for first Jewish therapists (n = 3). First Muslim therapists (n = 1) demonstrated a mean number of 4.0, while first therapists whose religious affiliation was unknown (n = 14) had a mean number 3.35.

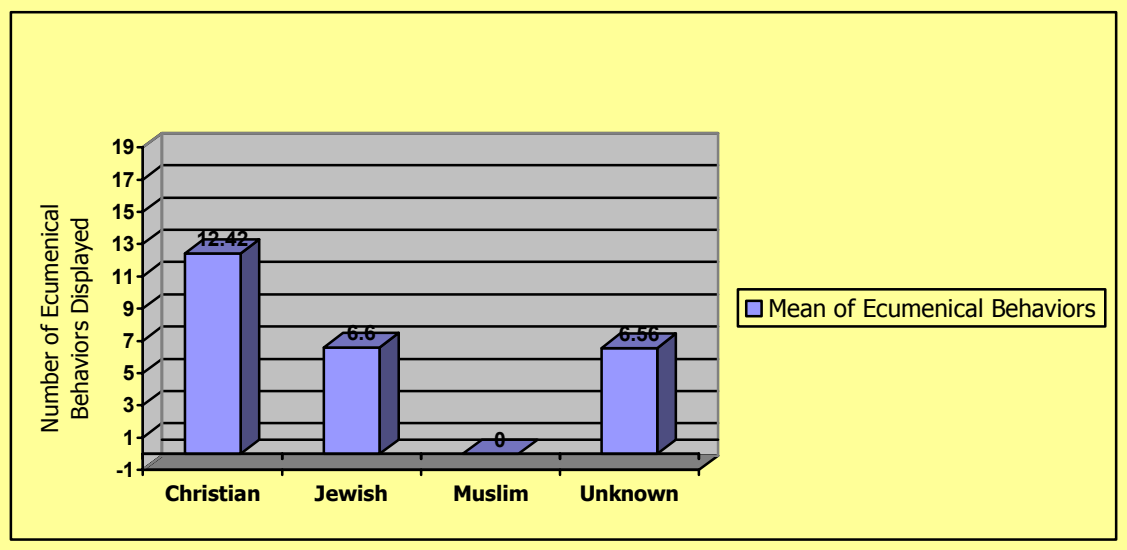

Figure 3. Relationship between Current Therapists' Religious Affiliation and Ecumenical Behaviors

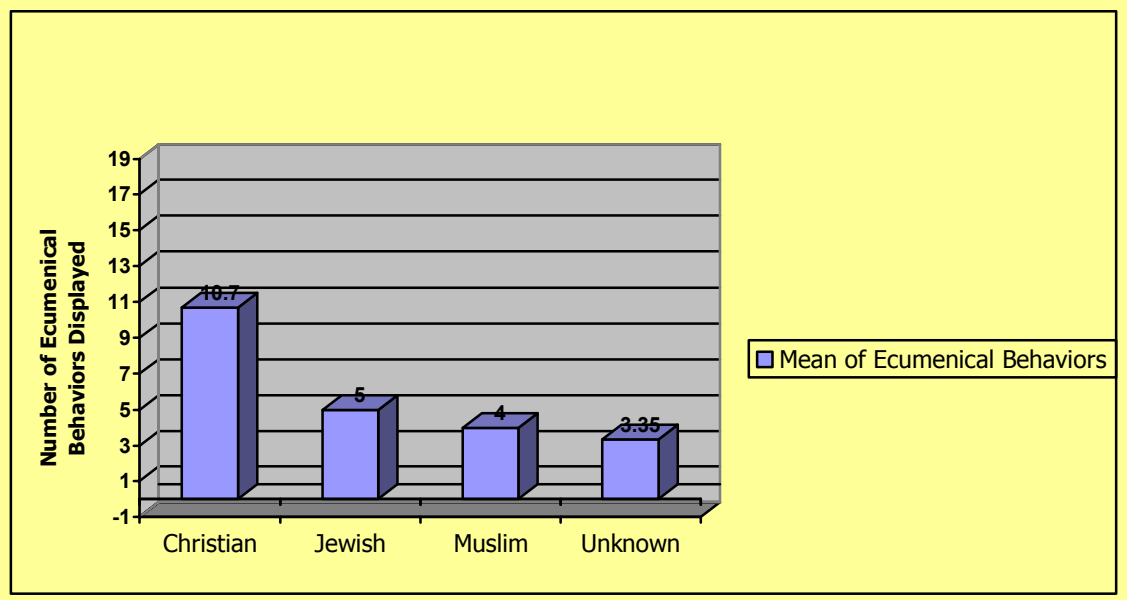

Figure 4. Relationship between First Therapists' Religious Affiliation and Ecumenical Behaviors

Research Question 3

The third research question inquired if the perception of therapists' helpfulness would differ based on the religious affiliation of the client. Again, descriptive analyses were conducted to test this hypothesis. Specifically, the purpose was to ascertain the impact of client religious affiliation on the perception of therapists' helpfulness.

Based on the percentage of ratings for current therapists (see Table 1), which is based on the total number of possible ratings that could be provided by each of the three religious groups of participants (Christians 19, Jews 12, and Muslims 4), tentative descriptive data found Muslims to report a higher level of helpfulness from therapists (75% of Muslims rated current therapists as "very helpful" and 25% rated current therapists as "fairly helpful"). Christians reported the next overall highest level of perceived helpfulness followed by Jewish participants. Based on raw scores, however, Christian participants who reported on current therapists tended to give higher ratings than Jews and Muslims, separately and combined.

The descriptive results above also hold true for descriptive data found with participant evaluations of first therapists (see Table 2). Muslims reported a greater percentage (i.e., 50%) of "very helpful" perceptions of therapists' helpfulness. Christians held the next highest percentage at 46.15%. In reporting perceived helpfulness for current and first therapists, Jewish participants indicated the largest raw number (3) and total percentage (33.33%) of therapists as being "not at all helpful." Christians had the lowest percentage of participants who viewed their therapists, current and first separate and combined, as "not at all helpful."

Table 1

Impact of Clients Religious Affiliation on Perceived Level of Helpfulness with Current Therapists

	Destructive	Not at All Helpful	Fairly Helpful	Very Helpful
Christian	0%	0%	36.84%	63.16%
Jewish	0%	8.33%	41.67%	50%
Muslim	0%	0%	25%	75%

Table 2

Impact of Clients Religious Affiliation on Perceived Level of Helpfulness with First Therapists

	Destructive	Not at All Helpful	Fairly Helpful	Very Helpful
Christian	0%	15.39%	38.46%	46.15%
Jewish	0%	25%	62.5%	12.5%
Muslim	0%	25%	25%	50%

Research Question 4

The fourth research question asked if the perception of therapists' helpfulness would differ based on the clients' strength of religiosity. A correlational analysis was conducted to test this hypothesis. Participants' strength of religiosity could range between 10 and 40, with higher scores reflecting stronger levels of "strength of religiosity. Correlational analyses of perceived helpfulness of current therapists' and clients' strength of religiosity was initially performed and exploratory findings showed a positive

relationship. As ratings of helpfulness increased, client strength of religiosity decreased (see Figure 5). The highest mean strength of religiosity, 33.0, was of those participants (n = 1) who perceived therapists helpfulness as "not at all helpful." The lowest mean strength of religiosity, 30.6, was for participants (n = 21) who perceived therapists helpfulness as "very helpful." Participants who perceived therapists helpfulness as "fairly helpful" (n = 13) had a mean strength of religiosity of 32.9.

