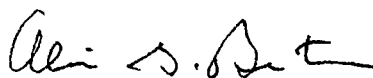


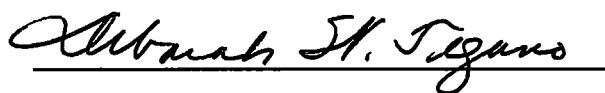
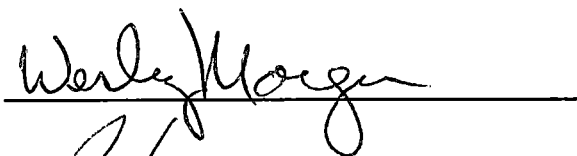
To the Graduate Council:

I am submitting herewith a dissertation written by Jodie Sutton Castellani entitled "The Treatment of Religious Issues in Psychotherapy: An Investigation into the Experiences of Psychotherapy Patients." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.



Alvin G. Burstein, Major Professor

We have read this dissertation
and recommend its acceptance:



Accepted for the Council:



Associate Vice Chancellor and
Dean of the Graduate School

THE TREATMENT OF RELIGIOUS ISSUES IN PSYCHOTHERAPY:
AN INVESTIGATION INTO THE EXPERIENCES OF
PSYCHOTHERAPY PATIENTS

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Jodie Sutton Castellani

May 1999

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DEDICATION

To Pete

...he restoreth my soul...

ACKNOWLEDGEMENTS

There are many people to thank for their contributions toward the completion of my degree. First and foremost, I would like to thank Alvin G. Burstein who has never wavered in his faith in me and who has been an incredible role model of academic integrity. I would also like to thank each member of my doctoral committee, Ron Hopson, Wes Morgan and Deb Tegano, for providing many valuable contributions to this project from their own unique perspectives. My undergraduate assistant, Colleen Everett, also deserves special recognition for her helpfulness, insight, and tenacity, as does Daniel Day for his assistance with the computer software.

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ABSTRACT

Despite the consensus that some form of free association is a useful psychotherapeutic enterprise in most talk therapies, there is nevertheless both anecdotal and empirical evidence that certain topics, including religion, are rarely therapeutically explored. Indeed, some evidence exists that therapists, perhaps inadvertently, sometimes display bias against their religious patients. If this is the case, it is particularly striking given that 96% of the American population endorses a belief in God. To address this concern, an exploratory project was designed to assess the real life experiences and perceptions of actual psychotherapy patients via existential-phenomenological perspectives and techniques. Patients were interviewed and their transcripts were evaluated by thematic analysis. Ten themes emerged from this process and the results indicated that the vast majority of this sample had indeed experienced at least one negative encounter when attempting to discuss religious issues with a therapist. Other themes which emerged included the patients' beliefs that religious exploration is necessary for effective psychotherapy outcome, that patients are often afraid to bring up religious topics, that they wish to know their therapist's religious orientation, and that they prefer therapists who have some interests or characteristics similar to their own. Each theme was illustrated by verbatim case examples, and a post-interview questionnaire was utilized to provide further verification of the findings. Future research should explore whether the themes found in this exploratory study also emerge in a more

representative population. Implications of the findings and further suggestions for future research are also presented.

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CHAPTER 1

INTRODUCTION

Psychoanalytic technique dictates that within the therapeutic setting patients must freely discuss, without any form of censorship, all issues that come to mind, no matter how seemingly irrelevant, embarrassing or socially inappropriate (free association). By doing so, patients reveal glimpses of their unconscious life in a process then subjected to the analyst's interpretation. As a result of these interpretations, the patient is said to benefit by having a greater understanding of their internal psyche. They are thus potentially more able to live a consciously-driven, willful existence rather than being swept through life by unconscious conflicts with their attendant emotional and behavioral sequelae. Interestingly, the analyst is also said to benefit from this endeavor for such in-depth explorations can sometimes yield not only a richer understanding of the individual patient but also a richer understanding of human nature in general.

Although many other forms of "talk therapy" evolved from this analytic tradition, including many non-interpretative therapeutic strategies, the basic premise of free association has survived in at least an attenuated form. The psychotherapy culture consequently expects that within both analytic and non-analytic talk therapies, patients should feel free to broach any topic, no matter how taboo or politically incorrect, within the confidential therapeutic hour. How such matters are dealt with therapeutically, of course, vary according to the

therapist's specific theoretical orientation, but the patient's ability and responsibility to initiate such discussions continues to be valued.

Despite the consensus that some form of free association is a useful psychotherapeutic enterprise, there is nevertheless both anecdotal and empirical evidence that certain topics, including religion, are rarely therapeutically explored. If this is the case, it is particularly striking, given that 96% of the American population endorses a belief in God (Miller, 1994) and that psychologists, with their inherent interest in all aspects of humanity (i.e., motivation, emotion, and behavior), should not be at least somewhat interested in their patients' religious lives. In fact, there is some research evidence that therapists, perhaps inadvertently, display a bias against religionists.

Researchers suggest a variety of rationales for this reported phenomenon, including inadequate professional training. However, others argue that there is a cultural disparity between the typical psychologist and the typical client, and it is a difference in worldviews that ultimately creates the alleged bias. Bergin & Jensen (1990) argue that every therapeutic relationship is a cross-cultural experience requiring sensitivity and attention to the differences between therapist and client. These differences may indeed be significant, for in addition to the fact that therapists typically have higher levels of education, income and family class background than their patients, Lovinger (1984) adds that therapists tend to have a "scientific Weltanschauung, a humanistic orientation, and a liberal political outlook that their patients may not." Comas-

Diaz (1995) adds that it is critical to ascertain the nature and degree of these and other potential differences because such ethnosociocultural factors are well known to impact both clinicians' and patients' ideas of psychopathology, diagnoses, and expectations of treatment; therefore, they inevitably impact the psychotherapy experience.

Clearly this phenomenon demands more investigation, as religion is an integral part of contemporary American culture. While psychology may avoid the ontological question about the existence of God, it should take seriously exploration of the psychological ramifications of a religious or spiritual life.

Focus of the Present Study

This thesis aims to further explore the degree to which religious beliefs are discussed or avoided in the psychotherapy process in three ways:

1. Historical Overview - By providing a cultural and historical basis for research through two overviews: 1) the relevance of religion in American culture¹ (to demonstrate the significance of the issue) and 2) the historical relationship between psychology and religion in America (to acquire a better contextual understanding).
2. Literature Review - By providing an overview and critique of the literature of the past two decades which examines the impact of psychotherapists' religious attitudes on the psychotherapy process

¹This survey will be limited to religion and psychotherapy in the United States due to the massive scope of the topic and also because religion has a very unique and peculiar historical role in United States culture.

with religious patients. The paper will then examine if therapists do, indeed, have significantly different religious orientations than the mainstream public (and perhaps their patients), and if so, how such differences might subsequently impact various aspects of the therapy process.

3. A Pilot Research Project - Based upon the historical context and critiques gleaned from the literature review, by creating a new research project which examines how religious issues unfold in the psychotherapy setting and how they are handled. Unlike prior studies, this study will approach the issue exclusively from the patient's perspective using a markedly different philosophy and methodology than traditionally utilized (phenomenological inquiry) in hopes of providing fresh insights.

CHAPTER 2

HISTORICAL OVERVIEWS

The Relevance of Religion to American Culture

Quantitative Analyses

Armstrong (1993) argues that humans have always been fascinated by religion because, like art, it has been one of the most significant and accessible ways for humans to make meaning of their lives. In fact, Armstrong continues, there is a strong case for arguing "Homo sapiens" is synonymous with "Homo religiosus" (p. xix). This label may be especially fitting in the United States, given the religious interest characterizing this country since Colonial times. Such religious investment was well documented in 1830 when Frenchman Alexis de Tocqueville studied religion in America and found that, despite the explicit policy of separation of church and state, religion was nevertheless "first of their political institutions" (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985, p. 253). In fact, de Tocqueville believed that religion was an extremely potent political force since it played an essential role in supporting the very mores that made democracy possible--self-control, individualism, and keeping rampant competitiveness in check.

Religion has continued to flourish in American culture despite the passage of two hundred years and a multitude of political and social counterforces. In marked contrast to the 1960s cry that "God is Dead" (e.g.,

Elson, 1966), Bloom instead finds that in the United States, "No Western nation is as religion-soaked as ours, where nine out of ten of us love God and are loved by him in return" (1992, p. 30). Even a quick perusal of polls conducted by popular American newspapers and magazines (see Tables 1 and 2) support Bloom's contention (Woodward, 1993; Miller, 1994; Sheler, 1994; Gibbs, 1995). In fact, the only European country to exceed the United States in endorsement of religiosity is Ireland where, according to Ruthven (1989), underdevelopment conspired with tribalism to produce an average Sunday church attendance of 82%. Comparing these figures to Great Britain, whose average weekly attendance is 14%, helps put American religious interest in perspective (p. 1-2).

Until recently, the popular media and occasional Gallup polls were the primary sources for statistics on religion, since such questions were not permitted on the United States Census. However, in 1990 the most extensive survey of religious identification in 20th century America was conducted by the Graduate School of the City University of New York. This project, called the National Survey of Religious Identification (NSRI), surveyed a representative sample of 113,000 Americans and asked one question: "What is your religion?" Among the results was the finding that religion was indeed a pervasive phenomenon in the United States; only 7.5% replied "none" to this question and an unusually low figure (2.3%) declined to respond at all (Kosmin & Lachman, 1993).

Table 1. Sample of Polls on the General Population's Religious Beliefs.

Belief/Activity	%	Source
Believe in God	96	Miller (1994)
Believe in Heaven	90	Miller (1994)
Believe in Angels	72	Miller (1994)
Believe in Miracles	69	Gibbs (1995)
Prays daily	50	Woodward (1993) Kantrowitz (1994)
Attends church weekly	40	Woodward (1993) Kantrowitz (1994)
Believes in Contact with the Dead	28	Miller (1994)
Believes in Reincarnation	27	Miller (1994)

Table 2. Facts on Religion in America.

Fact	#	Source
# of Religious Bodies/Sects in the US	1,500	Woodward (1993) Kantrowitz (1994)
# of varieties of Baptist denominations	75	Woodward (1993) Kantrowitz (1994)
# of churches per capita	1 : 900	Sheler (1994)
Voluntary financial giving to churches annually	38 billion	Sheler (1994)

Qualitative Analyses

Despite this remarkably consistent statistical portrait of religion in America, some researchers proclaim that what is truly interesting about the phenomenon is not necessarily the sheer volume of its devoted masses, but instead the history, demographic trends, and idiosyncrasies which the numbers obfuscate.

Changing demographics. One such finding is that American religion, though remaining statistically significant throughout, has undergone dramatic underlying demographic shifts since the 1960s. In other words, though religion has consistently remained important to Americans, the actual face of religion has changed in a remarkable fashion over the last three decades. After the immense religious revival of the 1950s, when church membership ultimately reached a pinnacle of 62% (Kepel, 1994, p. 108), the 1960s brought social and cultural shifts that fiercely challenged the core of mainline, traditional American religion. The result was a cultural split in which there was an increased secularism oddly coupled with a simultaneous explosion in new religious forces. Hence the generation that spawned the "death of God movement" also gave rise to "other gods" with the increased popularity of such groups as the Hare Krishna, Zen Buddhists, Sufis, mystical cults, religious communes, occult, "Jesus People", Eastern spiritualism and the human potential movement (Roof & McKinney, 1987, p. 11-12; Bellah, Madsen, Sullivan, Swidler, & Tipton, 1993).

In an attempt to counter these trends, mainline religions attempted to adjust their old-fashioned formats in hopes of adapting to the demands of

modern society—a strategy that proved drastically unsuccessful. Then, in the mid-1970s, a new religious force entered the public arena: the ultra-conservatives or fundamentalists. Their philosophy, in contrast to the mainline traditions, was not to adapt to society—but to have society adapt to them! Using Islam as an example of this powerful zeitgeist, "the aim was no longer to modernize Islam but to Islamize modernity" (Kepel, 1994, p. 2). The result of this movement was that by the 1970s religion was "flourishing on the right and left fringes but languishing in the middle" (Kepel, 1994, p. 2). While old, once powerful, mainline churches suffered decreased memberships, conservative evangelical fundamentalist religions, Roman Catholics, Black Protestants and new religious movements grew and continue to prosper today (Roof & McKinney, 1987; Ammerman, 1987; Bellah et. al., 1991). Consequently, Sheler finds that American religionists today are less committed to a specific denomination, more eclectic in views, more tolerant, more focused inward on their personal spiritual journey, and observe more dynamic religious styles than their predecessors (1994, p. 52).

The Americanization of Religion. Another American idiosyncrasy is the "Americanization of Religion" described by Bloom (1992). One reviewer writes that "Though America considers itself a Christian nation, in fact America has spawned its own peculiar theology"—a melting pot phenomenon known as the "Americanization of Religion" (Bloom, 1992). Unlike the fairly discrete world religions and American denominations described by scholars of comparative

religion (e.g., Rosten, 1975; Smith, 1989), some researchers are more impressed with the similarities of apparently diverse American religions and how they have essentially evolved and blended to create a generic "American Civil Religion" (Kosmin & Lachman, 1993; Bloom, 1992; Bellah et. al., 1991; Chalfant et. al., 1981, p. 221-3). This process includes another phenomenon, the "Protestantization of minority religions": As but one example, American Catholics and Jews have reportedly become more "Protestant" in their stance over time (e.g., less reliant on authority); hence, they now have more in common with American Protestants than they do with their international Catholic and Jewish cohorts (Kosmin & Lachman, 1993; Chalfant, Beckley, & Palmer, 1981).

A natural consequence of these changes is that any given religion's unique theology is either diluted or obliterated. In 1979, Gallup argued that Americans are "spiritual illiterates" and historian Henry Steele Commager remarked that the 20th century was a unique era in that "religion prospered while theology went bankrupt" (Kosmin & Lachman, 1993, p. 46). America's civil religion indeed has no coherent theology except perhaps a creed of "America First," and Carter (1993) posits that the movement has been successful primarily because it demands nothing of its believers and can thus be easily ignored by outsiders (p. 51). "God," Carter continues, "is asked to bless the nation, its people, and its elders. But nobody, in the civil religion, is asked to do anything for God" (p. 51-52).