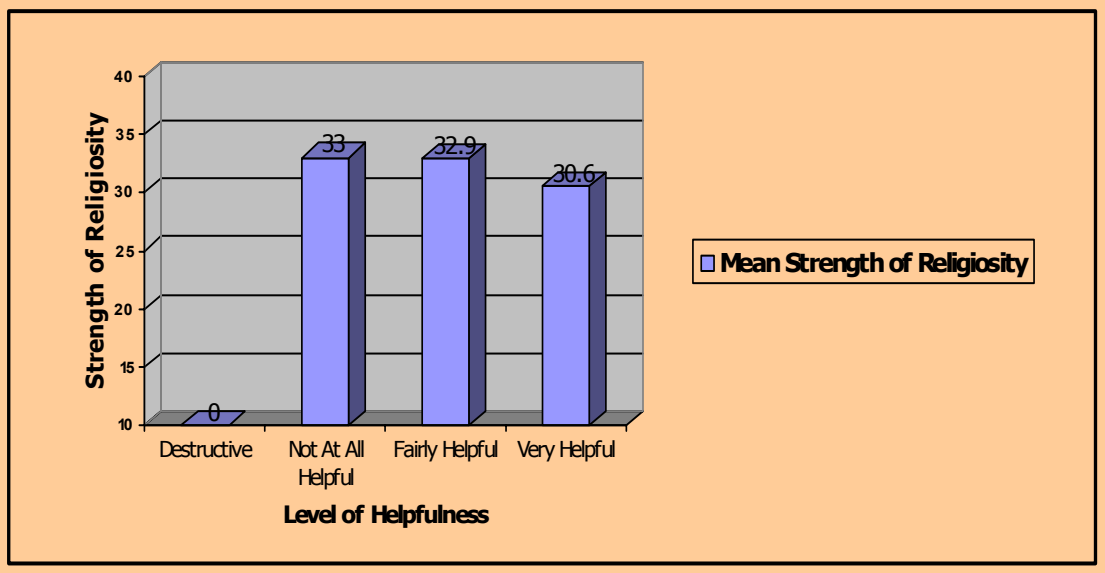

Figure 5. Impact of Clients Strength of Religiosity on Perceived Level of Current Therapists' Helpfulness

Exploratory findings did not reveal a relationship; however, between client perception of first therapists' helpfulness and client strength of religiosity (see Figure 6). The mean strength of religiosity was 30.8 for those participants (n = 5) who perceived

therapists helpfulness as "not at all helpful." The highest mean strength of religiosity, 30.9, was for participants (n = 11) who perceived therapists helpfulness as "fairly helpful." Participants who perceived therapists helpfulness as "very helpful" (n = 9), however, still showed the lowest mean strength of religiosity at 30.5.

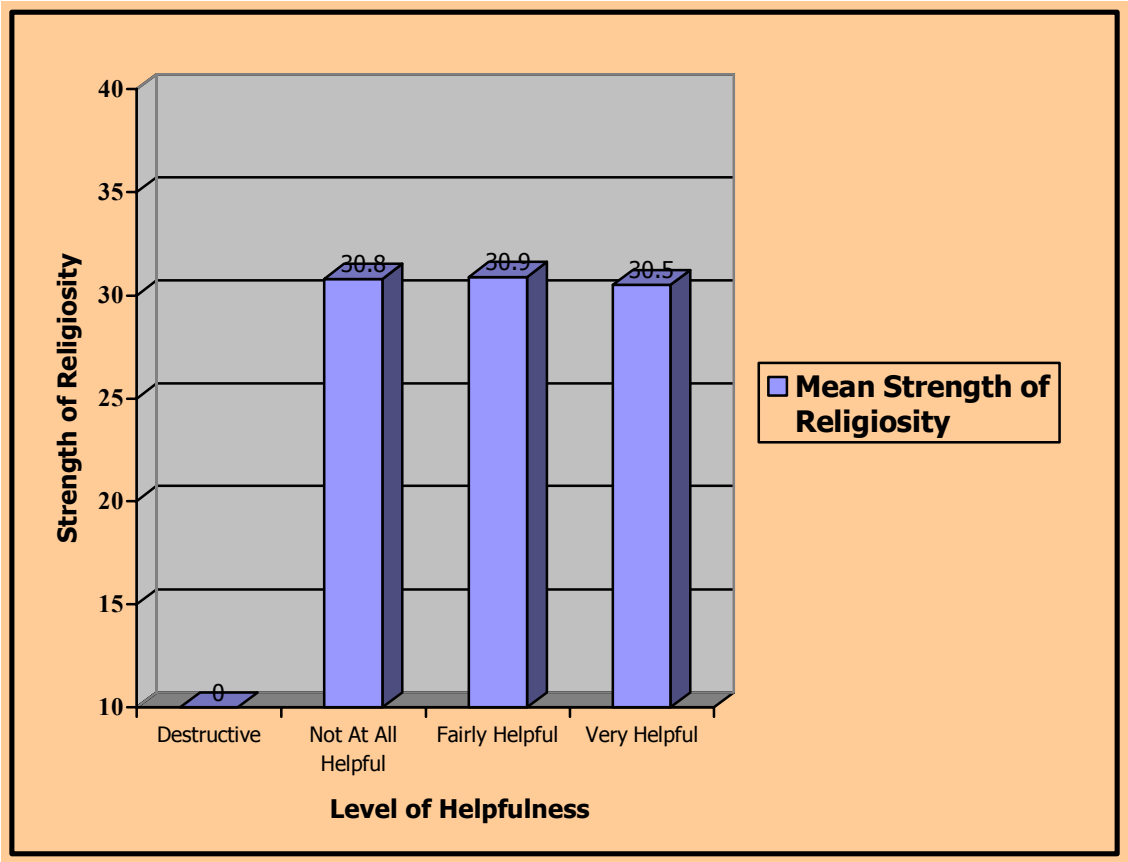

Figure 6. Impact of Clients Strength of Religiosity on Perceived Level of First Therapists' Helpfulness

Research Question 5

Finally, the last research question asked if the effectiveness of individual therapist ecumenical behaviors would significantly relate to client satisfaction ratings. A

correlation analysis was conducted to test this hypothesis. Tentative results found a positive relationship between effectiveness of both current and first therapists' ecumenical behaviors (i.e. level of helpfulness) and client satisfaction ratings (see Figures 7 and 8). Analysis showed that as the perceived level of helpfulness increased the client satisfaction rating mean increased.

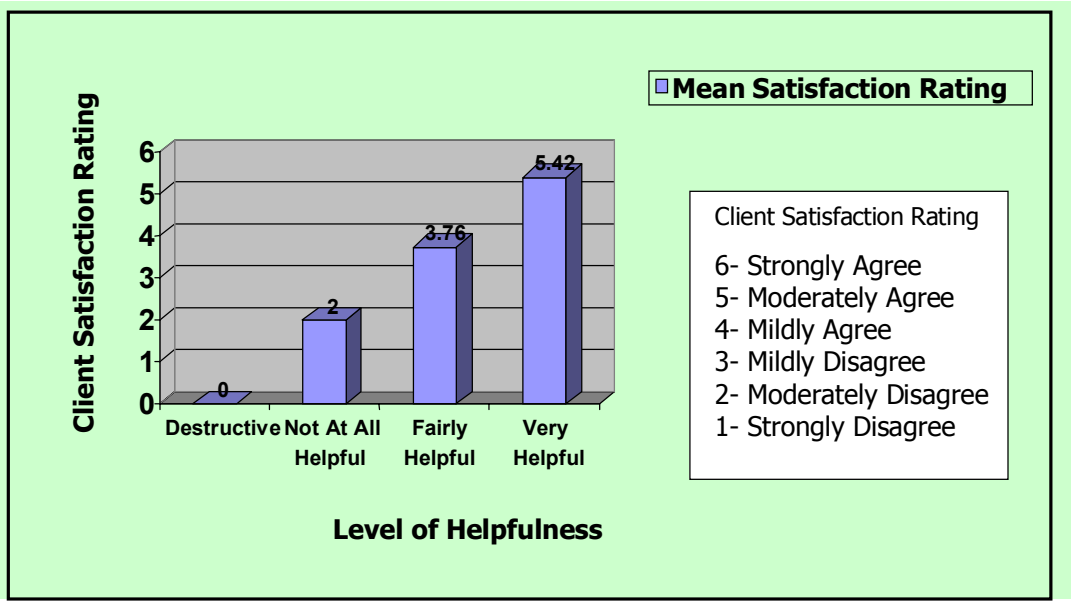

Figure 7. Relationship between Clients' Satisfaction Rating and Perceived Level of Helpfulness of Current Therapists

Initial analyses of perception of current therapists' helpfulness and client satisfaction rating revealed that participants who perceived therapists' helpfulness as "not at all helpful" (n = 1) had a mean client satisfaction rating of 2.0. Subjects who scored current therapists' helpfulness as "fairly helpful" (n = 13) had a client satisfaction rating mean of 3.76. Finally, the mean client satisfaction for participants who labeled current therapists' helpfulness as "very helpful" (n = 21) was 5.42.

Initial descriptive data also found a positive relationship between the perception of first therapists' helpfulness and client satisfaction rating (see Figure 8). Participants who perceived first therapists' helpfulness as "not at all helpful" (n = 5) had a mean client satisfaction rating of 1.8, while client who viewed therapists' helpfulness as "fairly helpful" (n = 11) had a satisfaction mean of 3.72. The mean client satisfaction rating for participants who deemed first therapists' helpfulness as "very helpful" (n = 9) was 5.55.

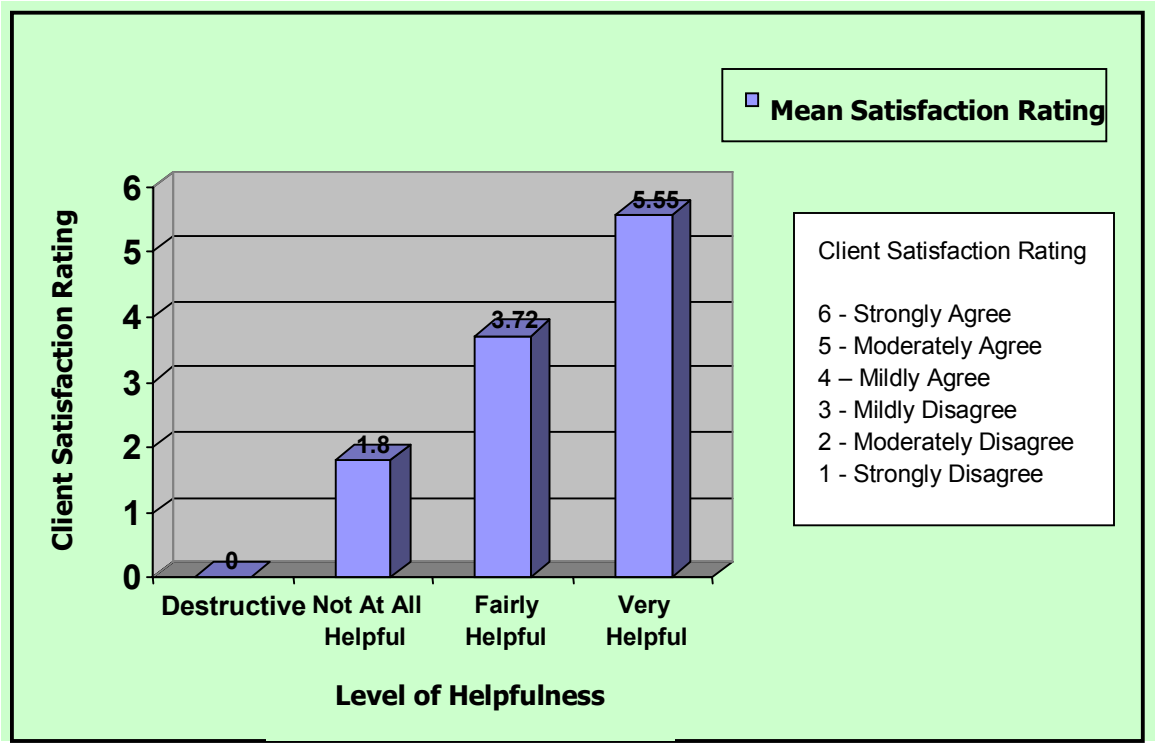

Figure 8. Relationship between Clients Satisfaction Rating and Perceived Level of Helpfulness of First Therapists

V. DISCUSSION

The purpose of this study was to conduct an exploratory assessment of the helpfulness of therapists as perceived by religious clients. This study also attempted to investigate the influence of different variables on religious clients' view of therapists' helpfulness. Specifically, the influence of therapists' overt display of ecumenical behaviors, clients' religious affiliation, and clients' strength of religiosity on clients' perception of therapists' helpfulness was evaluated. Ecumenical behavior refers to sensitive and effective behavior that will help therapists intervene in the religious and spiritual dimensions of their clients' lives regardless of their clients' religious affiliation and spiritual beliefs. (Richards & Bergin, 1997).

Summary of Findings

Descriptive results showed that religious clients, in general, appeared to view therapists as more helpful as the number of therapists' ecumenical behaviors increased. This tentative finding supports the assumptions offered by previous studies on the subject matter of religious clients and their therapeutic experiences. Morrow, Worthington, and McCullough's (1993) study contended that how a counselor responds to a client's religious beliefs may affect the client's perception of the counselor. In addition, Propst,

Ostrom, Watkins, Dean, and Mashburn (1992) proposed that therapists' sensitivity to clients' values and beliefs was most important in assisting religious clients.

The majority of religious clients (90%) in this exploratory study tended to view therapist helpfulness as "fairly helpful" or "very helpful." Therapists were perceived as "fairly helpful" by 40% of religious clients, while 50% of the population sampled in this study labeled therapists as "very helpful." Only 10% of clients viewed therapists as "not at all helpful." However, further analyses of the latter finding illustrated that 50 % of the 10% who perceived therapist as "not at all helpful, reported that their therapists exhibited a low number of ecumenical characteristics (ranging from 2–3 characteristics out of a possible 19) throughout the therapeutic relationship. These particular clients also viewed religion as being relevant to their presenting concern, and possessed high strengths of religiosity. Even more interesting, is that these therapists who were deemed as "not at all helpful" were noted by the client to be affiliated with the same faith as the client.

The above preliminary finding not only reflects a certain query stated in the current research (e.g., fewer ecumenical behaviors being correlated with lower client evaluation of therapists' helpfulness and the impact of clients' strength on perception of helpfulness) but it also mirrors, assertions made by Propst, Ostrom, Watkins, Dean, & Mashburn (1992), as well. They contended that, many times, it is falsely assumed that sharing the same religious faith as clients is advantageous. This seemed to be the case in the above example (i.e., participants in the example above did not appear to maintain a positive perception of the therapist's helpfulness based on the fact that their religious affiliation was the same the therapists'). Propst et al. (1992) also found that religious inclusion in the treatment approach was more important than the personal religious

commitment of the therapist. King's (1978) survey results revealed similar results. His study emphasized that the concern of the clients was not about the religious orientation of the counselors, but more on the therapist response to their religious beliefs.

The second research question asked if therapists' religious affiliation related to therapists' display of ecumenical behaviors. Data analyses to assess this hypothesis indicated that current and first Christian therapists demonstrated the highest number ecumenical behaviors. These results should be taken as merely descriptive results. These results may not be representative of Christian therapists, in general, versus Jewish and Muslim therapists. It must be emphasized here that participants of this study collectively reported their experiences with 14 Christian therapists, 8 Jewish therapists, and 1 Muslim therapist. Given the caveat above, it would follow that Christian therapists evaluated in this study would be more likely to display a greater number of ecumenical behaviors.

The third research question also inquired about the influence of religion. In this case, however, it was asked if clients' perception of therapists' helpfulness differed based on clients' religion. Descriptive results revealed that a higher percentage of Muslim clients, versus Christians and Jews, reported that their perception of therapists' was "very helpful." As with the results from the second hypothesis, these results must take into account the low participant rate of Muslims. It must be emphasized here that a total of 19 Christians, 12 Jews, and 4 Muslims participated in this study. With this being said, one Muslim perception of a therapist as "very helpful" equals 25% of the Muslim population. Therefore, theses results may not be representative of the Muslim therapeutic experience in general. Furthermore, caution must be taken also when using raw data from the current study to evaluate the effect of clients' religion on clients' perception of therapists'

helpfulness. Since approximately 54% of this study's sample size consisted of Christians, raw data, by chance rather than based on statistical significance, would reveal a greater number of "very helpful" perceptions of therapists' helpfulness. Again, results should be viewed as descriptive and may not be generalized.

Limitations of the Study

There are several limitations of this current study, such that the results interpretation of the results may not be externally valid and thus, may not be generalizable to anyone other than those who participated. The sample size of this study was extremely low (N = 35). Only 11% of 261 Christian, Jewish, and Muslim organizations contacted to solicit research participation actually agreed to participate in this study. It is worth highlighting, however, that the largest religious group in this study was Christian (n = 19), which represented 54% of the sample size. There was also a poor response rate from the Jewish (n = 12) and Muslim (n = 4) populations, which is very disconcerting and will be discussed later. It is not possible to report on the number of people who received the recruitment e-mails, as anyone designated to receive a recruitment letter could have forwarded the e-mail to other people.