Cultural "schizophrenia". Americans therefore live a paradox in which their country is "at once the most religious and the most secular of nations"--a situation that creates a "collective schizophrenia where the modern and the traditional become both seductive and repulsive simultaneously" (Kosmin & Lachman, 1993, p. 282). Indeed, although we live in a nation where most attend church and where our "national leaders lace their public statements with religious sentiments with a frequency surpassed perhaps only in Middle Eastern countries" (Moore, 1994, p. 4), religion is nevertheless taboo in certain circumstances. Berman (1990) writes:

Religion is seldom a topic of conversation at the typical American dinner party, or even in intimate talks among friends, where people focus more upon work, family problems, and the political and economic issues of the day. Discussions about personal, moral, and spiritual beliefs are seldom encouraged. And if you bring them up, you run the risk of offending your hosts (1990, p. 5).

Carter (1993) adds that though mainstream America endorses belief in God, what is not mainstream are those who are publicly vocal about it. While freedom of religious belief runs deep in our political ideology, Carter continues, our society is also plagued with fear of religious political domination and is therefore wary of anyone who takes their religion "too seriously" (p. 8). Evans (1994, p. 39) adds that, in fact, two of the major sources of religious hostility stem from the idea that religious absolutes are congenial to oppression and the idea that a

strong belief in anything inevitably translates into a desire to thrust it upon others. Berman (1990) illustrates this odd stance:

Meaningful living in the modern world requires the ability to lead a dual life. In our private lives we must live and act as though our beliefs and values are the most important thing in the world. In our public lives we must respect the right of others to believe as they choose and carrying our commitment to tolerance as far as possible before we attempt to limit the act of others (p. 13).

American society therefore seems to communicate that it is acceptable to be religious—but not too strongly and preferably in private.

The Relationship of Psychology and Religion

Given the prevalence of religion in the lives of the American people, coupled with our national religious idiosyncrasies, it seems inevitable that psychology would both historically and currently have a deep interest and curiosity in the psychological study of religion. Yet reality presents a markedly different picture.

Historical Overview

Part of psychology's difficulties with religion stem from its historic alliance with science which, by default, threw it into the age-old conflict between science and religion. Ludwig, for example, writes that while Christianity prevailed in power in the pre-modern era of Western culture, it drastically lost its treasured power when it made a series of strategic mistakes vis-a-vis the rapidly

developing scientific paradigm (1995). The most significant mistakes were that the church apparently claimed to be the final authority on every issue (even subjects unrelated to matters of faith) and also failed to address the pivotal scientific observations of Darwin and Galileo. As often happens when old powers are either unwilling or unable to accommodate to new worldviews, a massive paradigm shift occurred (Kuhn, 1970). The church lost most of its credibility while science simultaneously gained momentous power, thus cementing the already vast divide between religion and science (Ludwig, in press).

Academic psychology was born on the heels of this paradigm shift and, though its roots are clearly traced back to Greek philosophy and religion, the emerging schools of psychology typically sided with the new scientific worldview of its time and consequently incorporated vast amounts of classical physics into its conceptual core (Capra, 1982, p. 164). Shafranske & Gorsuch (1984) noted several reasons why spiritual issues were "ushered out of the legitimate purview of psychology": 1) the "urgency to dissociate itself from philosophy, to earn its credentials and respectability as an empirical science"; 2) Freud's seminal influence with psychoanalysis; and 3) the rising influence of American schools of behaviorism (p. 231-232).

The Influence of Freud

Shafranske & Gorsuch (1984) are correct in that Freud, with his phenomenal influence upon both Western culture at-large and subsequent

generations of scholars, single-handedly changed the course of the psychology of religion. Since Freud was such an awesome intellectual force, his views on religion would enjoy marked readership, discourse, and credibility. However, at the same time, Shafranske & Gorsuch (1984) are inadvertently misleading on one critical point: Freud ushered religious issues *into*—not *out of*—the legitimate purview of psychology. Freud devoted a considerable portion of writings to the psychoanalytic understanding of the religious life and his book, *The Future of an Illusion* (1927), was highly read and debated over the years. The real issue, therefore, is not that Freud ushered the psychology of religion out of consideration, but rather that many did not favor his conclusions about the neurotic aspects of religion. Again, due to his influence, these unfavorable comments carried much weight in the academic community and general public alike.

Capra believes that the Newtonian rational-mechanistic model utilized by Freud made it especially difficult for him to contend with religious issues since, according to Capra, Freud equated religion with ritual rather than mystical experience (1982, p. 187). While some of Freud's work on religion may reflect the reductionistic viewpoint inherited from physics (e.g., Freud, 1907), both his lifelong interest in the subject and his intensely passionate writings negate the view that he was embarked upon a strictly scientific mission devoid of any genuine personal interest. Indeed, Streaun (1994) points out that, although Freud was an avowed atheist, he was nevertheless an active member of B'nai B'rith,

spoke and wrote frequently on Jewish subjects, was enamored of Moses, and married an Orthodox Jewish woman (p. xii). Kung (1990) believes that the "genesis of Freud's atheism" may have stemmed from negative early childhood experiences with religion as much as, or more than, any Newtonian scientific influence. Freud, a Jew raised in Moravia where 96% of the population was Catholic, reportedly suffered intense pain and humiliation from both his strict, rigid Catholic nanny and his anti-Semitic Christian peers (Kung, 1990); such torturous experiences are thus bound to appear in Freud's subsequent career.

But regardless of the actual source of the influence, Freud himself admitted he was vehemently anti-religious and once said "I regard myself as one of the most dangerous enemies of religion" (E. Jones, 1955, p. 124). Peter Gay contributed that Freud's explicit goal was to "demolish religion with psychoanalytic methods" (1988, p. 526).

It is certainly undeniable that Freud's viewpoints on religion have had tremendous impact upon psychology, psychiatry, and Western culture at-large. Schaer (1950) summarizes the impact as follows:

Following the example of Freud...most psychoanalysts view religion with a jaundiced eye and are of the opinion that although religion may indisputably have had a certain significance in the spiritual evolution of mankind, it no longer bears any relation to man's present psychic state and had better be dropped overboard (p. 9).

Other Voices

C.G. Jung. Though Freud clearly has proved most influential in the culture and mainstream psychology, C.G. Jung is best known in the field known as the "psychology of religion." Whereas others, most notably Freud, saw religion primarily as a neurotic enterprise, Jung held a markedly disparate view: that religion was instead an essential ingredient of healthy psychological functioning (Wehr, 1971). Jung writes:

Among all my patients in the second half of life...there has not been one whose problem in the last resort was not that of finding a religious outlook. It is safe to say that every one of them fell ill because he had lost what the living religions of every age have given to their followers, and none of them has been really healed who did not regain his religious outlook (Wulff, 1991, p. 433).

It must be noted, however, that this passage does not endorse religion in the traditional sense for after years of observing his father, a Lutheran minister "tormented by the hollowness of his faith," Jung acquired an intense disdain for historic Christianity (Brome, 1978). Jung, in fact, only half-jokingly remarked that he would have burned as a heretic in the middle ages. To Jung, a meaningful religious experience could be located in the psyche, and such intense feelings, rather than realities per se, could provide stability and meaning to life if genuinely pursued (Ewen, 1988, p. 114).

William James. William James, like Jung, initially began the systematic study of religion due to his own father's deep spiritual commitment. However, unlike Jung, James did not reject his father's religion but instead sought to understand it more so he could perhaps better understand his father. Religion was also somewhat of a curiosity to James since, unlike the experiences of his friends and his devout father, God was only "dimly real" to him and he was "totally unable to pray" (Reck, 1967, Brennan, 1968, Feinstein, 1984). In this context, James sought to acquire knowledge of religion through the lens of psychology and, thus, exhaustive accounts of religious testimonies and experiences were gathered and consolidated into the text *The Varieties of Religious Experience* (James, 1902/1961). Writing to a primarily scientific audience, James needed to first somehow influence his audience to suspend their disbelief and, at least momentarily, consider religion the "reality of the unseen." Toward this goal, James proclaimed that:

If we look at man's whole mental life as it exists, on the life of men that lies in them apart from their learning and science, and that they inwardly and privately follow, we have to confess that the part of it of which rationalism can give an account is relatively superficial (p. 74).

To support his contention, James then gives examples such as the presence felt by a blind man, and the sense of surrealness that occurs in morbid melancholy. It seems that James cleverly handled this difficult topic because, rather than

challenging and debating the steadfast beliefs of his scientific community, James merely wanted to add something—to address realms that rationalism could not (e.g., religion) while still maintaining its prominence in other areas.

B.F. Skinner. B.F. Skinner is the quintessential example of the American behavioral schools of psychology which posit that religious beliefs are simply techniques of religious control which emerge as a matter of common reinforcement schedules. "Behavior," Skinner notes, "is not simply classified as good and bad, or legal and illegal, but as moral and immoral, or virtuous and sinful. It is then reinforced or punished accordingly" (Skinner, 1953, p. 352-353). Skinner continues that traditional descriptions of Heaven and Hell simply epitomize positive and negative reinforcement and, while the features may vary from culture to culture, it is doubtful whether any thing but well-known positive or negative reinforcers have been used.

Gordon Allport. Unlike the theorists mentioned above, Allport was an integrationist. He felt that explicitly using religion as part of the psychotherapeutic process would be a useful endeavor. So rather than simply promoting the psychological study of religion, Allport went a step further and promoted the psychological *use* of religion.

Allport believed that religion can be extremely helpful therapeutically in that it provides a unifying philosophy that gives meaning to one's life and provides some answers to life's hardships (Allport, 1950, p. xii). Religion was therefore included as one of the six facets incorporated into his system of value

orientations and Allport was indeed very critical of allegedly comprehensive theories that neglected this realm. Also, due to its potential helpfulness, Allport discounted theorists who only focused upon the psychopathology of religion: "The neurotic function of religious belief, its aid as an 'escape from freedom' is indeed commonly encountered, so commonly that opponents of religion see only this function and declare it to dominate any life that harbors a religious sentiment..." (p. xii). Allport was also concerned with the future of the human race and felt that, if religion and psychology could somehow be integrated, it would certainly be of great help. However, Allport realistically added, both would need greater flexibility in order to reach this potential for "a narrowly conceived science can never do business with a narrowly conceived religion" (p. x).

Summary of Theoreticians

The above illustrations not only provide the diverse perspectives of some of the most prominent theoreticians who addressed the problem of religion, but they also serve to illustrate the marked diversity in conclusions within the field.

Wulff (1991) commented that:

It will be obvious that psychologists are profoundly at odds about these matters. At one extreme are those who sweepingly condemn religion as hopelessly irrational and destructive, at the other those who see it as an essential resource for the fullest realization of human potential. How are such vastly different conclusions possible among scholars in the same field? In part they testify to

the widely varying assumptions about human nature and the goals and methods of psychology that psychologists bring to their study of religion. Although some textbooks attempt to present psychology as a unified science, most of the early "schools" are still with us, in spirit if not in name (p. viii).

Evolution of the Psychology of Religion

Despite the fact that religion was a highly respected area of study in the 1890s, and was given considerable attention by aforementioned notables such as Freud, James and Jung, it nevertheless suffered a sharp decline in subsequent years. Spilka, Hood, and Gorsuch (1985, p. xi) wrote that "a rapidly developing behaviorism that had no place for religion...forced work on religion to the periphery of scientific respectability" and indeed Strommen (1984) reports that between the years 1942-1968 only 2% of the empirical studies in psychology included religion as a variable. In 1959, Gross wrote that:

To the great body of clergy in the U.S., psychiatry was an insidious foreign plot to wreck the Church...To many psychiatrists, on the other hand, religion was an antiquated illness that had fettered man for centuries and in the light of modern needs and knowledge, could no longer be tolerated (1959, p. 3).

In addition to these historical factors, the personal religious beliefs (religious or irreligious) of psychologists, independent of their professional training and theoretical viewpoints, also appear to be highly significant. As early

as 1934, for example, Leuba reported that psychologists were considerably less religious than their natural scientist cohorts: 38% of physicists believed in God whereas only 10% of psychologists agreed (p. 294). Fifty years later Malony (in Shafranske & Gorsuch, 1984) surveyed American Psychological Association members' biographical data and found that only 1.1% endorsed any interest in religion—clearly, a marked discrepancy from the American public.

Outside the realms of psychology and psychiatry, however, the psychology of religion thrived in departments of religion and seminaries, while the pastoral psychology movement exploded in popularity after Anton Boisen founded Clinical Pastoral Training (Wulff, 1991).

It was only in the mid-1950s, when religion was at its pinnacle of popularity within the general American culture, that the psychology of religion slowly reemerged at its homebase. In this era, Martin & Nichols (1962) published findings in a mainline journal which refuted previous beliefs that religionists were inherently "rigid, prejudiced, unintelligent, suspicious, and generally pessimistic" (p. 3). New specialty journals were created, the American Psychological Association formed a division specifically dedicated to "Psychologists Interested in Religious Issues," and there was more empirical research published the next 20 years than had occurred in the preceding 75 (Spilka, Hood & Gorsuch, 1985, p. xii).

Despite this apparent renaissance, Spilka, Hood, & Gorsuch nevertheless concede that as of 1985 only a handful of specialists were cognizant of any of

the field's empirical and theoretical contributions. As Wulff (1991) explains, since the psychology of religion is often deemed "too scientific for the religious, and too religious for the psychologists," it is typically either neglected altogether or treated with contempt (p. 31). Kung (1990) labeled this neglect as the "repression of religion" (p. 127-134) and wrote that the topic, especially academic psychology, seemed to be avoided much like sexuality was in the past. Indeed, Martin & Nichols (1962) noted that, though religion was a fairly popular topic for student theses and dissertations, it was virtually ignored by "mature investigators" (p. 7). Lovinger (1984) adds several examples of rather conspicuous neglect, including a survey of introductory psychology textbooks which revealed that most entirely omitted religion in their otherwise exhaustive contents (p. 1).

Some argue that this apparent repression of religion in the psychological community simply reflects norms of American society. Indeed, as noted earlier, Berman (1990) writes that "religion is seldom a topic of conversation at the typical American dinner party," so in this sense the psychologists' apparent repression of religion simply reflects societal norms. The problem with this argument, however, is that psychologists are not supposed to reflect American etiquette in their confidential therapy sessions. In fact, the entire premise of free association explicitly requires that etiquette is not expected in sessions and that the patient should say whatever comes to mind without any censorship. So, in

this context, the apparent repression of religious topics is not expected or particularly useful.

On the rare occasion when religion is not repressed, Kung (1990) notes that it is then often only couched in a negative context (e.g., the clinical literature predominantly focuses on the psychopathology of religion among psychiatric patients rather than any potentially healthy aspects). Numerous renowned psychologists have also recently acknowledged this phenomenon: Vitz (1994) wrote that "psychology is hostile to most religions (p. 9-10); Szasz (in Ankerberg & Weldon, 1995, p. 13) declared that "medical psychiatry is not merely indifferent to religion, it is implacably hostile to it" and, in his American Psychological Association presidential address, Donald Campbell stated that "modern psychology was more hostile to religiously based moral views than could be justified" (in Ankerberg & Weldon, 1995, p. 13).

As noted earlier, there has very recently been marked improvement as several texts have emerged in the past two years with contributions by some of the most prominent researchers in the field (e.g., Shafranske, 1996). Due to recent advances in sensitivity to cultural issues, these particular books have not been relegated to special interest groups, but have instead been promoted by mainstream psychological journals. In keeping with the Stanton Jones' plea for a more constructive relationship between psychology and religion (1994), these books contain information on both theory and technique and are also immediately useful in the clinical setting as they cover clinical applications in a

variety of realms including marital therapy (Sperry & Giblin, 1996), 12-step programs (Hopson, 1996); cognitive-behavioral therapy (Propst, 1996) and psychoanalytic therapy (Rizzuto, 1996).

Summary of Historical Overviews

Certainly, as Strommen noted, "there is a cost to the field of psychology in ignoring religion for it means a loss of understanding" (p. 154). In the past few years, significant steps have been taken to better understand the psychology of religion and the time is therefore ripe to forge ahead with further research and attempts at improved understanding.

Before embarking on a research program to better understand and explore what the psychotherapy process is like for those with religious faiths of various kinds, it is first essential to examine the past. The first step then is to conduct a literature review, to analyze the methods and findings therein, and then to arrive at conclusions on how to plan continued exploration through a pilot research project.

CHAPTER 3

LITERATURE REVIEW

This literature review was designed to evaluate any prior studies that explored how psychotherapists and religionists interact in the psychotherapy process. The goal of the review was to determine 1) if therapists do, indeed, have significantly different religious orientations than the mainstream public (and thus perhaps their patients), and 2) whether any detected similarities/differences in the therapeutic dyad subsequently impact psychotherapy process.

The survey was conducted using the 1996 *PsychLit* computerized database and all relevant articles from the past two decades (1976-1996) were evaluated. As part of the search process, the following factors were considered.

First, religiously-identified counselors (e.g., "Christian counselors"), particularly those at a religiously-based facility (e.g., a church setting), would ostensibly handle religious/spiritual issues differently than a secular psychotherapist (e.g., they might quote scripture, ask the client to pray, etc.). Articles which exclusively pertained to these situations were therefore omitted from our study since our focus is instead on what happens when religious issues unfold in "*secular* psychotherapy" settings with therapists who are not explicitly clinically trained in such matters.

Secondly, from the remaining articles that focused upon psychotherapy, psychodiagnosis, and religion, only articles on therapist characteristics, client

characteristics, religion, bias/discrimination, therapist clinical and non-clinical decision-making, and psychotherapy process/outcome were selected for review. These articles were deemed most relevant to this project's goal and they typically were found in specialty, rather than mainline, journals. Of this select group, a substantial bulk of the articles were theoretical in nature; few were experimental, and none were phenomenological. These remaining articles were reviewed for methodological rigor and the author's conclusions.

Surveys of Psychotherapists' Religious Beliefs and Behaviors

Overview of the Literature

Although aforementioned studies (e.g., Leuba, 1934) indicated that psychologists, as a profession, were typically less religious than both the general public and their scientific cohorts, an evaluation of more recent data is needed. The following studies therefore provide insights into polls taken within the past two decades and, furthermore, many provide a categorical breakdown of psychologists by area of specialization so that the views of clinical practitioners in particular can be obtained.

In 1984, Shafranske & Gorsuch mailed surveys to 1,400 members of the California Psychological Association Division of Clinical Psychologists. Results demonstrated that these psychologists as a group are indeed less religious when compared to the general population, but not categorically irreligious or anti-religious when criteria for spirituality are "broadened beyond the measures of institutional affiliation, sectarian beliefs and practices" (p. 235). Indeed, the

majority felt that spirituality was, in fact, personally relevant, and though only 23% reported commitment to a traditional religious institution, 33% were committed to an alternative spiritual path. They further reported that those who see spirituality as personally relevant are more likely to see it as relevant in clinical work--however, since psychologists reportedly receive little or no formal psychological training in these areas, they must instead rely on other experience, rather than clinical training, as their guide.

Bergin & Jensen (1990) polled 424 mental health providers (e.g., psychologists, psychiatrists, clinical social workers, and marriage & family therapists) nationwide in 1985 and achieved a 59% response rate. The results stated that although 80% of the respondents endorsed some religious preference, regular attendance at religious services (thought to be a better measure of religious commitment) was considerably lower at 41%. Another finding was that striking differences emerged across the mental health professions: clinical psychologists endorsed religious beliefs/practices least, whereas marriage and family counselors endorsed them the most. Despite this apparent overall commitment, however, only 29% felt that religious matters should be an integral part of therapy, which may again highlight the clinicians' inadequate training, education and practical experience handling matters in this realm.

Kivley (1986) surveyed 99 therapists in East-Central Illinois and found that although a 53% majority endorsed that they were "deeply religious," other

findings within the study, according to the authors' interpretations, suggested a more complex ambivalence. For example, although no one endorsed the item that explicitly equated religious belief with neurosis, 58% nevertheless endorsed agreement with at least one of Freud's critiques of religion that highlighted its neurotic aspects.

In 1990, Shafranske & Malony surveyed 1,000 clinical psychologists randomly selected from the American Psychological Association Division of Clinical Psychology membership roster and received a 41% response rate. Unlike other studies, this one conducted a non-participant check, which enhanced the validity of their findings. Overall, 65% of the respondents stated that spirituality was personally relevant; however, only 18% stated that organized religion was the primary source of their spirituality and 51% noted that their definition of spirituality was "an alternative spiritual path which is not part of an organized religion." Furthermore, while 74% of the respondents believed that religious, or spiritual, issues are not outside the scope of psychology, only 5% reported that these issues were presented in their professional training and 62% believe that clinical supervision is essential when handling religious issues in therapy.

Eckhardt, Kassirer, & Edwards (1992) examined the extent to which religious and humanistic ideologies existed in a random sample of 400 psychologists selected from the 1990 American Psychological Association (APA) Membership Register. This sample reported mild to moderate religious beliefs

and a moderate to frequent religious participation rate of 38%. Thirty-three percent of the respondents prayed regularly and 7% believed in the accuracy of the Bible. A vast majority (91%) believed that science provides a better explanation of the world than does religion; however, 75% also conceded that "since science cannot and does not adequately account for all mysteries, religion cannot be entirely discounted either."

Critique

Although these studies present some interesting suppositions, there are some methodological concerns which obfuscate the validity of the cited research.

Construct specification. The first problem is that of construct specification: the term "religious" is not well-defined, nor is it held constant across studies so that results can be meaningfully compared. At first glance, then, these studies indicate that clinical psychologists are "more religious" than previously reported; hence the implication is that the therapists' religious worldviews may not be as disparate from the public's worldviews as previously supposed. However, upon closer examination it is evident that the psychologists are "more religious" only when the term is broadened to include nontraditional definitions. The semantic difference is consequential since the psychologists, though admittedly "religious" in this specific sense, still may endorse beliefs markedly different than the general population. Indeed, this discrepancy is particularly apparent when one remembers the recent surge of conservative

evangelical denominations in the general public (e.g., Roof & McKinney, 1987; Ammerman, 1987; Bellah et. al., 1991) while therapists are simultaneously reporting more liberal, Eastern-informed, private religious quests. As another example of a construct specification problem, Eckhardt et al.'s 1992 study surveyed a group of general psychologists (e.g., academicians). This data set was subsequently inappropriately used to discuss psychotherapists in particular. This type of contamination clearly makes the findings questionable. Another study used survey anchors such as "rarely" and "sometimes" to illustrate the degree of one's religious participation and practice; yet explanations for what these terms specifically meant were never provided--considerable overlap was therefore likely, as one was forced to make a subjective appraisal of the subtle differences between the two.

Response bias. Apart from construct specificity, other methodological problems call the validity of these findings into question. For example, while many studies reported low response rates, only one conducted a non-response bias check. This one study found that those who agreed to respond to the survey indeed endorsed greater religious belief/participation; hence the ensuing conclusion that therapists are "religious," even in the nontraditional sense, may be greatly overreported.

Assumptions about the comparison population of patients. Another assumption common to these studies is that the beliefs of the American population are inherently representative of the beliefs of psychotherapy patients.

Not one study cited research which specifically assessed the religious beliefs of psychotherapy patients in particular. While the assumption that the beliefs of psychotherapy patients mirrors general population norms may indeed be valid, it is still an assumption until proven otherwise.

Miscellaneous. Other areas of concern include the fact that some of the psychometric instruments had only moderate reliability/validity indices and many of the sampling groups were geographically limited and thus of questionable generalizability.

Summary

While these studies suggest that therapists as a group do have some degree of spiritual interest, it is also noted that the therapists are not as religious in attitude or practice as the general American public. In addition, due to the prevalent response bias in this body of research, the religiosity of therapists may even be over-reported, thus making the professional population appear more religiously-inclined than they truly are. Simultaneously, it is also notable that the religious beliefs of patients were never assessed and it was merely assumed that the patients' beliefs were congruent with general public polls. While this assumption may be warranted, it nevertheless remains an untested assumption.

Surveys of Psychiatric Diagnostic Practices

Overview

There have been several articles describing the presence of religious bias in the American Psychiatric Association's *Diagnostic and Statistical Manual of*

Mental Disorders-3rd Edition and 3rd Edition, Revised (DSM-III and DSM-III-R) (American Psychiatric Association, 1980 & 1987). In a strictly theoretical paper, Richardson (1993) writes that the DSM's apparent attempt to pathologize participation in religious activities makes the document less valid and less reliable as it apparently presents misleading information; hence, one is more apt to label a patient as "deviant" when they, in fact, are not. Richardson believes that since the religious examples tied to definitions of psychopathology are controversial and only anecdotal, there is considerable room left for subjective assessment--hence more power--in the hands of individual therapists.

As but one example, Richardson reports that "highly visible" psychologists and psychiatrists have already extended the application of Post-Traumatic Stress Disorder (intended for victims of natural/human disasters) to members of religious cults. Richardson contends that this style is particularly insidious because the authors of the DSM simultaneously fail to address any therapeutic potentialities of religion other than mentioning alleged trauma to non-mainstream religious cults.

Post (1990, 1992) posits that the alleged negative interpretation of religion in the DSM-III/DSM-III-R is especially problematic since the widely-distributed manual is used as an international standard in diagnosis and training. To support his contention of bias, Post reviewed the Glossary of the DSM-III-R and found that religious examples were used to illustrate psychopathology in several sections including, but not limited to, catatonic posturing, delusion,

incoherence, magical thinking, and poverty of content of speech. As one example, prayer was used to illustrate the term "magical thinking"; any potentially healthy aspect of prayer was not mentioned, thus leaving the impression that prayer in general is indicative of pathology.

Larson et. al. (1993) empirically documented the actual proportion of religious examples utilized in each of the DSM-III criteria by surveying 100 boldface Glossary terms for use of either religious and/or general demographic material to illustrate psychopathology. Of the 100 definitions surveyed, 45 utilized demographic examples of which 22% involved religion. Since none were found for ethnicity, race, age, gender or culture, the authors concluded that, given the low frequency of studies actually assessing religion, the rates of religious examples (particularly those related to psychopathology) were exceedingly high.

Critique

Larson et al.'s 1993 article addressed many of the critiques of Post's earlier work by obtaining exact statistical counts of each example relative to the total number of demographic examples. Larson et al., therefore, had a stronger claim that religion was disproportionately and unfairly overutilized than did Post's rudimentary listings.

One issue, however, remained unaddressed by both authors: is it ever appropriate to utilize religious examples when defining psychopathology or does it always inherently reflect bias? Given that religious beliefs are so common to

the American culture at-large, even if not necessarily intensely or maturely held, it seems evident that religious issues would inevitably arise in health as well as psychopathology due to their sheer ubiquity.

Although the overutilization of religious examples needs to be monitored lest an unintended bias is delivered to readers, there are times when religious examples could be exceedingly valid and crucial. For example, religious delusions are common in paranoid schizophrenia not because religion is to be equated with schizophrenia, but because it may have been a salient part of the person's pre-psychotic life. Both Larson et al. & Post, however, apparently want such examples omitted altogether, thus inadvertently contributing to the repression of religion described by Kung. Furthermore, both authors seem to be comfortable in their assumption that psychotherapists will inevitably and unthinkingly become biased by merely reading such examples, although no empirical evidence of this assumption is evident.

Summary

This section evaluated articles which found that the DSM diagnostic system has historically utilized examples of religious beliefs to describe psychopathology, thus suggesting that religion is to be equated with psychopathology. One study in particular found that demographics of ethnicity, race, age, gender or culture were never used as examples of pathology whereas religion, with a very low base rate of research, was notably utilized 22% of the time. In light of these critiques, the current version of the DSM—the DSM-IV—has

omitted many of these examples and has additionally incorporated a V-Code for Religious or Spiritual Problems. Although this V-Code is couched in terms of religion being a "problem," it nevertheless calls attention to the fact that religious issues can be a significant issue to explore with clients.

Religious Beliefs and the Psychotherapy Process

Clinical and Nonclinical Judgements of Clinical Psychologists

Unlike psychiatric nosology, empirically-based studies are available that illustrate how clinicians' religious attitudes impact psychotherapy and psychodiagnostic assessment, especially in the area of clinical and nonclinical judgement. Without exception, these papers sought to detect if the clinicians' religious attitudes (pro or con) can be related to their clinical decision-making with religious clients.