Another limitation was the criterion that participants had to be college students. Participants were comprised of undergraduate and graduate students. College students were targeted because they were considered to be more likely to deal with religious identity issues (Fowler, 1994; Marcia, 1994) and therefore thought to be more likely to seek psychotherapeutic services. Most traditional college students are thought to be at a period in their lives where they are developing their own identity, becoming more

independent of their parents, and exploring a world that is probably different from which they were reared (Fowler, 1994). Some college students have to deal with potential conflict between knew experiences and ideals, that may be entertained as are part of the college experience, with family values, beliefs and attitudes. Although, the rationales above may be valid and supported in the literature, these particulars did not appear to be causative for college students to necessarily have more experiences in therapy. By limiting the sample to college students it becomes more difficult to contend that the results are generalizable to adults out of college and elderly populations.

The specific use of Christian, Muslim, and Jewish clients also causes concern for the external validity of the results gathered from data analysis. Results may not be generalizable to clients expressing a religious faith outside of Christian, Jewish, and Muslim or specific denominations within these groups. The results, however, may at least provide preliminary information to the field of psychology, at large, on the issue of how therapists can be most helpful when counseling religious clients and addressing religious issues in counseling.

The method utilized to recruit participants is also a limitation of this study. Letters were e-mailed to Christian, Islamic, and Jewish student organizations on various campuses, referring them to a website which contained surveys relevant to the study. Only Christians, Jews, and Muslims who had at least one therapeutic relationship were asked to complete the online survey. Because this study solicited actual clients, it is not clear the extent to which selection biases may have influenced the results. Perhaps religious "potential" clients would have viewed therapists' helpfulness differently. It is

possible that clients who had been most helped by therapists were also those most likely to participate in this study.

Finally, rephrasing the list of behaviors and practices proposed by Richards and Bergin (1997) as being effective, ecumenical, and ethical when working with religious clients into statements which could be observed and reported by participants, is a limitation of the study. For example, the original statement "Effective ecumenical therapists are capable of communicating interest, understanding, and respect to clients who have religious and spiritual worldviews, beliefs, and values that are different from the therapist" (Richards & Bergin, 1997, p.120), was reworded into the following item "My therapist communicated interest, understanding, and respect to my religious and spiritual worldviews, beliefs, and values." The new statement did not include the ending phrase "that are different from the therapist." This omission changes the original content and if included in the actual survey may have elicited a different response from the participants.

Future Research and Implications for Psychologists

One particularly interesting preliminary finding of the current study was that the majority of research participants (60%) did not consider their presenting issue in therapy as being relevant to their religion. However, as stated earlier, there was an initial positive relationship between therapist display of ecumenical behavior and client perceived level of helpfulness by the therapist. This initial finding may reflect religious clients' need to have their religious beliefs accepted in therapy even if those beliefs are of no therapeutic concern to the client. Further preliminary comparative analyses were performed and

illustrated that 53% of Christians seemed to agree with the statement of their presenting issue in therapy being relevant to their religion. This observation may have some implication for therapists as they work with religious clients, particularly Christians. This issue may be worth future investigation and research, as Christians may have different levels of expectations of therapy versus Jews and Muslims, where 90% of Jews and 75% of Muslims reported that their presenting issue in therapy was not relevant to their religion.

Additional descriptive statistics and comparative analyses were conducted of each religious group looking at the impact of client strength of religiosity on client perception of therapist helpfulness. Results showed that Christian clients tended to deviate from the majority on this variable as well. Christians' strength of religiosity was noted to decrease as perception of therapists helpfulness increased, whereas no correlation was found for the Jewish or Muslim participants. Future exploration in this area may, again, provide valuable information and enlightenment to the current knowledge base therapist may or may not have obtained on "actual" religious clients in psychotherapy. There may be something to say and learn about different experiences and expectations between religious groups and other potential factors that may impact religious clients' evaluation of therapy.

It may be beneficial for future research to explore potential internal and external factors that may contribute to better clinical understanding of Jewish and Muslim populations. For instance, literature, although not empirically supported, on the psychotherapeutic treatment of Jews point out that although Jewish persons may have high regards for the medical profession, their view of mental health is less favorable

(Rabinowitz, 2000; Zedek, 1998). Zedek stated that sociologists have documented Jews as having an exceptional emotional stability and that many Jews have adopted such belief. As a result, Jewish persons may present with denial, shame or guilt toward personal "emotional fragileness." This is possibly just one of many potential factors that may have played a role in the low participation of Jews in the current study.

Similarly, Muslims do not hold a favorable view of the mental health profession. In fact, most Muslims maintain a negative and suspicious outlook toward the field of psychology (Kobeisy, 2004; Hedayat-Diba, 2000). Hedayat-Diba reported that, typically, Muslims believe that professionals in the medical field disregard religious values and do not acknowledge the healing power within religious beliefs systems. As a result of this belief, Muslims are often distrustful of not only therapists, but also of psychiatrists and doctors alike. Consequently, this lack of trust is said to contribute to the under utilization of mental health services by Muslims. Again, these claims are not empirically supported in the cited references but, a focus of future research should inquire about these and other factors that may contribute to the avoidance of mental health services by Jews and Muslims and question what factors contribute to the usage of such services at all, even if it is rare. It is acknowledged, however, that the small sample size of Jews and Muslims within the present study could be representative of the small percentage of Jews and Muslims in the United States. Jews who identify with Jewish religion represent 1% of the U.S. population (Pew Research Council, 2001). Muslims also represent 1% of the U.S. population (Pew Research Council, 2001).

Expansion of the current study may also prove to be beneficial to the field of psychology. Specifically, future research should include a larger sample size, as to

provide more externally valid results. Research should target religious clients who identify their presenting issue as being relevant to their religiosity. Researchers should take into account, however, that religious topics are a rarity in counseling settings, whether the setting is secular or religious (Morrow et al., 1993). This endeavor may, therefore, be very time consuming and labor intensive, as the search for such a specific population of clients can become challenging. It would also be advantageous to focus on or identify religious clients who have had therapeutic experiences with secular therapists. It would be a disservice to the religious population to not investigate and evaluate the clinical treatment of religious clients with religious concerns, as Lukoff, Lu, and Turner (1998) report that there is currently little research in this area.

Further implications for psychologists include more education and training and the development of guidelines for the profession of psychology to follow to competently counsel clients who express a religious faith. Incorporating issues of religion in multicultural coursework in psychology may provide aspiring psychologists a conceptual framework for understanding the role of religion in the worldview of clients who identify with a religion. Psychologists should have some general knowledge of the fundamental concepts and core beliefs of the world's major religions and receive supervised experience in dealing with religious issues in therapy. Secular psychologists may become more skilled and comfortable in working with clients expressing a religious faith by attending workshops and conferences that focus on topics related to religion and mental health. Such workshops should also be included in in-service training. Although there is literature in the field of psychology that address issues of religion, its impact on mental health, and recommends behaviors and practices therapists should display when working

with clients of a religious faith (APA, 2002; Gartner, 1996; Johnson, Ridley, & Nielsen, 2000; Richards & Bergin, 1997), APA guidelines for psychotherapy with religious clients would be ideal to help psychologists better service clients of a religious faith.

Conclusion

The possible selection bias of this current study is actually a major strength of this study (i.e., the use of actual clients). Increased utilization of "real" religious clients in research in psychology is needed. It has the potential to provide first hand insight to therapeutic practices of psychologists with religious clients and also to the therapeutic effects of religion. Research with "real" religious clients could also provide an increased presentation of their preferences and experiences in therapy. Worthington, Kurusu, McCullough, and Sandage (1996) indicated that studies in this area have generally used "potential" clients, instead of "actual". They contended that "research on actual clients should be a priority" (p. 451). Despite the possible selection bias, this study, because of its use of real clients, is an important contribution to the literature on religion and psychotherapy.

A second strength of this study is that subject participation was not limited to Christians. Literature on psychology and religion has commented on the failure of our profession to research psychotherapeutic experiences of clients of a broad range of faith groups. Worthington (1988) and Morrow, Worthington, and McCullough (1993) called for research to include non-Christian participants. This study has, therefore, aided in preliminary efforts to close this gap in the literature.

Sensitivity to religious diversity is an important aspect of being culturally competent to offer therapeutic services in the field of psychology. Psychologists must challenge themselves to explore how their beliefs about religion may affect their work with religious clients. In striving to be professionally ethical and competent, counseling psychologists, are responsible for being attentive to effective approaches to utilize with religious clients (Miller & Thoresen, 1999), whether or not their presenting concern is related to religious issues or not.