Studies which reported an impact. Since individuals tend to dislike those with disparate values, Gartner, Harmatz, Hohmann, Larson, & Gartner (1990) hypothesized that clinicians might also display an "ideological countertransference" to patients who held markedly different worldviews. This study relates to the Lewis & Lewis study (1985) which posited that therapists might respond to the patient's conservative values more than any religious content per se. In Gartner et al.'s study, 1,800 psychologists were randomly selected from the National Register of Psychologists; 17% responded. Each respondent received two randomly chosen case vignettes from one of four ideological groups (left wing political, left wing religious, right wing religious,

right wing political). The hypotheses of this study were 1) the therapist would respond more negatively to ideological patients; 2) the therapist would specifically respond more negatively to patients with ideologies opposite their own; and 3) therapists with extreme ideologies would respond more negatively than moderate therapists to patients of opposite worldviews. As predicted, extremely ideological patients were rated more negatively (more disturbed) on each of the four clinical judgment dimensions; they were also more likely to be diagnosed Obsessive-Compulsive and less likely to be diagnosed with Generalized Anxiety Disorder. There was only limited support for the other hypotheses, however. This study could have important implications since Strupp (1968) found that a high degree of value discrepancy may equate poor treatment outcome. Although this study has sound generalizability since it used a random national sample, the low response rate of 17% likely offsets this one strong asset.

Gartner (1986) utilized an analogue design on non-clinical judgment to determine if a mock graduate school applicant's religiosity would impact admissions decisions made by clinical psychology professors. Nine hundred and eighty full-time professors at APA-approved programs were asked to participate; 36% responded. The author designed a packet including a cover letter, a mock application (including GRE scores, GPA, and a personal statement) and a brief questionnaire from a male applicant. Using this framework, three alternative packets were created, identical in all respects

except: 1) the "nonreligious control" made no mention of religion; 2) the "Evangelical" volunteered that he had become a fundamentalist in college; and 3) the "Integrationist" stated that he had become an evangelical in college and actively hoped to integrate his religious orientation within his practice of psychology. Each professor was randomly assigned one of these packets and asked to rate the applicant on four dimensions: 1) positive feelings about the applicant's ability to make a good clinical psychologist; 2) any doubts; 3) the necessity of interviewing him in comparison with other comparable applicants; 4) the probability of admitting this applicant. The results were significant and unanimous: the nonreligious control was viewed most favorably on all four dimensions and, in addition, the Evangelical was rated higher than the Integrationist on three dimensions, though the differences did not quite achieve significance.

Though this study had a fairly acceptable response rate, a non-response check was not performed so response bias cannot be ruled out. Also, since each person was asked to rate only one case, the resulting outcome could be an artifact of the specific case. Gartner adds that it could have been the applicant's apparent sudden conversion (the write-up says the subject was just converted in college), rather than religion per se, that accounts for the discrepancy. This hypothesis would certainly be in keeping with Houts & Graham's 1986 finding where the moderately-religious were rated as more disturbed than the very religious since long-term commitment and conviction seemed to be the more

salient factors. Another type of control would have been helpful in which a "popular" versus "unpopular" belief was evaluated. Including this type of evaluation would help assess if the professors simply tend to endorse what is mainstream in the academic community or if they were instead genuinely biased against religion in particular.

In 1991, Neumann, Thompson, & Woolley used an analogue design to explore the nonclinical judgements of a national sample of Veterans Administration (VA) psychologists. Specifically, the psychologists were asked to make approval decisions after reading a proposed inservice, a state professional society presentation, and a publication abstract each of which contained either Christian or humanistic beliefs. The authors hypothesized that 1) the humanistic proposals would receive highest approach; 2) the type of vignette would influence approval ratings; and 3) the raters' personal values would correlate with their approval ratings. Packets were sent to 248 VA psychologists and a 67% response rate was achieved. The randomly assigned packets were exactly alike except that they contained a few lines revealing either a Christian or humanistic orientation. Respondents were then asked to indicate approval of the proposal as either a VA function or as a community non-government function; in addition they were asked whether they would approve an honorarium and if they had any personal interest in the proposal. The results showed that the VA psychologists consistently favored the humanist proposals across all questions and vignette styles.

Generalizability is again a factor, however, in that these results were strictly obtained from VA settings. Also, since the proposal contained vague, complex terms such as "liberal Protestant" without definitions or examples, the results may have been seriously impacted.

Studies which did not report an impact. To address research which posits that diagnostic errors occur systematically, not randomly, when specific patients are diagnosed, Wadsworth & Checketts (1980) examined 228 Utah psychologists in an analogue design to determine if psychologists' diagnoses are biased by 1) the psychologists' religious affiliations; 2) the patients'; or, 3) an interaction between the two. Sixty usable responses were received (26.32% response rate), 65% of which were from Mormon psychologists. Each volunteer completed a demographic questionnaire (religious items were embedded within) and then asked to read and diagnose four ambiguous case reports: an active Church of Latter Days Saints (LDS) member, an inactive LDS member, an active "Other Religion," and one inactive "Other Religion."

No significant results were found for any of the hypotheses and the authors thus concluded that either the therapists were truly unbiased or, alternatively, that they had learned to control their personal biases through professional training. The authors also suggested that the task of psychodiagnosis may not elicit bias whereas psychotherapy, a more intimate modality, might. Given that no non-religious controls were implemented in the research design, no clear cut determination can actually be made regarding

therapists' alleged bias between religionists and nonreligionists. Indeed, at best this study differentiates therapists' attitudes between active and nonactive religionists of either a Mormon or "Other Religion" category.

Lewis & Lewis (1985) designed a psychodiagnostic study to address Szasz's belief that the more a given patient's worldview deviated from their therapist's, the more likely they would be assigned a "severe" diagnosis and poor prognosis. It was therefore hypothesized that the therapist would also rate such individuals as less attractive patients. To address these questions, 123 Iowa psychologists were solicited to participate in this study; 62.6% complied. Respondents were then divided into two groups, religious and nonreligious, based upon the therapists' own subjective impressions. They were then randomly assigned to hear a ten-minute audiotaped therapy session in which a depressed patient demonstrates either "a strong" or "no" religious orientation in three brief portions of the tape. No significant differences were found in any of the hypothesized areas. However, an aberrant finding emerged: the religious patient was seen as requiring fewer therapy sessions than non-religious patients--and nonreligious therapists were most apt to endorse this belief! Since no follow-up interviews were conducted, it is impossible to ascertain the exact cause of this anomaly. The authors, however, contend that the nonreligious therapists may have felt that the religious patients were simply poor candidates for long-term therapy--not essentially healthier--or, alternatively, that the religious needed less sessions since they had substantial support available

through the church network. Another finding was that religious therapists were more likely to pick both religious and non-religious patients as desirable for their caseload. Again, understanding this intriguing information is not possible since there were no follow-up interviews. In this instance, the authors hypothesized that the therapists were merely identifying more with the sample case's conservative values than any religious preference per se. Another explanation might be that the religious therapists were less selective since, as many religions profess, religionists are directed to be merciful to all those in need. It is also possible that the religious therapists, perhaps unconsciously, sought to "heal" or "convert" the non-religious, and were therefore just as eager to work with them. Clearly, a lot of potentially interesting information was lost since the respondents were not asked to reveal their reasoning and decision-making processes.

In 1986, 251 Memphis psychologists (with a 26% return rate) were asked to complete a survey on their religious beliefs, and then watch a 10-minute video of a mock intake interview (Houts & Graham). The core scenario was that of a depressed young man feeling guilty about his girlfriend's abortion. From this basic scenario, two segments were formed in which either a moderately religious or extremely religious viewpoint was presented. No therapist bias was found, as both religious and nonreligious therapists viewed the moderately religious client as having greater psychopathology, and thus a poorer prognosis, than the extremely religious client. In this case, the authors concluded that it may be the degree of one's conviction, rather than any specific religious belief per se, that

was the more salient factor. In keeping with other studies, Houts & Graham also failed to include non-religious control groups and, given that respondents were exclusively from Memphis, generalizability is also a concern. Finally, given that only one case example was used, the results could be an artifact of the particular case presented for diagnosis.

Shafranske & Malony (1990) investigated a sample of 1,000 clinical psychologists by randomly assigning them one of two case studies, identical except that one mentioned religion whereas the other did not. The psychologists were then asked to assess the likelihood that the case would make good progress in therapy and, additionally, to estimate the number of sessions apt to be required for substantial progress. In keeping with the Lewis & Lewis finding (1985), no differences were found in this study except that "religiously-sensitive" therapists were more likely to rate both clients (religious and non-religious) as having substantial therapeutic promise. Again, no follow-up interviews were conducted, so the rationale for this decision-making is unavailable for scrutiny. Plausible hypotheses can be formed, however, based upon the considerations mentioned in the 1985 Lewis & Lewis study. Another possible confound is that the theoretical orientations of the therapists were not considered. It is possible that therapists who practice long-term therapy, for example, would inevitably endorse that both types of clients needed long-term therapy--hence, no significant difference.

Reed (1992) utilized an analogue design to explore how psychologists' clinical judgments might vary when given a specific referral question. In this example, 500 psychologists randomly selected from the National Register were asked to evaluate a scenario in which an individual was applying to adopt a child; a 46% response rate was obtained. The volunteers were then randomly assigned to read one of four vignettes which differed in only one sentence which indicated that the applicant was either religious or nonreligious, stable or unstable. They were then asked to rate the applicant on three considerations: 1) is it recommended that the individual be permitted to adopt a child?, 2) is therapy recommended as a contingency for this individual's permission to adopt?, and 3) what is the level of the patient's current level of adaptive functioning? Results of this study also revealed a striking anomaly: neither religion nor stability impacted the clinicians' judgement. The authors concluded that either bias genuinely did not exist or their survey lacked enough sensitivity to measure any bias present. Given that the therapists did not even respond differentially to the patients' stability at a significant level (certainly a critical consideration given the referral question), it may indeed be that the case stimulus was simply not strong enough to command attention. In addition, only one case study was provided and the findings could be an artifact of that particular case. A possible alternative would have been to give therapists a couple of vignettes and ask them to choose the best adoptive couple; this may demonstrate the importance of religion and/or stability in comparing candidates.

Patients' Perceptions about Therapists

Another area that has received attention is to determine how psychotherapists' religious attitudes impact clients' perceptions of the therapists and the psychotherapy process. Prior studies (e.g., Greenberg, 1969) have found that patients routinely give higher ratings to therapists perceived as either "warm," or in some way similar to themselves. In this context, it is thought that patients would report a more positive psychotherapy experience with therapist's who are known or perceived to have similar religious beliefs.

Studies which detected an impact. Keating & Fretz (1990) hypothesized that any negative anticipations Christians have about counselors can be affected by presentations that either ignore, show empathy for, or identify with their Christian beliefs. They also hypothesized that those with strong beliefs would show higher levels of negative anticipations than those with less strong beliefs, and would be most impacted by the descriptions. Three hundred and one undergraduate Christians from a state university, 98 general studies undergraduates at a Christian university, and 79 volunteers from Washington D.C. churches were evaluated. Subjects read a counselor description (Christian, secular, or spiritual-empathic secular) and then completed a measure of five negative anticipations that Christian clients might endorse about counselors (e.g., the counselor will ignore my spiritual concerns). Results confirmed the hypothesis that reading descriptions with spiritual-empathic components could affect the level of negative anticipations. Subjects with higher religious scores

had more negative anticipations: the strongest negative anticipations endorsed were for secular counselors, moderately negative ones occurred regarding spiritually- empathic counselors, and the least negative attitudes were endorsed for Christian counselors. Those with the highest religiosity scores demonstrated the strongest reaction to the scripts. Results may have been impacted, however, in that subjects were given specific, not general, negative anticipations to address. Other salient factor was that the study failed to address any positive attitudes, thus possibly by design placing a negative skew on the results.

McMinn (1991) investigated the effects of emphasizing religious values above clinical skills in clients' perceptions of a therapist as trustworthy, likeable and approachable. McMinn hypothesized that religious values will positively influence clients' perception of a therapist, especially among the religious. One hundred fifteen students in a continuing education program at a Pacific northwest Christian college were randomly assigned a quotation to read from a therapist which either emphasized religious sensitivity over clinical skills or vice versa. Subjects were then asked to rate the therapist on likability and how likely they would be to attend therapy with this particular therapist. The hypothesis was supported: therapists who emphasized religion were seen as more likable, more trustworthy, and more likely to be consulted by the individual. However, this study is flawed in that the subjects were not given the option of seeing a therapist who equally valued religion and clinical skills.

Privette, Quackenbos, & Bundrick (1994) examined the relationship between religious values and preferences for religious or secular therapists in two geographic regions: Pensacola, Florida and Appleton, Wisconsin. One hundred sixty-four respondents were selected using a systematic intervals procedure with phone directories. The respondents were asked to complete a counseling and religious survey. Results were as follows: approximately 50% would use a pastoral counseling center if it were available; 25% endorsed negative beliefs about religious counseling; and 25% were highly negative about secular counseling. The frequency of church attendance correlated with choice: high frequency church attendees endorsed a higher preference for a religious therapist. Differences also emerged for type of presenting problem: respondents endorsed preference of a religious therapist to deal with marriage/family issues, and a secular therapist for severe mental disorders, schizophrenia, weight problems, nervousness, and alcohol and drug issues. Secular and religious therapists were equally endorsed for treatment of depression.

Studies which did not detect an impact. Haugen & Edwards (1976) sought to demonstrate that, given pretherapy information, evangelical Christians would clearly prefer assignment to a therapist they perceived as also Christian. They hypothesized that Christian respondents would 1) be more attracted to Christian therapists, 2) be more attracted to "warm" therapists, and 3) would prefer a "cold" Christian therapist to a "warm" non-Christian therapist. Seventy-

one undergraduates at a Christian evangelical college volunteered for this analogue study. Subjects were given the K scale of the MMPI, a fundamentalism scale, and several questionnaires. They were then randomly assigned to listen to one of five taped presentations (Christian, non-Christian, warm, cold, neutral) after reading a brief description of the therapist. None of the hypotheses were borne out and, in fact, the respondents did not even endorse the expected preference for a "warm" therapist." These results, however, may be an artifact of the methodology since critical stimulus material (the therapist description) was not read outloud; thus the subjects could have rapidly skimmed the information, overlooking the salient material. Another interesting happenstance was that the term "non-Christian" seemed to be a more powerful stimulus than "Christian;" apparently one needs more than a label to prove one is truly a Christian to this conservative population. The authors concluded that a description, or a denominational label, would have been a preferable stimulus to the simple label.

Pecnik & Epperson (1985) tested the idea that patients have different expectations of Christian and secular counselors. To explore this consideration, 238 psychology undergraduates were given two surveys and the Shepherd Scale of Religious Beliefs; they were then told that the sample therapist was either Christian or not. The results revealed that secular counselors were clearly expected to be more expert and more effective than Christian counselors. The authors hypothesized that either the Christian counselor label seems to be

associated with clergy (who may seem less credentialed as therapists) or that a perception of role conflict may have emerged. No follow-up interview data was obtained to confirm these hypotheses, however. Also, since this analogue design had no built-in referral question, variations might have occurred otherwise.

Atkinson, Furlong, & Poston (1986) explored the preferences of 128 African-American community college students to determine whether or not they desired a counselor similar or dissimilar to themselves across several counselor characteristics. In this study, "Religious Similarity" was ranked only 8th out of 16 categories in importance: similar education, similar attitudes, older, similar personality, similar ethnicity, opposite sex, and similar SES were ranked higher in preference. This study did not provide operational definitions for the presented characteristics, so there may have been some confusion over terms such as "similar attitudes" —does it, for example, include religious attitudes? The authors also noted that these findings are only useful to the extent matching is useful—indeed, it may at times be best to mismatch therapist/patient dyads.

Wyatt & Johnson (1990) asked 125 university undergraduates to read one of five scripts depicting value orientations of a counselor: 1) basic; 2) agnostic; 3) a religious counselor who believes religion is core of therapy; 4) a coreligionist who does not believe religion is the core; and 5) a Christian who uses the Bible in therapy. After completing a religious attitudes inventory, respondents were then asked to evaluate the therapist as a potential counselor

for them. Results revealed that the religious orientation of the counselor was not a significant factor in either the subjects' confidence in the therapist's ability to be helpful or in the subjects' willingness to seek the therapist's services personally. However, since the extreme Christian counselor was not rejected either, the author proposes that the detailed scripts may have had a humanizing effect--all the therapists seemed likeable--and this personal information may indeed be more important than one's religious beliefs per se.

Morrow, Worthington & McCullough (1993) posited that how a therapist treats a client's religious beliefs may affect perceptions of the counselor and thus hypothesized that interaction effects would be evident. One hundred and two undergraduate psychology students participated in an analogue design study. Subjects were grouped according to whether they endorsed high or low Christian beliefs, and then asked to watch a videotape in which the last three seconds showed a therapist either ignoring, supporting, or challenging the mock patient's religious beliefs. The outcome showed that the subject's religious beliefs did not affect their ratings of the therapist, and the therapist who ignored the patient's beliefs was rated highest. The authors suggested that the respondents may be stereotyping what a therapist "should" do; thus, when a therapist attends to religious issues, it may look as if s/he is operating outside his/her boundaries of competence. Other relevant findings include 1) the "supported" client was given a better prognosis, and 2) the respondents indicated they would be personally less likely to return to the challenging therapist. Overall, the authors concluded

that respect for the individual was far more important than the specific content of one's values.

Critique

Upon reviewing these numerous empirical articles, it became evident that many of the articles contained similar methodological issues which obfuscated the author's conclusions. The most prominent of these methodological concerns are noted below.

Analogue designs. The majority of these studies are analogue designs in which therapists typically provide diagnoses and prognoses of mock case studies of religious/non-religious individuals. Or, alternatively, college undergraduates imagine the role of patients and rate how their perceptions vary as a function of the mock therapist's apparent acceptance of religiosity. Such studies, though interesting, are of limited utility as it is likely that a therapist would respond quite differently when confronted face-to-face with an actual patient. Furthermore, it seems even more certain that genuine patients would respond much differently than ostensibly well-functioning college undergraduates. Although such studies have provided the requisite foundation, it is now evident that future research projects must examine first-hand, not imitative, phenomena.

Operational definitions. Other methodological concerns prevalent in the literature include lack of operational definitions for constructs such as "religious" and "spiritual," and how to best measure these constructs using

psychometrically valid instruments. Certainly, in order to measure how therapists' religious attitudes impact therapy with religious patients, one must first have a clearly specified construct of what "religious attitudes" are. Most studies fail to include this critical information and, thus, it is difficult to effectively compare findings. For example, several studies concluded that clinical psychologists in general are "more religious" than previously studies supposed; hence the implication was that the therapists' worldviews may not be as disparate from the general public's as expected. However, upon closer examination it was learned that the psychologists were "more religious" only if the term "religious" was broadened to include nontraditional meanings (e.g., belief in spirituality versus a specific belief in God). Some authors contend that denominational labels or simple descriptions are far more preferable to confusing terms like "religious" and "liberal Protestant."

Generalizability. Although a few of the studies utilized random national samples, most did not; thus, it is unclear whether these findings will apply to other settings. Also, the use of presumably well-functioning undergraduates to rate therapists instead of the real target group of interest (psychotherapy patients, often with markedly poor functioning) is clearly problematic, as is the exclusive utilization of therapists from isolated communities. Another remarkable instance was the use of psychotherapists in Mormon-driven Utah (65% of whom were Mormon themselves) to represent psychotherapists nationwide (Wadsworth & Checketts, 1980).

Lack of hypotheses. Another empirical flaw permeating many of the studies was that few offered a priori hypotheses--a step that is deemed mandatory for empirical methodologies. If the researchers wanted to employ a methodology which allowed for the emergence of themes, without preconceived hypotheses, then an existential-phenomenological project would have been more appropriate, yet none were conducted using this type of methodology.

Response bias. Another factor is that little attention was given to the problem of response bias. The questionnaires typically have low response rates to begin with (one study reported only a 17% return) and, apart from a few notable exceptions, few researchers attempted to contact nonrespondents. Hence, the literature is likely skewed, as those who completed and returned the test materials may have been more pro-religious, and hence less biased, from the start.

Transparency of the research question. When psychotherapists, and perhaps even undergraduates, are blatantly asked if they discriminate against the religious, it seems likely that those with any degree of sophistication would deny such a fact, even if it were true. Indeed, studies which tackled the subject using several test instruments and less transparency, often obtained the most fruitful findings. One study, for example, found that although the majority of surveyed therapists denied bias toward religious patients, they nevertheless endorsed at least one item that suggested religion is neurotic when assessed with a second survey instrument (Kivley, 1986).

Lack of nonreligious controls. It was extremely rare to find studies which incorporated nonreligious control groups into their methodological design. Since in most studies religious and nonreligious therapists might evaluate only religious patients, it is at least technically possible that these same therapists might demonstrate "bias" against nonreligious patients as well, a scenario that was never addressed. In other words, factors other than religion could have been the actual source of the reported bias.

Failure to address confounds. As suggested above, there is some evidence that the outcomes may be the result of therapists reacting to the patients' conservatism, for example, rather than their religiosity per se. Since no follow-up interviews were conducted, there is no way of verifying the plausibility of this argument, though it is certainly worthy of future exploration. Another potential confound never addressed was that demographic factors, particularly age and education, may have a profound impact on one's religious beliefs and, therefore, upon one's attitudes toward psychology. It is indeed likely that if groups other than undergraduates were asked to rate their potential therapists (e.g., elderly nursing home residents) the results would be dramatically different.

Psychometrics. As noted in earlier research, other prominent areas of concern include the fact that some of the psychometric instruments had only moderate reliability and validity indices; in fact, several studies even failed to present this information. Given that the results will be directly related to the

reliability and validity of the test instruments used in empirical designs, it is therefore difficult to make any sound conclusions about this body of research.

Summary

It is noteworthy that research in this realm does contain some empirical studies which, at face value, seems to be a considerable improvement over related areas which have yet to test their theorists' assumptions. However, it is also immediately apparent that the findings are remarkably and almost equally discrepant and difficult to disentangle; indeed, each side has intriguing evidence for their respective stance. However, the research is flooded with methodological problems so that the original question (do therapists' religious attitudes impact the psychotherapy process?) is difficult to determine at this time.

Conclusion

Upon conducting a literature review of the past two decades, it is evident that considerable attention has been devoted to the topic of how therapists' religious attitudes impact the psychotherapeutic process in numerous ways such as clinical and non-clinical decision making, and patient's perceptions of the psychotherapy experience. Despite the extended discourse, little has been accomplished either empirically or particularly phenomenologically to test, illustrate, or extend the theorists' arguments and assumptions. The few empirical studies that have been conducted are plagued with some fairly significant methodological problems and consequently the question of whether psychotherapists' religious attitudes significantly impact the psychotherapy

process cannot yet be answered. However, the evidence of bias in therapists' nonclinical decision-making does seem strong and, in fact, it has been noted that therapists are most biased in situations that potentially involve them in a direct fashion (e.g., admitting a highly religious graduate student to a doctoral program).

Scope of the Present Study

This present study was conceived as an initial step toward addressing critiques of the literature noted earlier, the most notable of which was the pervasive use of the analogue design. To help remedy this situation, this exploratory project was devised to provide a unique glimpse into the real life experiences of individuals with actual psychotherapy experience rather than relying on imagined scenarios.

Another unique feature of this study is that it departs from the prominent Cartesian, positivist approach, with its attendant reliance on the traditional scientific method, and instead utilizes the philosophy and research methodologies of the existential-phenomenological school of thought. This tradition, based upon the philosophy of Dilthey, Sartre, Heidegger, and Merleau-Ponty and the research methods of Gestalt psychology (Thompson, Locander & Pollio, 1989), is a fresh, viable alternative because of its inherent alignment with the individual's actual life-world experience. The researcher is there to learn and elicit information, rather to impose beliefs and test theories, so the emergence of fresh, unexpected material is deemed more likely.

For the purposes of this study, information was gathered by asking participants in an interview situation to relate, in as much detail as possible, a time when they either discussed, or wanted to discuss, religious issues with their therapist. Other data such as demographic information, brief survey materials, and case summaries are also provided to further enhance understanding of this topic from both an individual and a group perspective. This choice of method is not to discredit the utility of positivist approaches but rather to enhance the literature by examining the focal issue from a radically different perspective²

² Thompson, Locander & Pollio (1989) and Hudson & Ozanne (1988) both provide detailed accounts of the conceptual and practical differences of these two distinct schools of thought.

CHAPTER 4

METHOD

Subjects

Selection Criteria

This study was conducted over a two-year period from 1996 to 1998 using participants from Knoxville and Memphis, Tennessee. To be included in the project participants had to consent to be interviewed on tape about their psychotherapy experience(s). Subjects were furthermore asked to have a minimum of three months of psychotherapy experience, either currently or in the past, and they had to be over age 18 both upon interview and at the time of their therapy. A final requirement of the selection process was that qualifying subjects had to agree to specifically relate, in as much detail as possible, a time in which they discussed, or desired to discuss, a "religious" or "spiritual" issue with their psychotherapist. Given the significance of this requirement to the research question, it is necessary to provide operational definitions of these terms at this time.

Operational Definitions

One of the prominent critiques noted in the literature review is that few studies provide operational definitions for significant terms such as "religion" or "spirituality" in their research methodology. It has proved to be an exceedingly complicated issue and notable historians and researchers alike (e.g., Smith,

1963; Spilka, Hood & Gorsuch, 1985) have spent considerable effort studying the semantics of language relevant to the field of religion. Indeed, some of the religionists themselves protest labels applied from those outside their faith (e.g., some fundamentalist Christians earnestly state that "Christianity is a *relationship*, not a *religion*." There is no current consensus in the literature on how to best address this issue and while some researchers propose specific, descriptive phrases (e.g., religion as defined by denomination) others posit that the best practice is to develop the most parsimonious description with the greatest generalizability possible (Spilka et al., 1985).

Due to the exploratory nature of this study, we have designed a more parsimonious description in order to be more inclusionary than exclusionary; the consequence is that anyone self-identified as "religious" or "spiritual," regardless of their personal definitions of these terms, were accepted into the study. The terms "religious" and "spiritual" are also used synonymously in this text, and though some religious scholars will inevitably protest the marriage of these terms, we again feel that it is best for our purposes to paint with a broader brush. We want to understand how any individual with any variety of religious or spiritual issues, regardless of any idiosyncratic label or content, fares in psychotherapy with a secular psychotherapist.

Atheists, therefore, are included in our study. While this may be counterintuitive to some, atheists indeed have a religious belief system--in this case it is that God does not exist. This, too, could be significant in the therapy

setting as it plays out vis-à-vis the relationship with one's therapist, and as such it is deemed equally worthy of exploration. Atheists are therefore not excluded from our study.

Solicitation and Screening Procedures

In keeping with the exploratory nature of the study, the convenience-sampled subjects were solicited from a variety of sources including notices placed in the waiting rooms of clinical psychologists in private practice (Appendix 1), notices placed on bulletin boards located at various community and university sites (see also Appendix 1), and classified advertisements in local newspapers (Appendix 2).

In these notices, respondents were asked to contact the investigator by leaving a phone message on a designated answering machine. When the call was returned, general information about the nature of the project was provided, as well as specific information about the requirements of participation (see Appendix 3). If the participant had any specific concerns (which typically involved the tape-recording requirement), these were carefully addressed before an appointment was made.

All interested subjects who met the general selection criteria were given an interview appointment at this point and were furthermore allowed to select any convenient public site for their interview. Respondents who did not meet the general project criteria were thanked for their interest and given an explanation for their exclusion. For example, those individuals who were seeking clinical

help rather than research participation were referred to either local private practitioners or to community mental health centers. Table 3 illustrates the number of telephone contacts received relative to the number of appointments made and interviews completed.

Table 3. Participant Response Profile.

Site	# of Telephone Inquiries	Appointments Made	Appointments Kept	% Completed
Knoxville	7	6	4	57%
Memphis	11	7	6	55%
Total:	18	13	10	56%

Although a higher number of respondents was desirable, the response rate is reasonable given that the participants had to 1) be willing to identity themselves to an unknown researcher as a psychotherapy patient; 2) be willing to meet face-to-face to discuss very intimate details about their religious and therapy experiences; and 3) be willing to be tape-recorded while doing so, which may have heightened the tension for some. While analogue designs would certainly have provided a higher number of subjects, we believe that information gleaned

from actual patients, even if fewer in number, would be more useful at this exploratory stage than vast numbers of pseudo-patients. Furthermore, the number of subjects obtained for this study is in line with similar qualitative research projects (Polkinghorne, 1986).