More religious sensitivity training is needed in the profession of psychology, just as sensitivity training has been provided on other groups serviced by psychologists (e.g., Ethnic groups labeled as minorities, LGBT population, low SES groups, etc.). It has been reported that only 10 percent of newly graduated doctoral psychologists have received moderate to high levels of training in religious sensitivity and that most of that training was said to take place in doctoral programs with a religious training model (Kersting, 2003). Training is not to benefit the therapists alone, as current and potential religious clients benefit from having a therapist who is sensitive and appropriately responsive to their worldview. The field of psychology must continue to strive to improve upon demonstrating an open and supportive stance toward clients who identify with a religious faith.

REFERENCES

Albee, G. (2001). Same office, different aspirations: When it comes to determining values, APA ex-presidents agree to disagree. *Monitor on Psychology, 32 (11)*. Retrieved March 30, 2005, from http://www.apa.org/monitor/dec01/aspirations.html.

Al-Faruqi, I. R. (1984). Islam. In A. N. Kobeisy, *Counseling American Muslims: Understanding the faith and helping the people*. Westport, CT: Praeger Publishers.

Allport, G., & Ross, J. M. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology*, *5*, 432-443.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

American Psychological Association. (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist*, *48*, 45-47.

American Psychological Association. (1996). *Monitor on psychology.* Washington, DC: Author.

American Psychological Association. (2002). *Ethical principles of psychologists and code of conduct.* Washington, DC: Author.

American Psychological Association. (2003). *Division membership statistics 2003 year end.* Retrieved August 1, 2006, from http://my.apa.org/directory/divstat.cfm.

American Psychological Association. (2005). *2005 APA membership profiles.* Retrieved August 1, 2006, from http://research.apa.org/profile2005tl.pdf.

Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, *24*, 42-78.

Batson, C. D., Schoenrode, P., & Ventis, W. C. (1993). *Religion and the individual: A social-psychological perspective.* New York: Oxford University Press.

Bergin, A. E. (1991). Values and religious issues in psychotherapy and mental health. *American Psychologist*, *46*, 394-403.

Bergin, A. E. (1993). *Adaptive/healthy versus maladaptive/unhealthy religious lifestyles*. Unpublished manuscript, Brigham Young University, Provo, UT.

Bergin, A. E., & Jensen, J. P. (1990). Religiosity of psychotherapists: A national survey. *Psychotherapy*, *27*, 3-7.

Beutler, L. E., Clarkin, J., Crago, M., & Bergan, J. (1991). Client-therapist matching. In C. R. Snyder & D. R. Forsyth (Eds.), *Handbook of social and clinical psychology: The health perspective* (pp. 699–716).

Beyer, P. (1999). Secularization from the perspective of globalization: A response to Dobbelaere. *Sociology of Religion*. Retrieved March 30, 2005, from http://www.findarticles.com/cf_0/m0SOR/3_60/57533383/p1/article.jhtml.

Boyd-Franklin, N. (1989). *Black families in therapy: A multidimensional approach*. New York: Guilford Press.

Brawer, P. A., Handal, P. J., Fabricatore, A. N., Roberts, R., & Wajda-Johnston, V. A. (2002). Training and education in religion/spirituality within APA-accredited clinical psychology programs. *Professional Psychology: Research and Practice*, *33*(2), 203–206.

Brooks, V. R. (1981). Sex and sexual orientation as variables in therapists' biases and therapy outcomes. *Clinical Social Work Journal*, *9*, 198-210.

Chadbad on campus: The heart of Jewish student life. Retrieved March 30, 2005, from http://www.chabad.edu/templates/articlecco.html?AID=88366.

Chappelle, W. (2000). A series of progressive legal and ethical decision-making steps for using Christian spiritual interventions in psychotherapy. *Journal of Psychology and Theology*, *28*(1), 43–53.

Conte, H. R., Buckley, P., Picard, S., & Karasu, T. B. (1994). Relations between satisfaction with therapists and psychotherapy outcome. *Journal of Psychotherapy Practice and Research, 3,* 215–221.

Croce, P. J. (1995). *Science and religion in the ear of William James*, Vol. 1. Chapel Hill: University of North Carolina Press.

Cross, D. G., & Khan, J. A. (1983). The values of three practitioner groups; Religious and moral aspects. *Counseling and Values*, *27*, 13-19.

Dossey, L. (1993). *Healing words*. New York: HarperCollins.

Edwards, L. C., Lim, B. R. K. B., McMinn, M. R., & Dominguez, A. W. (1999). Examples of collaboration between psychologists and clergy. *Professional Psychology: Research and Practice*, *30*(6), 547–551.

Elkins, D. N. (1995). Psychotherapy and spirituality: Toward a theory of the soul. *Journal of Humanistic Psychology*, *35*(2), 78–98.

Ellis, A. (1980). Psychotherapy and atheistic values: A response to A. E. Bergin's "Psychotherapy and religious values." J*ournal of Consulting and Clinical Psychology*, *48*, 635–639.

Ellis, A. (1985). *The case against religion: A psychotherapist's view, and the case against religiosity*. Austin, Texas: American Atheist Press.

Faiver, C., Ingersoll, R. E., O'Brien, E., & McNally, C. (2001). *Explorations in counseling and spirituality*. Pacific Grove, CA: Brooks/Cole.

Fisher, S. F. (1985). Identity of two: the phenomenology of shame in borderline development and treatment. *Psychotherapy*, *22*, 101–109.

Fitzgibbons, R. P. (1986). The cognitive and emotive uses of forgiveness in the treatment of anger. *Psychotherapy*, *23*, 629–633.

Fowler, J. (1994). Moral stages and the development of faith. In B. Puka (Ed.), *Fundamental research in moral development* (pp.344–374). New York: Garland Publishing.

Frankiel, S. S. (1993). Christianity: A way of salvation. In H. B. Earhart (Ed.), *Religious traditions of the world*. San Francisco: Harper San Francisco.

Freud, S. (1961). Civilization and its discontents. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. *21*, pp. 64–145). London: Hogarth Press. (Original work published 1930)

Freud, S. (1968) The future of an illusion. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 21, pp. 5–56). London: Hogarth Press. (Original work published 1927)

Gallup Foundation (1996). *Religion in America: Gallup report No. 236*. Princeton, NJ: Author.

Gartner, J. (1996). Religious commitment, mental health, and prosocial behavior: A review of the empirical literature. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 187–214). Washington, DC: American Psychological Association.

Gartner, J., Larson, D. B., & Allen, G. D. (1991). Religious commitment and mental health: A review of empirical literature. *Journal of Psychology and Theology, 19*, 6–25.

Georgia, R. T. (1994). Preparing to counsel clients of different religious backgrounds: A phenomenological approach. *Counseling and Values*, *38*, 143–151.

Giglio, J. (1993). The impact of patients' and therapists' religious values on psychotherapy. *Hospital and Community Psychiatry*, *44*(8), 768–772.

Hackney, C. H., & Sanders, G. S. (2003). Religiosity and mental health: A meta-analysis of recent studies. *Journal for the Scientific Study of Religion*, *42*(1), 43–55.

Hall, G. S. (1901). The new psychology. *Harper's Monthly*, *103*, 727–732.

Haque, A. (2004). Religion and mental health: The case of American Muslims. *Journal of Religion and Health*, *43*(1), 45–58.

Hartford Institute of Religion Research (2001). Muslim mosque growing at a rapid pace in the US. Retrieved March 30, 2005, from *Faith Communities Today* website http://fact.hartsem.edu/Press/mediadvsry5.htm

Hartsman, E. E. (2002). Jewish Anthropology: The stuff between. In R. P. Olson (Ed.), *Religious theories of personality and psychotherapy: East meets west* (pp. 211–245). New York: Haworth Press.

Hawkins, I., & Bullock, S. L. (1995). Informed consent and religious values: A neglected area of diversity. *Psychotherapy*, *32*(2), 293–300.

Hedayat-Diba, Z. (2000). Psychotherapy with Muslims. In P. S. Richards & A. E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (pp. 289-314). Washington, DC: American Psychological Association.

Helminiak, D. A. (2001). Treating spiritual issues in secular psychotherapy. *Counseling and Values*, *45*(3), 163–189.

Henning, L. H., & Tirrell, F. J. (1982). Counselor resistance to spiritual exploration. *Personnel and Guidance Journal*, *61*, 92–95.