Demographic Characteristics

Using these selection techniques, ten subjects passed the telephone screening, kept their appointment, and completed the research program.

Table 4 illustrates basic demographic information about this group.

Data Collection

Initial Phase

Participants were met at the time and public location that had been arranged by telephone and these meetings typically took place at libraries, restaurants or at the participants' place of business. After an initial phase of rapport-building by informal conversation, the transition phase was begun in which the content of the initial telephone call was reviewed and the subject was presented with the consent form. The investigator reviewed the form with the individual, and ensured that the prospect understood the nature of the study and any risks involved. The subject then signed the consent form after any questions were answered. No subject who appeared for an interview appointment refused to participate.

Table 4. Demographics.

Demographic	N=10
AGE:	
25-29	3
30-39	3
40-49	4
SEX:	
M	5
F	5
EDUCATIONAL LEVEL:	
High School	4
Undergraduate	2
Graduate/Masters	3
Graduate/Ph.D.	1
EMPLOYMENT STATUS:	
Employed	7
Full-Time Student	3
MARITAL STATUS:	
Married	4
Single	6

Interview Phase

Once the consent was signed, transition to the interviewing phase was begun and the tape-recorder was started. Since interviewer style and technique can bias data collection, the same investigator conducted each of the ten interviews so that any bias inadvertently introduced would be relatively the same across subjects (Hyman, 1975).

An existential-phenomenological clinical interview technique was used by the interviewer (Kvale, 1983; Thompson, Locander & Pollio, 1989; Hopson, 1993), in which the subject was asked to describe, in as much detail as possible, their psychotherapy experiences, particularly focusing upon a time when they discussed, or wanted to discuss, religious issues with their therapist.

As expected with this methodology, the course of the interview was set largely by the subject. The interviewer intervened only when necessary to query unclear descriptions and to promote further elaboration and discussion (Thompson et al, 1989; Hopson, 1993). To the extent possible, the interviewer's questions and probes followed the natural flow of the conversation and did not explicitly attempt to confirm a priori hypotheses (Thompson et al, 1989); however, these probes were typically unnecessary as many participants spontaneously covered all realms in adequate detail. In keeping with recommendations of Thompson et al. (1989), any probes utilized in the interview never included "why" questions since the goal of the phenomenological interview is to obtain a thorough description of the patient's experience, not to have them

analyze or defend it. Although this process is inherently patient-driven, this interview technique is nevertheless semi-structured in nature as the interviewer has a very active role, through sparse and judicious questioning, to keep the conversation from becoming either highly regimented or highly irrelevant (Kvale, 1983)

As anticipated, this interview style typically fosters good rapport with the subjects as evident by the fact that most had little, if any, difficulty with the interview requirements. The length of this phase averaged 55 minutes and the interviews had a range of 45-75 minutes.

Closing Phase

After the formal interview was completed, the recording was stopped and the subject was then asked several demographic questions to close out the interview. Any questions were answered, and the subject was then given a copy of the consent form for their personal use, invited to sign up for a summary of the project's final results, and thanked for their participation.

Follow-up Questionnaire

Several months after the interview portion was completed, a cover letter and a questionnaire survey was sent to each participant (see Appendix 4) in order to supplement the interview data and to specifically inquire about hypotheses posited in the literature that were not probed by the examiner. This 15-item pilot questionnaire was delivered via mail to their home address and was returned by participants by the stated deadline in the addressed, postage paid

envelope which had been provided. After receiving the returned survey, post-cards were sent to each subject thanking them for their additional participation.

Data Analysis

Interviews

After each interview was conducted, it was transcribed verbatim from the audiotaped recording which was then promptly erased to ensure confidentiality. Any potentially identifying information was removed from the transcripts and replaced with blank underlines to indicate that a portion had been removed. In addition, each participant was given the opportunity to review the final transcripts to ensure confidentiality; however, only one participant elected to do so and this individual made no revisions to the transcript.

The ten completed transcripts, void of identifying information, were then subjected to a phenomenological interpretative methodology, in this case a thematic analysis, performed by an interpretive team. The interpretive team of this study consisted of two raters: the first rater was the principal investigator, a Ph.D. candidate in clinical psychology, and the second was a senior undergraduate in psychology chosen by her interest in acquiring research experience. Given that neither rater was naïve to the topic at hand, as is typical for phenomenological research, the raters were required to "bracket" their preconceived theoretical notions so that, as expressed by Thompson et al. (1989), they might "grasp, rather than impose, meanings emerging from the dialogue."

The interpretive team met for ten sessions over a five-week period of time in July 1998 to conduct a series of thematic analyses, the goal of which was to determine what, if any, global theme(s) could be identified in the interview data which would contribute toward a better understanding of the research question. Thompson et al (1989) stipulate that any uncovered themes must be directly relevant to the patient's own description; hence, it is a requirement that the interpretive team must identify specific passages of the verbatim transcript that are immediately relevant to proposed themes.

The specific steps of this analytic process consisted of the following steps as adapted from Hopson (1993):

1. The interview was read aloud in units as determined by natural transitions in the interviewer's questions.
2. The units were then examined to ascertain the meaning of that unit, with each unit progressively collapsed until sub-themes (or key phrases), in the subject's own words, were identified.
3. The sub-themes were then synthesized across each of the interviews until a pattern of global themes emerged.

Table 5 illustrates a sample of this process by illustrating the thematic analysis of a short passage of text. Column 1 contains the verbatim text from the transcript,

Table 5. Sample Thematic Analysis.

Verbatim Transcript	Sub-Theme	Global Theme
...I was already feeling depressed about my family and I wanted to feel a sense of family somewhere--that was the whole point. And in a way he was fatherly to me, though not very warm and fuzzy, and I didn't want to accept that we were really worlds apart.	...I wanted to feel a sense of family somewhere. ...I didn't want to accept that we were really worlds apart.	Identifying Similarities with the Therapist - Patients seek to identify similarities in order to strengthen the therapeutic alliance.

Column 2 contains the identified sub-theme, and Column 3 illustrates the proposed global theme.

Hopson (1993) notes that "Multiple perspectives and disagreements are an important element of this approach. Themes are arrived at through synthesis of the multiple perspectives represented by the team, thereby enhancing the reliability of the themes." Indeed, only those sub-themes and themes that were consistently endorsed by both raters, after much consideration and discussion, were utilized in the findings.

While this project is closely aligned with Hopson's protocol, there is one important deviation which occurred due to the exploratory nature of this project. Whereas his research criteria demanded that a particular theme must occur in every transcript for it to be given theme status, our study was more inclusionary

and contains themes with a significant, but not necessarily total, endorsement.

The rationale for this departure is that our study seeks to identify as many trends as possible which may prove fruitful for future research programs.

Supplementary Data

After the thematic analysis of the transcripts was completed, a descriptive case summary of each of the ten subjects was created which incorporated all gathered data ranging from screening comments, interview impressions, interview data, endorsed themes, correspondence and questionnaire data. The goal of this consolidation was to obtain a well-rounded, integrated glimpse of each unique participant in order to better understand how (if at all) their religious beliefs impacted their psychotherapy experience. These qualitative analyses were then used as a complement to the thematic analyses of the transcripts to provide a glimpse into both individual and group perspectives on the research question.

CHAPTER 5

RESULTS

Subject Characteristics

The following tables provide overviews of the subjects' backgrounds on a variety of topics ranging from personal demographic information, psychotherapy experience, religious beliefs and behaviors.

Personal Demographic Information

Table 6 contains characteristics of the ten individuals. Ages of these convenience-sampled subjects ranged from 26 to 46 years with a group average of 37 years. This sample is therefore older than traditional studies which assess college undergraduates. The sample was equally divided between males and females and was roughly equivalent regarding marital status (married = 4 and single = 6). There were three university students (one undergraduate, two graduate) in the study; the remaining seven individuals were employed on a full-time basis. There was more educational diversity with the highest level of completed education being high school for four individuals, undergraduate for two, master's level for three and Ph.D. status for one individual.

Psychotherapy Background

A second area of background material was the individuals' history in psychotherapy. Table 7 illustrates the three main factors examined: number of

Table 6. Basic Demographic Information.

Subject #	Age	Sex	Marital	Education	Occupation
1	46	M	S	High School	Service Industry
2	37	M	S	Masters	Social Work
3	28	M	S	Masters	Graduate Student
4	45	F	M	Undergraduate	Mental Health Aide
5	46	F	M	High School	Clerical
6	45	F	M	Ph.D.	Adjunct Professor
7	28	M	S	Undergraduate	College Student
8	26	M	S	Masters	Graduate Student
9	37	F	M	High School	Family Consultant
10	35	F	S	High School	Clerical

Table 7. Psychotherapy Experience Profile.

Subject #	No. of Therapies	Time Spent in Longest Therapy (in years)	Average No. of Weekly Sessions
1	3	8	2
2	4	3	2
3	3	2	3
4	3	2	1
5	4	1	2
6	3	1	1
7	5	4	1
8	2	2	1
9	6	1	1
10	2	2	2
	X = 3.5	X = 2.6	X = 1.6

discrete therapy experiences, time spent in the longest therapy, and the average number of therapy sessions attended per week.

The findings demonstrate that the participants were not psychotherapy novices; every individual had been in therapy on more than one occasion. The range of psychotherapy experiences varied from 2 to 6 with a mean number of 3.5 experiences. Although some of the terminations occurred due to job transfers, a significant number of the changes were attributed to dissatisfaction with the initial therapist.

This chart also suggests that at least some individuals become quite invested in the process of psychotherapy. This particular sample averaged 2.6 years in therapy with a range of 1 to 8 years and attended an average of 1.6 sessions per week with a range of 1 to 3.

Denominational Evolution

Table 8 highlights the religious/denominational variables that were discussed in the post-interview phase. Three main categories were targeted: the subject's religious or denominational heritage, other religions/denominations that have been explored, and, finally, the subject's current religious or denominational preference. The findings suggest that this sample, in addition to being experienced in psychotherapeutic matters, is also quite experienced in exploration of religious issues. The data reveals a pattern of changes in the subjects' religious beliefs; 90% currently practice a religious tradition other than

Table 8. Denominational Evolution.

Subject #	Religion of Origin	Other Religions	Current Preference
1	Baptist	None	Atheist but interested in Zen Buddhism
2	Catholic	None	Atheist
3	Lutheran	None	Agnostic
4	Baptist	Mormon	Pentecostal
5	Baptist	Agnostic	Unity & Lutheran
6	Episcopalian	Catholic, Unnamed Cult	Catholic
7	Southern Baptist	Native American spiritualism	Paganism, Humanism
8	Presbyterian	Episcopalian, Baptist	Christian (no denomination)
9	Catholic	Methodist, Presbyterian, Baptist, Catholic	Christian (no denomination)
10	Southern Baptist	None	Southern Baptist

the one in which they were raised. Three of the respondents now report being atheistic or agnostic, one has converted to paganism/humanism, whereas five have departed from their original mainline faiths to a new Christian denomination. This is clearly consistent with Sheler's observation that religionists today are "less committed to a specific denomination, more eclectic in views, more tolerant, more focused inward on their own spiritual journey, and observe more dynamic religious styles than their predecessors" (1994, p. 52). Furthermore, the five who changed denomination migrated from the mainline traditional churches toward one of two groups: 1) the less traditional forms of Christianity such as a mixture of Unity and Lutheranism, a mixture of feminism and Catholicism, and non-denominationalism; or, 2) toward more fundamentalist faiths such as Pentecostalism. This result aligns with Roof & McKinney's report that religion is "flourishing on the right and left...but languishing in the middle."

Religious Beliefs and Practices

Table 9 lists the ten subjects' responses to brief questions regarding their religious beliefs and actual practices: specifically, whether religion is significantly important in their present lives and whether or not they currently engage in traditional practices such as praying, reading scripture or attending worship services on a regular basis.

Of our sample, seven endorsed the statement that religion/spirituality is very important in their life; whereas three, the two atheists and the agnostic, stated that it was not. Furthermore, the results indicated that although this

Table 9. Religious/Spiritual Beliefs and Practices.

Subject #	Religion is Significant	Attends Church	Prays Daily	Reads Scripture
1	No	No	No	No
2	No	No	No	No
3	No	No	No	No
4	Yes	Yes	Yes	Yes
5	Yes	Yes	Yes	Yes
6	Yes	Yes	Yes	Yes
7	Yes	No	Yes	No
8	Yes	Yes	Yes	Yes
9	Yes	Yes	Yes	Yes
10	Yes	Yes	Yes	Yes
	No=3 Yes=7	No = 4 Yes = 6	No = 3 Yes = 7	No = 4 Yes = 6

sample's religious preferences may not include mainstream, traditional theologies, many of the respondents nevertheless engage in traditional religious practices. Six of the respondents, for example, attend church regularly (at least once a month), whereas seven of the individuals pray daily, and six read scripture on a daily basis. These findings are congruent with the subjects' already noted commitment to religious exploration. What is interesting in this phase is that although the religionists have typically shifted toward more liberal theologies, they have nonetheless by-and-large retained traditional religious practices to reflect these newly acquired theologies.

Summary of the Sample

In summary, our sample is fairly diverse regarding age, sex, marital status, education, and religious orientation. The group as a whole is older than samples found in prior studies and therefore may have had more time and life experiences in which to explore issues relevant to our study.

This assumption is borne out in many ways. First, the group is unique, when compared to earlier studies, in that it is extremely well versed in psychotherapy--none of the respondents had only one therapy experience to report. Each respondent, in fact, had been in psychotherapy on at least two occasions (one had over 6 therapies), averaging 1.6 sessions per week for well over 2 years. This sample is also extremely experienced with religious concerns. For example, only one of the subjects retained their religion-of-origin over the years; the remainder of subjects had gone through a marked religious

evolution, some trying on a number of various denominations before ultimately settling upon a new religious orientation or becoming irreligious altogether.

Given the maturity of this group and the degree of accumulated experience in both religion and psychotherapy, our findings should add a valuable perspective to studies conducted thus far.

Thematic Analysis of Interviews

Introduction

Results of the thematic analyses were obtained using the phenomenological techniques described earlier. Due to the volume of the transcribed material, several rounds of data reduction techniques were required but four major categories of themes and ten sub-themes were ultimately identified. Table 10 contains an overview of this material and illustrates both the four major categories and the sub-themes. To identify which subjects endorsed which themes, Table 11 identifies the interview themes across subjects. The total tally (in number of subjects) of endorsements per individual sub-theme is also identified in this table. It is important to note that all identified categories and sub-themes are to be interpreted strictly as coming from *the patient's perspective*.

Before proceeding to the identification of categories, one important caveat must be noted: for the purposes of this section of data analysis, there are only

Table 10. Thematic Analysis Overview.

1) <u>PATIENT-RELATED / RELIGIOUS</u> a) Religious exploration is necessary for effective therapy. b) Demonstrates reticence in Discussing religious issues. c) Desires to know therapist's religious orientation.	2) <u>PATIENT-RELATED / CLINICAL</u> a) Patient naïveté. b) Patient wants to be similar to therapist and/or have something valuable to contribute to the relationship.
3) <u>THERAPIST-RELATED / RELIGIOUS</u> a) Feels that therapist responds positively and proactively to religious discussions. b) Feels that therapist responds negatively to religious discussions.	4) <u>THERAPIST-RELATED / CLINICAL</u> a) Desires a proactive therapist. b) Seeks therapist with humanistic qualities. c) Seeks a trustworthy relationship and tests to evaluate.

nine usable datasets rather than ten. For reasons that will be discussed in detail in the individual case descriptions, Subject #2 was inappropriately included in the study. It was later determined that he did not ultimately meet inclusion criteria since our project specifically requires that the patient talked with their therapist, or at least attempted to talk, about religious/spiritual issues. Subject 2, however, has been a contented atheist throughout his life and therefore never had any reason to discuss his atheism with this therapist. Given that the point of our study is to analyze patients' efforts to discuss religion, this patient presented no such data and is therefore included only in the demographic analysis and in the case descriptions so that his case can be better understood. It must be emphasized that he was not omitted because he was an atheist—for other atheists are still included in our study—but rather simply that he never discussed religion in his psychotherapy relationship.

Thematic Identification and Description

The four major categories identified by our sample are as follows:

- 1) Patient-Related Religious Issues, 2) Patient-Related Clinical Issues,
- 3) Therapist-Related Religious Issues, and 4) Therapist-Related Clinical Issues.

These categories are deemed to be a logical fit for their individual sub-themes and for the purposes of analytic inquiry; however, in reality there is inevitably marked overlap between these categories.

The following section identifies each theme and sub-theme that was provided in Tables 10 and 11 and provides details, case examples and levels of endorsement for each issue.

Category 1: Patient-related Religious Issues. Category 1 contains three sub-themes which pertain to the patient's interest, thoughts and fantasies about discussing religious issues with their therapist. The three identified sub-themes are as follows:

- (a) Relevance of religious discussions - Patients that endorsed this theme feel that religious discussions are essential for effective treatment. It does not, however, indicate whether the subject actually acted upon this belief system but rather that, in their opinion, religious views are so significant that they should be included in any effective therapeutic endeavor. This stance was endorsed by 8 of the 9 final respondents (89%), verbatim examples of which can be found in Table 12.
- (b) Reluctance to discuss religious issues - This theme reflects a vast number of fears and concerns expressed by the patients and are hence at least partially responsible for their reported reluctance to address religious issues with their therapist. Examples of this reluctance are illustrated in Table 13 and include fear of offending the therapist, fear of causing discomfort in the relationship,

Table 12. Theme 1(a) Relevance of Religious Discussions.

#	Verbatim Illustration
1	And I then realized that my spiritual life does not hinge on church services...it was OK for these pieces of my life to come up and for me to realize that this was the environment that I grew up in, and that I'm always going to have that in the background, and that even if I became Hindu or Buddhist I would always have that dynamic.
3	Well for awhile religion was important to me... I talked a lot about the church
4	N/A
5	It might have not been too long into therapy before I brought it up, because at that time in my life I was going to church, and then I went to al-Anon, and then I went to therapy and so probably I was pretty strong and devout at that time.
6	I do remember having a strong sense a couple of times that it would really help if I could talk about it... Actually it might have been a therapeutic resource that could have been drawn upon. And that made me feel that maybe a strength that I had was being left out... And I thought I shouldn't pursue it but then I said to myself "No, no, no... it is implicated in the last 5-10 year history...
7	And he pushed me to take some risks and try different things... actually he was the one who turned me onto like the Native American spirituality and through that I met some people and ended up going to South Dakota one summer with the Lakota Indians and that was one of the most spiritual things that ever happened. And it just changed me...helped me get through that and find another way.
8	For most people um religion is a central part of their life and how can you do good therapy without that being considered? I don't see how it could really be effective... Obviously I know sometimes people can get real destructive, but I feel there's a big difference between Heaven's Gate cult and Presbyterians and I think people should realize that and do whatever helps people get better. Maybe use the religion to help the people get better.
9	I see this happening all the time, where people will come into AA and have spent thousands and thousands of dollars of psychotherapy and it doesn't help, but then they get what they need from a 12 step recovery program and all this program does is to help people learn how to lead a spiritual life....
10	Church was very important to me so I know I emphasized this more than some other topics on the few times I brought it up.

Table 13. Theme 1(b) Reticence to Discuss Religion.

#	Verbatim Illustration
1	N/A
3	...maybe it was inevitable after being in therapy for so long that I became agnostic... I didn't try to talk about it much in therapy because it wasn't really a therapy issue and maybe by then I didn't want to offend my therapist... it would just be uncomfortable to talk about religious beliefs because maybe I thought they wouldn't be defensible. I knew intellectually they wouldn't hold up but I didn't want to have to look at it....maybe I just don't like it when people try to talk me out of something I believe in and I just sort of thought why bring up something that depressing?
4	I guess religious beliefs are kind of private, hmm, that sounds weird that it's too private to talk about. There are times I guess that I don't want anyone to judge me on it and I don't want to have anybody try to convince me that I'm wrong....I don't think I felt strong enough about my beliefs for them to be up there. It's like someone could beat them up or they'd say "Oh I can't believe you believe this way, that's just ridiculous."
5	I don't think it was main topic but it was just woven in there.
6	I never felt that I could talk about religious issues with him... It's kind of just a fear... I felt like it was not a topic... I was just left with the feeling that this was outside of the boundaries of what it is that can be talked about... I only brought it up because it was really implicated... I feel if I say something I better be prepared to back it up... I have kept my spiritual experiences away from her.
7	...I didn't feel free to bring anything up because it takes awhile to build up trust... that I would get shamed or that they would try to impose their beliefs on me... I didn't go down that lane.
8	I guess I had some concerns because I've heard that some shrinks see religion as a defense... he would think I was just being irrational or clinging to something or looking for hope. I feel he just didn't understand... I just let it go.
9	The whole time I was going there no spirituality was discussed... nobody wants to talk about God, nobody wants to cross that line.
10	I wondered too if he thought religion was dumb because he was obviously very educated... I was afraid of looking dumb or not having the right words to say... I didn't know if it was a touchy subject...

concern that their beliefs will be labeled as irrational or crazy, fear that the therapist will attempt to convert them away from their belief system, and concern that they will be intellectually challenged on their beliefs and not know how to effectively debate. Again, endorsement of this theme does not necessarily mean that the patient failed to discuss the issues with their therapist, only that they were hesitant or had concerns about doing so. Many of the patients reported bringing up religious issues only after the therapeutic relationship had already been solidified in other ways in order to minimize any perceived risk. Others brought upon religion only as an aside to other issues presented for therapeutic exploration (e.g., discussing suffering post-miscarriage) rather than discussing them directly. In contrast, some patients withheld all religious content from therapy for fear of judgment while others attempted religious discussions and based on a perceived poor response from the therapist, then stopped such discussions altogether. This broad category was endorsed by 8 respondents (89%).

- (c) Curiosity about the therapist's beliefs - This theme suggests that patients have a strong desire to know their therapist's religious orientations. Indeed, this item was endorsed by 9 (100%) of the

respondents, specific examples of which are in Table 14. While this level of endorsement may simply suggest personal curiosity, it may also suggest the desire to minimize their anxiety by knowing a priori exactly where the therapist stands on the topic of religion. Perhaps it is the not knowing, and hence assuming that the therapist is dramatically different, that causes the greatest concern or it may be simply the patient's desire to understand where they stand vis-à-vis the therapist's own worldview. This finding is particularly interesting given that the therapist historically seeks to remain neutral in their therapeutic setting so as not to contaminate the patient's transference issues. Self-disclosure, although used more so in "person-centered therapies, is used only sparsely and with careful consideration in psychoanalytically-informed therapies.

Category 2: Patient-Related Clinical Issues. Category 2 contains two themes in which the patients expressed great interest or concern about clinical issues. Since they are not specifically related to religion, but rather to general psychotherapy technique, they are itemized as a separate category.

- (a) Patient naiveté - This theme, endorsed by 9 individuals (100%) indicates that patients are not initially sophisticated about what therapy can and cannot do for them. They sometimes enter therapy with unrealistic expectations about what will occur and what results to expect. They do not know how to evaluate therapy

Table 14. Theme 1(c) Curiosity about Therapist.

#	Verbatim Illustration
1	...I don't especially know what Dr. Smith's religious values were...and I never asked him but I thought that maybe that meant he was Jewish.
3	...it would surprise me a lot if he wasn't agnostic or atheist but he never said anything but he never um said anything positive either.
4	...Now I have no idea what her religious beliefs were...but it still felt like her beliefs were very much like mine...I never asked her.
5	I believe he believed in God though I never knew what religion or anything.
6	...he was not a self-disclosing person...he indicated that...there were a lot of new, entertaining things doing on in religion...
7	...he went to church and stuff too so he wasn't locked into any kind of ideal of what spirituality should be. He was real firm in his beliefs but he's not into imposing his beliefs on you.
8	I don't know if he was Christian or Jewish or agnostic or atheist.
9	...I was shocked when I found out she was a reverend.
10	I was very curious...I wondered whether my doctor was saved or not.

and which factors such as their own limitations, their therapist's competence, or the therapeutic match might be operative. Many of our patients stated that it was only when they eventually found a good therapeutic match that they retrospectively realized that the prior therapist was, in fact, not highly skilled and/or a good match. From these trial and error efforts, these individuals have acquired a great deal of experience; however, had patient education been offered initially, it might have prevented needless upheavals. Table 15 provides specific verbatim examples.

- (b) *Similarity with the Therapist* - This sub-theme illustrates the patient's desire to identify similarities and common interests with their therapist to help develop a sense of belonging and connection. In keeping with this desire, many of the patients also specifically expressed a desire to contribute something back to the relationship. Although therapy is generally deemed a one-way relationship, these patients expressed an interest in giving something back to assist the therapist in some way. Examples include wanting to educate a therapist about a religious cult or sexual orientation, providing information on hobbies, and even evangelizing for the therapist's salvation. In this vein, these patients reported being very sensitive to perceived power differentials in the therapeutic relationship and will resist any

Table 15. Theme 2(a) Patient Naiveté.

#	Verbatim Illustration
1	So then by the time that I got into therapy with Dr. Smith, I knew what I had to do. It was already laid out in front of me because after six weeks of treatment I knew what the issues were... after having done that much group...I knew what to do.
3	... she was getting more out of the session than I was...now with my new therapist like I'm not getting everything from him either and someone told me I should go to someone else and I'm not sure what to do...it's not gratifying to me. It's not like I uh, it's not entirely nurturing....I guess I'm wondering how do I ultimately end up getting better?
4	I had never tried therapy before so I guess at first I thought, "Well is this what its supposed to be like?" ...but I was expecting more answers from him and he kept asking me for answers.
5	..."Well, you've got to have some goals" and hell, I didn't even know what a goal was as sick as I was. So either they didn't know how sick I was or they didn't care.
6	I don't remember really ever having a sense that he had any feeling of direction for me. I didn't really know what I was doing either. So I think maybe I was on edge about what I could and could not talk about. So I said, well yeah, I guess this has kind of helped.
7	Like now that I've had some good therapy, something to compare the others to, most of what I had was pretty bad.
8	...I knew I didn't have many friends but I didn't think it was anything that therapy would be able to help... I guess I thought therapy was for if I was having problems with myself.
9	But now that I have more experience, I see this happening all the time, where people will come into AA and have spent thousands and thousands of dollars on psychotherapy and it doesn't help, but then they get what they need from a 12-step recovery program...
10	Well I got in therapy and it really wasn't what I expected as far as the pace. Um, I think I thought we'd have goals and have an agenda every week... I guess I thought I would come out with some change that would be really noticeable but it wasn't... I kept thinking something magical was going to happen.

flaunting of power accordingly if and when it is identified. The group was unanimous in identifying this theme--9 subjects endorsed the theme making a 100% response rate--and specific examples are found in Table 16.

Category 3: Therapist-Related Religious Issues. Category 3 describes the patient's views of how the therapists responded when presented with religious discussions. It includes two categories:

- (a) Positive response - This theme, as illustrated in Table 17, includes retrospective memories that the therapist responded with great interest to their religious discussions as demonstrated by curiosity, asking follow-up questions, not changing the subject, listening intently, and perhaps tying in religious themes with the patient's general therapeutic themes. In other words, a positive response occurred when the therapist displayed markedly proactive therapeutic involvement. However, only 5 (56%) of our sample had ever experienced this type of response in any of their numerous therapy experiences and this was accordingly the weakest identified sub-theme.
- (b) Negative response - This theme encompasses memories of unexpected and/or undesirable responses that occurred when the topic of religion was broached. Examples (see Table 18) stem from a variety of remembered responses such as ignoring the

Table 16. Theme 2(b) Similarity with the Therapist.