Heppner, P. P., Cooper, C., Mulholland, A., & Wei, M. (2001). A brief, multidimensional, problem-solving psychotherapy outcome measure. *Journal of Counseling Psychology*, *48*(3), 330–343.

Hoge, D. R. (1996). Religion in America: The demographics of belief and affiliation. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp.21–41). Washington, DC: American Psychological Association.

Hoge, D. R. (1972). A validated intrinsic religious motivation scale. *Journal for the Scientific Study of Religion*, *11*, 369–376.

Holden, J. M., Watts, R. E., & Brookshire, W. (1991). Beliefs of professional counselors and clergy about depressive religious ideation. *Counseling Values*, *35*, 93–103.

Hope, D. (1987). The healing paradox of forgiveness. *Psychotherapy*, *24*, 240–244.

Hood, R. W., Jr., Spilka, B., Hunsberger, B., & Gorsuch, R. (1996). *The psychology of religion: An empirical approach* (2nd ed.). New York: Guilford Press.

Houts, A. C., & Graham, K. (1986). Can religion make you crazy? Impact of client and therapist religious values on clinical judgments. *Journal of Consulting and Clinical Psychology*, *54*(2), 267–271.

Ibrahim, F. A. (1985). Effective cross-cultural counseling and psychotherapy: A framework. *Counseling Psychologist*, *13*, 625-638.

Jay, G. (1997). *Ten global trends in religion*. Address delivered to the World Future Society. Retrieved March 30, 2005, from the World Network of Religious Futurists' Web site http://www.wnrf.org/cms/tentrends.shtml

Johnson, W. B., Ridley, C. R., & Nielsen, S. L. (2000). Religiously sensitive rational emotive behavior therapy: Elegant solutions and ethical risks. *Professional Psychology: Research and Practice*, *31*(1), 14–20.

Jones, S. L. (1996). A constructive relationship for religion with the science and profession of psychology: Perhaps the boldest model yet. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 113-147). Washington, DC: American Psychological Association.

Kersting, K. (2003). Religion and spirituality in the treatment room. *Monitor on Psychology*, *34*(11), 40–42.

King, R. (1978). Evangelical Christians and professional counseling: A conflict of values. *Journal of Psychology and Theology*, *6* (4), 276–281.

Kobeisy, A. N. (2004). *Counseling American Muslims: Understanding the faith and helping the people*. Westport, CT: Praeger Publishers.

Koenig, H. G. (Ed.). (1998). *Handbook of religion and mental health*. San Diego, CA: Academic Press.

Koenig, H. G., Meador, K., & Parkerson, G. (1997). Religion Index for Psychiatric Research: A 5-item measure for use in health outcomes studies [Letter to the editor]. *American Journal of Psychiatry*, *154*, 885-886.

Kurtz, E. (1999). The historical perspective. In W. R. Miller (Ed.), *Integrating spirituality into treatment* (pp. 19-46). Washington, DC: American Psychological Association.

Largest Religious Communities. Retrieved March 30, 2005, from http://www.adherents.com/largecom/index.html

Larson, D. B., Sherrill, K. A., Lyons, J. S., Craigie, F. C., Thielman, S. B., Greenwold, M. A., & Larson, S. S. (1992). Associations between dimensions of religious commitment and mental health reported in the American Journal of Psychiatry and Archives of General Psychiatry: 1978-1989. *American Journal of Psychiatry*, *149*, 557–559.

Lauritzen, P. (1987). *Forgiveness: Moral prerogative or religious duty? Journal of Religious Ethics*, *15*, 141–154.

Legere, T. E. (1984). A spirituality for today. *Studies in formative spirituality*, *5*, 375–388.

Lehman, E. C., & Witty, P. A. (1931). Certain attitudes of present-day physicists and psychologists. *American Journal of Psychology*, *43*, 664–678.

Leuba, J. H. (1934). Religious beliefs of American scientists. *Harper's*, *169*, 291–300.

Levin, J., & Vanderpool, H. (1987). Is frequent religious attendance really conducive to better health?: Toward an epidemiology of religion. *Social Science Medicine*, *24*, 589–600.

Lewis, C. A., Shevlin, M., McGuckin, C., & Navra`til, M. (2001). The Santa Clara strength of religious faith questionnaire: Confirmatory factor analysis. *Pastoral Psychology*, *49*, 379–384.

Lewis, K. A., & Lewis D. A. (1985). Impact of religious affiliation on therapists' judgments of patients. *Journal of Consulting and Clinical Psychology*, *53*(6), 926–932.

Liddle, B. J. (1996). Therapist sexual orientation, gender, and counseling practices as they relate to ratings of helpfulness by gay and lesbian clients. *Journal of Counseling Psychology*, *43*(4), 394–401.

Liddle, B. J. (1999). Recent improvement in mental health services to lesbian and gay clients. *Journal of Homosexuality, 37(4),* 127–137.

Lovinger, R. J. (1984). *Working with religious issues in psychotherapy*. New York: Jason Aronson.

Lovinger, R. J. (1990). *Religion and counseling: The psychological impact of religious belief*. New York: Continuum.

Lukoff, D., Lu, F. & Turner, R. (1998). From Spiritual emergency to spiritual problem: The transpersonal roots of the new DSM-IV category. Journal of Humanistic Psychology, *38*, 21–50.

Mahoney, M. J. (1976). *Scientist as subject.* Cambridge, MA: Ballinger.

Marcia, J. E. (1994). Identity and psychotherapy. In S. L. Archer (Ed.), *Interventions for adolescent identity development* (pp. 29-46). Thousand Oaks, CA: Sage Publications.

McCullough, M. E. (1999). Research on religion-accomodative counseling review and meta analysis. *Journal of Counseling Psychology*, *46*, 92–98.

Miller, G. (2001). Finding happiness for ourselves and our clients. *Journal of Counseling & Development*, *79*, 382–384.

Miller, W. R. (1988). Including clients' spiritual perspectives in cognitive behavior therapy. In W. R. Miller & J. E. Martin (Eds.), *Behavior therapy and religion: Integrating spiritual and behavioral approaches to change* (pp. 43-45). Newbury Park, CA: Sage Publications, Inc.

Miller, W. R. (Ed.). (1999). *Integrating spirituality into treatment: Resources for practitioners*. Washington, DC: American Psychological Association.

Miller, W. R., & Thoresen, C. (1999). Spirituality and health. In W. R. Miller (Ed.), *Integrating spirituality into treatment* (pp.3-18). Washington, DC: American Psychological Association.

Morrison, M., & Brown, S. F. (1991). *Judaism*. New York: Facts on File.

Morrow, D., Worthington, E., Jr., & McCullough, M. (1993). Observers' perception of a counselor's treatment of a religious issue. *Journal of Counseling & Development*, *71*(4), 452–456.

MSA of the US & Canada. Retrieved March 30, 2005, from http://www.msa-national.org/resources/chapters.html.

Myer, M. S. (1988). Ethical principles of psychologists and religious diversity. *Professional Psychology: Research and Practice*, *19*(5), 486–488.

O'Donnell, J. M. (1985). *The origins of behaviorism: American psychology, 1870-1920*. New York: New York University Press.

Pate, R. H., Fr., & Bondi, A. M. (1992). Religious beliefs and practice: An integral aspect of multicultural awareness. *Counselor Education and Supervision, 32,*108–115.

Pargament, K. I., (1997). *The psychology of religion and coping*. New York: Guilford Press.

Pecnik, J. A., & Epperson, D. L. (1985). Analogue study of expectations for Christian and traditional counseling. *Journal of Counseling Psychology*, *32*, 127–130.

Pew Research Council. (2001). Largest Religious Groups in the United States of America. Retrieved July 27, 2006, from *Adherents* website www.adherents.com/rel_USA.html.

Plante, T. G., & Boccaccini, M. T. (1997). The Santa Clara strength of religious faith questionnaire. *Pastoral Psychology*, *45*, 375–387.

Plante, T. G., & Sherman, A. C. (Eds.). (2001). *Faith and health: Psychology perspectives*. New York: Guilford Press.

Plante, T. G., Yancey, S., Sherman, A., Guertin, M., & Partdini, D. (1999). Further validation for the Santa Clara strength of religious faith questionnaire. *Pastoral Psychology*, *48*, 11–21.

Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (Eds.). (2001). *Handbook of multicultural counseling* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Post, S. G. (1993). Psychiatry and ethics: The problematics of respect for religious meanings. *Culture, Medicine and Psychiatry*, *17*, 363–383.

Privette, G., Quackenbos, S., & Bundrick, C. M. (1994). Preferences for religious or nonreligious counseling and psychotherapy. *Psychological Reports*, *75*, 539–546.

Propst, L. R., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of depression in religious individuals. *Journal of Consulting and Clinical Psychology*, *60*, 94–103.

Rabinowitz, A. (2000). Psychotherapy with Orthodox Jews. In P.S. Richards & A.E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (pp. 237–258). Washington, DC: American Psychological Association.

Richards, P. S. (1991). Religious devoutness in college students: Relations with emotional adjustment and psychological separation from parents. *Journal of Counseling Psychology*, *38*, 189–196.

Richards, P. S., & Bergin, A. E. (1997). *A spiritual strategy for counseling and psychotherapy*. Washington, DC: American Psychological Association.

Richards, P. S., & Bergin, A. E. (Eds.) (2000). *Handbook of psychotherapy and religious diversity*. Washington, DC: American Psychological Association.

Richards, P. S., & Bergin, A. E. (2004). *Casebook for a spiritual strategy in counseling and psychotherapy*. Washington, DC: American Psychological Association.

Rose, E. M., Westefeld, J. S., & Ansley, T. N. (2001). Spiritual issues in counseling: Clients' beliefs and preferences. *Journal of Counseling Psychology*, *48*, 61–71.

Sarason, S. B. (1992, August). *Centennial address*. Paper presented at the 100th Annual Convention of the American Psychological Association, Washington, DC.

Sell, K. L., & Goldsmith, W. M. (1988). Concerns about professional counseling: An exploration of five factors and the role of Christian orthodoxy. *Journal of Psychology and Christianity*, *7*, 5-21.

Shafranske, E. P. (Ed.) (1996). *Religion and the clinical practice of psychology*. Washington, DC: American Psychological Association.

Shafranske, E. P. (2000). Religious involvement and professional practices of psychiatrists and other mental health professionals. *Psychiatric Annals*, *30*, 525-532.

Shafranske, E. P., & Gorsuch, R. L. (1984). Factors associated with the perception of spirituality in psychotherapy. *The Journal of Transpersonal Psychology*, *16*, 231–241.

Shafranske, E. P., & Malony, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy*, *27*, 72–78.

Shafranske, E. P., & Malony, H. N. (1996). In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 561–586). Washington, DC: American Psychological Association.

Spero, M. H. (1995). *Psychotherapy of the religious patient*. Northvale, NJ: Jason Aronson.

Spilka B., Hood, R. W., & Gorsuch, R. C. (1985). *The psychology of Religion: An empirical approach*. Englewood Cliffs, NJ: Prentice Hall.

Strong, S. R. (1968). Counseling: An interpersonal influence process. *Journal of Counseling Psychology, 15*, 215–224.

Sue, D.W., Arredondo, P., & McDavis, R.J., (1992). Multicultural competencies and standards: A call to the professional. *Journal of Multicultural Counseling and Development*, *20*, 64–88.

Sue, S., Zane, N., & Young, K. (1994). Research on psychotherapy with culturally diverse populations. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 783–817). New York: Wiley.

Vande Kemp, H. (1982). The tension between psychology and theology: I. The etymological roots. *Journal of Psychology and Theology*, *10*, 105–112.

Vande Kemp, H. (1996). Historical perspective: Religion and clinical psychology in America. In E. P. Shafranske (Ed.), *Religion and the clinical practice of psychology* (pp. 71–112). Washington, DC: American Psychological Association.

Wallis, J. (2002). Fundamentalism and the modern world. *Sojourners Magazine (SojoNet).* Retrieved March 30, 2005, from http://www.sojo.net/ magazine/ index.cfm/action/sojourners/issues/soj0203/article/020310.html

Wikler, M. (1989). The religion of the therapist: Its meaning to Orthodox Jewish clients. *Hillside Journal of Clinical Psychiatry*, *11*(2), 131–146.

Worthington, E. L., Jr. (1988). Understanding the values of religious clients: A model and its application to counseling. *Journal of Counseling Psychology*, *35*(2), 166–174.

Worthington, E. L., Jr. & DiBlasio, F. A. (1990). Promoting mutual forgiveness within the fractured relationship. *Psychotherapy*, *27*, 219-223.

Worthington, E. L., Jr., Kurusu, T. A., McCullough, M. E., & Sandage, S. J. (1996). Empirical research on religion and psychotherapeutic processes and outcomes: A 10-year review and research prospectus. *Psychological Bulletin*, *119*(3), 448–487.

Wulff, D. M. (1997). *Psychology of religion: Classic and contemporary*. New York: John Wiley & Sons.

Zeiger, M., & Lewis, J. E. (1998). The spiritually responsible therapist: Religious material in the psychotherapeutic setting. *Psychotherapy: Theory, Research, Practice, Training*, *35*(3), 415–424.

Zedek, M. R. (1998). Religion and mental health from the Jewish perspective. In H. G. Koenig (Ed.), *Handbook of religion and mental health* (pp.255–261). San Diego, CA: Academic Press.

APPENDICES

APPENDIX A

RECRUITMENT E-MAIL LETTER

If you identify yourself as Christian, Jewish, or Muslim, we invite you to participate in a research study about religious clients' perception of therapists' helpfulness, as it relates to clients' perceptions of the therapists' attention to and respect for clients' religious beliefs.

If you are **at least 18 years of age (at least 19 years of age if you are a student and/or a resident of the state of Alabama)** and **have seen at least one counselor or therapist** at some time in your life, please consider participating in this study on:

The Role of Religion in the Perception of Therapists' Helpfulness

This on-line study is designed to gain a better understanding of religious clients' expectations and experiences in therapy. Your task, should you choose to accept it, will be to answer a variety of questions about your therapeutic experience as a religious client. **YOUR RESPONSES ARE 100% ANONYMOUS –you will never be able to be identified in any way.** I believe the information gathered in this study has the potential to provide some form of preliminary guidance on practices therapists should consider when working with clients who are religious.

I very much hope that you will support my effort to learn as much as possible about this critical area of counseling. You will find detailed information about this study and will be asked whether or not you would like to participate at this time on the following site:

https://fp.auburn.edu/education/ccp/bostcry

Please check it out!!

The institutional Review Board of Auburn University has approved this study. If you would like further information about the study, please feel free to contact:

Crystal A. Bost, Doctoral Candidate
bostcry@auburn.edu

Thank you very much for your valuable time!

APPENDIX B

INFORMATION SHEET

The Role of Religion in the Perception of Therapists Helpfulness

You are invited to participate in a research study that examines the helpfulness of therapist as perceived by religious clients. This study is being conducted by Crystal A. Bost, a doctoral student in Counseling Psychology under the supervision of Dr. Renee A. Middleton, Professor. I hope to learn the impact of therapist behaviors and characteristics toward religious issues in therapy on religious clients' perception of therapists' helpfulness. You were selected as a possible participant because you identify yourself as Christian, Jewish, or Muslim. Organizational advisors of Christian, Jewish, and Muslim student organizations at eight institutions of higher learning were contacted and asked to forward an e-mail (i.e., the one you are reading now, which contains information about my research project and a link to an on-line survey) to all members within their respective organization. Thus, you are receiving this invitation to participate in the present study because of your membership in a Christian, Jewish, or Muslim student organization at a university located in a state identified as having a large population of Christians, Jews, and/or Muslims. However, please only participate if you are at least 18 years of age (at least 19 years of age if you are a student and/or a resident of the state of Alabama) and you have seen at least one counselor or therapist at some time in your life.

If you decide to participate, I ask that you complete the questionnaire sheets on-line by clicking on the web link provided at the end of this document. The questionnaire will take approximately 20-30 minutes to complete. When you have completed the questionnaire, click the "submit" button at the end of the questionnaire. I do not anticipate any risk to participating in this study. I hope the information gathered for this study will help identify therapeutic practices that may enhance the counseling experiences of religious clients.

Your participation in this study is voluntary and anonymous. You are not asked to put your name or any personally identifying information on the questionnaire. None of your school's faculty, administrators, or staff will have access to individual data, thus preserving your anonymity. Email addresses or URLs will not be captured, thus individual respondents cannot be identified. By completing and returning the survey on-line you are consenting to participate in the study. Information collected through your participation will be used to complete a dissertation as a requirement of the doctoral program in Counseling Psychology at Auburn University and may be submitted for publication and/or professional conference presentations. You may cease your participation at any time, without penalty, however, once you submit your data you cannot withdraw it from the study, as there will be no way to identify it.

Your decision whether or not to participate will not jeopardize your future relations with Auburn University or the department of Counselor Education, Counseling Psychology and School Psychology.

If you have any questions I invite you to ask me, Crystal A. Bost Jackson (586-943-0563; E-mail: bostcry@auburn.edu) or my faculty advisor, Renée Middleton, Ph.D (334-844-4446; E-mail: middlere@auburn.edu) and we will be happy to answer them. You may print a copy of this form to keep.

For more information regarding your rights as a research participant you may contact the Auburn University Office of Human Subjects Research or the Institutional Review Board by phone at (334)-844-5966 or e-mail at hsubjec@auburn.edu or IRBChair@auburn.edu . Thank you for your participation.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE WHETHER OR NOT YOU WISH TO PARTICIPATE IN THIS RESEARCH STUDY.

CONSENT: Clicking on the web link below certifies that you have read, understand, and agree to the terms of this study, and voluntarily agree to participate. You also acknowledge that you may cease your participation at any point during the study.
(CLICK HERE)

DECLINE: Not clicking on the above web link reflects that at this time, you choose not to participate in this study.

APPENDIX C

SURVEY OF RELIGIOUS CLIENTS' PERCEPTION OF THERAPISTS' HELPFULNESS

Survey of Religious Clients' Perception of Therapists' Helpfulness

(1.) What is your gender? Male Female

(2.) What is your age? _____

(3.) What is your Race/Ethnicity? _____

(4.) What is your Religious Affiliation?

Christian Jewish Muslim

Please answer the questions below (5-36) based on your most recent/current AND first (1st) therapeutic experience. If these two experiences are with the same therapist, please leave the second column blank and answer each question under the column for "Most Recent/Current Therapist."

		Most Recent/Current Therapist	**First Therapist**
(5.)	Therapist gender:	Male or Female	Male or Female
(6.)	Therapist Race/Ethnicity:	_____	_____
(7.)	Counseling Setting:	Secular or Religious	Secular or Religious
(8.)	If you know the religious affiliation of the therapist, please indicate here:	_____	_____
(9.)	How do you know your therapist's religious affiliation?	_____	_____
(10.)	This therapist was:	Destructive Not at all helpful Fairly helpful Very helpful	Destructive Not at all helpful Fairly helpful Very helpful

Please click your answers for questions 11-14 using the response format provided (1="Strongly Disagree" to 6="Strongly Agree").

		Most Recent/Current Therapist	First Therapist
		Strongly Disagree — Strongly Agree	Strongly Disagree — Strongly Agree
(11.)	I am satisfied with how counseling helped me.	1 2 3 4 5 6	1 2 3 4 5 6
(12.)	I would recommend this counseling service to other people.	1 2 3 4 5 6	1 2 3 4 5 6
(13.)	If the need should arise, I would seek counseling again.	1 2 3 4 5 6	1 2 3 4 5 6
(14.)	I considered my presenting issue in therapy as being relevant to my religion.	1 2 3 4 5 6	1 2 3 4 5 6

Please click your answers for questions 15-17 using the different response format provided for each question.

		Most Recent/Current Therapist	First Therapist
(15.)	Was there any discussion of your religious beliefs in therapy?	No or Yes	No or Yes
(16.)	If you answered yes to question 15, then who initiated the discussion of your religious beliefs?	You or Therapist	You or Therapist
(17.)	If you answered yes to question 15, at what point were your religious beliefs discussed?	(a.) Intake (first session) (b.) During therapy (c.) Both a and b	(a.) Intake (b.) During therapy (c.) Both a and b

Please click "Agree," "Disagree," or "N/A" (Not Applicable) to indicate your response to the statements made in numbers 18-36.

		Most Recent/ Current Therapist	First Therapist
(18.)	My therapist communicated interest, understanding, and respect to my religious and spiritual worldviews, beliefs, and values.	Agree Disagree N/A	Agree Disagree N/A
(19.)	My therapist showed an understanding of how my religious and spiritual worldview and values affect my sense of identity, lifestyle, and emotional and interpersonal functioning.	Agree Disagree N/A	Agree Disagree N/A
(20.)	My therapist had or sought specific knowledge and information about my religious beliefs and traditions when relevant.	Agree Disagree N/A	Agree Disagree N/A
(21.)	My therapist avoided making assumptions about my beliefs and values based on my religious affiliation alone.	Agree Disagree N/A	Agree Disagree N/A
(22.)	My therapist sensitively handled conflicts of values and beliefs that arose during therapy and did so in a manner that preserved my autonomy and self-esteem.	Agree Disagree N/A	Agree Disagree N/A
(23.)	My therapist made efforts to establish a respectful and trusting relationship with members and leaders in my religious community and sought to draw on these sources of social support to benefit me when appropriate.	Agree Disagree N/A	Agree Disagree N/A
(24.)	My therapist sought to understand the religious and spiritual resources in my life and encouraged me to use these resources to assist me in my efforts to cope, heal, change.	Agree Disagree N/A	Agree Disagree N/A
(25.)	My therapist sought to use religious and spiritual interventions* that were in harmony with my religious and spiritual beliefs when it appeared that such interventions could help me cope, heal, and change.	Agree Disagree N/A	Agree Disagree N/A

***Religious and Spiritual Interventions include:** Praying for clients, encouraging forgiveness, helping clients live congruently with their spiritual values, self-disclosing spiritual beliefs or experiences, consulting with religious leaders, and using religious bibliotherapy.

		Most Recent/ Current Therapist	First Therapist
(26.)	Before implementing a religious or spiritual intervention in therapy, my therapist described described the intervention to me and why he or she believed it could help me.	Agree Disagree N/A	Agree Disagree N/A
(27.)	When suggesting religious or spiritual interventions, my therapist ascertained whether I felt comfortable with the intervention and obtained consent from me to use it.	Agree Disagree N/A	Agree Disagree N/A
(28.)	My therapist respected my right to hold religious beliefs that differed from his or her own.	Agree Disagree N/A	Agree Disagree N/A
(29.)	My therapist did not proselytize or attempt to convert me to his or her own religious ideology or denomination.	Agree Disagree N/A	Agree Disagree N/A
(30.)	My therapist did not arrogantly condemn me when I engaged in value and lifestyle choices with which the therapist disagreed or believed to be destructive.	Agree Disagree N/A	Agree Disagree N/A
(31.)	If I wished, my therapist was willing to help me examine the moral and spiritual consequences and implications of my values and choices.	Agree Disagree N/A	Agree Disagree N/A
(32.)	My therapist assisted me with such explorations, as mentioned in question 31, in a morally and religiously open manner that was oriented toward resolving clinical problems rather than ideological indoctrination.	Agree Disagree N/A	Agree Disagree N/A
(33.)	If value conflicts between my therapist and me arose during therapy, my therapist respectfully and explicitly expressed his or her own values, and acknowledged my right to hold different values.	Agree Disagree N/A	Agree Disagree N/A
(34.)	If value conflicts between my therapist and me arose during therapy, my therapist explored whether the value disagreement could undermine the success of therapy, and referred me to another therapist if necessary.	Agree Disagree N/A	Agree Disagree N/A

		Most Recent/ Current Therapist	First Therapist
(35.)	If value conflicts between my therapist and me arose during therapy, my therapist safeguarded my autonomy and welfare and did not abuse his or her power in the therapeutic relationship.	Agree Disagree N/A	Agree Disagree N/A
(36.)	My therapist pursued religious and spiritual goals in therapy when I expressed my desire to do so.	Agree Disagree N/A	Agree Disagree N/A

Please click your answers to the following statements using the response format provided (1="Strongly Disagree" to 4="Strongly Agree").

1. My religious faith is extremely important to me

Strongly Disagree **Strongly Agree**
1 2 3 4

2. I pray daily
1 2 3 4

3. I look to my faith as a source of inspiration
1 2 3 4

4. I look to my faith as providing meaning and purpose in my life
1 2 3 4

5. I consider myself active in my faith or church
1 2 3 4

6. My faith is an important part of who I am as a person
1 2 3 4

7. My relationship with God is extremely important to me
1 2 3 4

8. I enjoy being around others who share my faith
1 2 3 4

9. I look to my faith as a source of comfort
1 2 3 4

10. My faith impacts many of my decisions
1 2 3 4