#	Verbatim Illustration
1	... he was a middle-aged man, and I'm a middle-aged man...like Dr. Smith, my parents came from farm backgrounds too. So I've always felt this real connection with the land...I think I'll write Dr. Smith and let him know how things are going because I know that this thing was really important for him too.
3	...I want to have this experience of feeling connected... I'm also aware of an urge to want to help him...I want to know how he's growing, it's important for me to know how I'm helping him, how I'm changing him.
4	...I could talk to a woman easier... I felt put down but maybe that was the male/female thing...I always get the impression that she agreed with me, I almost felt like she had the same belief system I had, even if she doesn't!
5	I wasn't sure how to talk to a man. And I wanted a woman, I thought she would understand... I don't think I felt we were worlds apart on religion...
6	...he was probably just a couple of years older than I... And I had the sense of him...using the opportunity to be with me to learn a little bit...
7	I would go into his office for fifteen minutes about once a month and that was it and he would try to work out some kind of plan for me in fifteen minutes a month. I felt like meat!...I feel that the majority of these therapists haven't been where I need to go... I'd be going through something and he'd share with me something similar that had happened to him. It made it more human, it made him more on my level rather than a hierarchy, it made him more like we were a team, almost.
8	We had some similar interests...I loved knowing he didn't like Rush!
9	It worked after all those years of therapy because here was somebody just like me who had said that and it really hit me...I remember with all the therapists I've seen that I always felt inferior.
10	At first it was very intimidating because he was a doctor and all and I have sort of a complex about my education...I remember trying real hard to become interested in them, feeling like I was "supposed" to like these things, or that if I wanted to get along better with him I "had" to like these things so I'd be more interesting to him. I felt put-down in a way, like it was yet another way that he was superior to me

Table 17. Theme 3(a) Positive Response.

#	Verbatim Illustration
1	...what Dr. Smith helped me do was to find my own individual beliefs rather than the stuff I was brought up with...
3	N/A
4	...she wanted to make us aware of what we were up against. Have you thought about this? Have you explored this thoroughly? She never changed the subject like the others, or interrupted me, or asked why I would want to change. She never asked me "why" where I had to defend myself.
5	So we did talk about all this stuff, and God, and him being a minister...that we were able to talk about what faith was because I was real gutted out about faith and think I had lost some.
6	So my therapist was interested in what it was like and through skillful questioning helped me see the relationship between my family dynamics and the dynamics between the cult.
7	...actually he was the one who turned me onto like the Native American spirituality... And it just changed me, it took me out of my little box that I didn't want to be in and I felt like it wasn't me, and he helped me get through that and find another way... He wasn't afraid to give feedback but he don't impose that unrealistic bullshit that other therapists try to impose.
8	N/A
9	N/A
10	N/A

Table 18. Theme 3(b) Negative Response.

#	Verbatim Illustration
1	N/A
3	...there were times I might of said something about the church I was going to and a couple of times she sounded defensive like she said that "God was on the mountain for her...he never said anything but he never um said anything positive either...
4	Do you really want that extra pressure of the Mormon church?
5	I was real sick spiritually then so I'm sure I had to bring that up because I know he didn't...it was very rare that when you're going to counseling that you would ever talk about God.
6	...I mean it may have been the scientific feeling of the environment so I was just left with the feeling that this was outside of the boundaries of what it is that can be talked about...I think he was really shocked that I had been in a cult. It was more the negative side to it rather than looking at it like I'm a spiritual person who's on a spiritual quest and whether I'm guided or misguided I'm always seeking.
7	... And you know they just immediately wanted to Christianize me, they wanted me to go to church and all that...she told me she was a Zen Buddhist but she didn't act like it...
8	...and he didn't respond at all. Um, he didn't respond. I told him this all had happened and he didn't say a word...I guess I feel he just didn't understand.
9	...I see this happening all the time, where people will come into AA and have spent thousands and thousands of dollars of psychotherapy and it doesn't help, but then they get what they need from a 12-step recovery program and all this program does is to help people learn how to lead a spiritual life...You're told so often that you can't do something that you don't --it's out of the picture. You replace it with something else... (Therapists should) be bolder. To be able to bring up stuff and at least put it on the table to see if the client wants to address it. If they don't, then you can go on to something else but at least you've brought it up.
10	...I tried to talk about church a whole lot for a few sessions...it went nowhere, absolutely nowhere. I couldn't get any kind of reading from him at all so I figured it wasn't that helpful so I just gave it up...the therapist should ask at least one question about it. Mine kept avoiding it and I didn't know if it was a touchy subject, if I was boring or what...

patient, remaining uncharacteristically silent, changing the subject, or even displaying explicit disdain. The ramifications of these perceived behaviors typically included the patient either giving up such discussions or in some instances ending the therapeutic relationship altogether. Eight members of our sample (89%) had experienced such negative responses to their attempts at religious discussions over their numerous therapeutic encounters.

Table 19 provides an overall tally of how patients rated their therapists' responses, both positively and negatively, to their attempts to discuss religious issues.

Category 4: Therapist-Related Clinical Issues - This category includes, the patients' view of therapist traits and behaviors that promote a positive therapeutic relationship.

Table 19. Results of Attempted Discussions

Results	# of Subjects
Positive Experiences Only	1
Both Positive and Negative Experiences	4
Negative Experiences Only	4

- (a) Proactive Therapeutic Stance - The 100% endorsement of this theme (9 subjects) indicates that our sample clearly does not want to work with passive therapists. They instead want therapists who are attentive, curious, who ask questions and who generally seem proactive, involved and invested in developing a positive therapeutic relationship. Table 20 gives examples of this proactive orientation.
- (c) Humanistic qualities - Whereas the above theme illustrates the therapist's behavior and therapeutic involvement (e.g., what they do), this theme loosely identifies perceived personality traits (e.g., what they are). Commonly identified traits, as described in Table 21, include warmth, openness, a good conversationalist and listener, empathic by nature, and a therapist who by nature, not effort, demonstrates unconditional positive regard for their patients. These traits may be expressed either positively (e.g., I want a warm therapist) or negatively (e.g., I do *not* want a cold therapist) but either way the message is that a nurturing relationship is essential. Every member of our sample endorsed this item (100%).
- (c) Trust and Testing - A key ingredient of the therapeutic alliance is trust and eight members of our sample (89%) reported that this trust had to be earned. Toward this end, many explicitly tested the

Table 20. Theme 4(a) Proactive Therapeutic Stance.

#	Verbatim Illustration
1	He seemed to know when to push and when to pull back and let me do the work and when to prod me...he would refocus my attention...there were times when I was at the end of my rope but it seemed like he always knew that, and he knew when to step in and when to shut up.
3	...he had heard what I said and was making an adjustment.
4	...I would rate my mood every day from 1-10 and take it into my therapist...she'd ask questions now and then...she did many things to get me started but she made it seem like it was my idea all the time.
5	...It wasn't really that he gave you an answer...but that he listened...he did the right thing...
6	I never got any type of feedback or diagnosis...I don't remember ever having a sense that he had any feeling of direction for me...I really don't think he was a very skilled therapist, I need to have a purpose for being in the room....we were able to do a lot with anger, restoration of self-esteem...my therapist was interested...and through skillful questioning...had better therapeutic skills...acquaintance with a wider variety of models and techniques too.
7	...I used him as a sounding board and learned from my own mistakes. I got his feedback.
8	I guess I was looking for more feedback, advice or maybe suggestions on what to do. But he pretty much just let me talk and I guess it all worked out for the best...he used to give me homework, but then he would never ask me about them... Sometimes he would ask questions, sometimes he would make a really penetrating statement... He made me look at my reactions in different ways.
9	...the therapist should lay the foundation by asking the client all the underlying issues about what's going on in your life...she was finally more proactive...people are looking for guidance...for the first time I found someone willing to confront me, to be honest with me and tell me what I was doing wasn't right.
10	He would stay quiet...the therapist should ask at least one question about it...

Table 21. Theme 4(b) Humanistic Qualities.

#	Verbatim Illustration
1	He would tell me little bits and pieces about himself...there was so much empathy there...he understood...
3	...the therapist would tell me what I was thinking...it wasn't my experience...he's introverted, timid...if he would bring more emotion...I would know he's being real...it's not entirely nurturing...I would like to be like therapists who are agnostic and benevolent.
4	...I felt like she understood...he always cut me off...I didn't always feel safe...I felt judged...she was real open to hearing us...it had to be real hard, it was very open on her part...
5	...he wasn't judgmental...he listened...he didn't act exactly warm...patient...
6	...he could be really nice and I had a feeling he cared about me...He was holding up a cracked mirror and I'm saying "No, that's not me!"...his ease and ability to establish rapport...I had the sense of him caring...she's a judgmental person...her personal style is just a little bit...abrupt.
7	...real dogmatic, real Christianized, they want you to see things their way...she said she was open but you could just tell her belief systems weren't really open...he's just so laid back...he's real liberal, real open minded...real open...he's been really loving, really caring...he'd share with me...he's constantly working on himself.
8	...it always felt sort of fake...he never volunteered much about himself.
9	...she just wasn't comfortable...I had to beat the door down to get her to come to me...I found someone willing to be honest with me...need to start with the therapist working hard to get into the client's comfort zone...
10	...a nice, gentle man...it seemed artificial at times...it was real-business-like.

therapist in some way (see Table 22 for examples) to see how the therapist responded before proceeding with more intimate, potentially embarrassing or even volatile issues. To illustrate, a patient who is reluctant to discuss religious issues might send out a test comment such as "I prayed that my dad would get well" to see how the therapist responded before delivering a potential bombshell such as "I joined a cult." Depending on the therapist's response to these tests, the therapeutic alliance will be either hindered or heightened accordingly.

Post Interview Questionnaire

The post-interview questionnaire was administered one year after the interview phase to explore the degree of congruence between the hermeneutically derived thematic data analysis and the subject's thoughts and feelings in response to direct questions. In addition to investigating some issues not emerging in the themes. Of the ten original subjects, nine could be located one year later. Each of these individuals returned the questionnaire by the due date, creating a 90% response rate. However the results actually reflect data from only eight individuals because, as explained, Subject #2 did not meet inclusion criteria.

The questionnaire results are found in Table 23 and although the results are generally congruent with the thematic analysis, some qualifications are in order. The initial question "I consider my religion to be the single most important

Table 22. Theme 4(c) Trust and Testing.

#	Verbatim Illustration
1	I could never jerk him around...there were times...I could tell God almighty, he's two steps ahead.
3	I didn't try to talk about it much in therapy...by then I didn't want to offend my therapist (tested in prior incident).
4	I even told her about the Mormon church and she handled it very well.
5	He really tolerated my behavior....I was awful...and I don't think any of that bothered him.
6	...I think it was his attitude toward me when I told him that I had taken LSD...he might of have had a reaction to that...the way he acted I thought, ooh, I'm not going to be able to tell him that I was ever...playing with an Ouija board.
7	...I did test him at first. Like I'd cancel appointments and not show up and stuff like that to see how he'd react...he was always just laid back...
8	...sometimes there were things I did bring up and he wasn't helpful so I sort of figured, why bother?
9	N/A
10	...I tried to talk about church a whole lot...it went nowhere, absolutely no where...so I just gave it up.

Table 23. Post-Interview Questionnaire Results (n=8).

#	ITEM	SA	A	N	D	SD
1	I consider my religion to be the single most important part of my life.	3	1	1	1	2
2	If given a choice, I would prefer to work with a therapist who shares my attitudes on religion.	4	2	0	1	1
3	For therapy to be truly effective, religious beliefs should be discussed at some point of the treatment.	4	2	0	2	0
4	From my personal experience, I find that most therapists are atheists.	0	2	3	3	0
5	I would better be able to trust a therapist who had religious beliefs similar to mine.	3	2	0	2	1
6	Therapists are generally well trained and skilled in handling religious issues that arise in therapy.	0	2	2	3	1
7	In my own therapy (or therapies), I personally raised religious issues for exploration with my therapist.	1	4	1	2	0
8	From my personal experience, I find that most therapists are very receptive when clients bring up concerns involving religion.	1	1	1	5	0
9	From my personal experience, I find that most therapists routinely ask about their clients' religious beliefs.	0	1	0	6	1
10	I would be very pleased if my therapist spontaneously asked about my religious faith.	2	3	0	2	1
11	I wanted to bring up religion more frequently in therapy but did not for fear of the therapist's reaction.	1	4	0	1	2
12	Therapists tend to see religious beliefs as neurotic.	0	4	2	2	0
13	I did not bring up religion in therapy more often because I did not want to debate religious issues with the therapist.	1	2	1	2	2

Table 23 (continued).

#	ITEM	SA	A	N	D	SD
14	The more therapists and clients have in common, the greater the chance for a good therapeutic outcome.	13	38	25	13	13
15	From my personal experience, I find that most therapists are accepting of any topic the client brings up and generally do not attempt to change the subject.	25	38	0	38	0

part of my life" received marked variation with four subjects (50%) strongly agreeing or agreeing, one remaining neutral, one disagreeing and two (the atheist and the agnostic) strongly disagreeing. This question was worded in a stronger fashion than the interview statement which simply asked "Is religion important in your life?;" therefore, a positive endorsement on the questionnaire would indicate that the subject is willing to place religion over all other personal considerations such as family and work. The fact that two of the religiously-identified subjects chose not to endorse such a strong statement accounts for the unexpected deviation.

Stronger trends were evident, however, in other questions regarding the patients' belief systems. Of the eight subjects, six (75%) either strongly agreed or agreed that, if given a choice, they would prefer to work with a therapist who shares their religious attitudes. Eight subjects (100%) concurred with the statement that religious issues should be discussed in treatment for therapy to be truly effective. Five of the eight subjects (63%) reported that they would be pleased if their therapist spontaneously asked about their religious faith whereas the same number reported that they would better be able to *trust* a therapist with religious beliefs similar to their own.

Whereas the questions above asked about the patient's belief system, the following questions instead asked about the patient's actual psychotherapy experience(s) and behaviors. Seven subjects (88%) found that, in their personal experience, therapists did not routinely ask about their clients' religious beliefs.

Only five subjects (63%) directly raised religious issues themselves for therapeutic exploration. Five subjects (63%) report that most therapists are not very receptive when clients bring religious concerns whereas six subjects (75%) expressed a desire to bring up religion more often but did not for fear of the therapist's reaction. Three subjects (38%) said they avoided religious discussions altogether because they believed a religious debate with the therapist would inevitably occur.

Questions asking subjects to make assumptions about therapists' beliefs and training showed marked variation. For example, when asked if most therapists were atheists, none strongly agreed or strongly disagreed, two agreed, three were neutral and three disagreed. When asked if therapists were well trained in handling religious issues, none strongly agreed, two agreed, two were neutral, three disagreed and one strongly disagreed. Finally, when asked if therapists saw religious beliefs as neurotic, none strongly agreed or strongly disagreed, four agreed, two were neutral and two disagreed.

Individual Case Descriptions

Brief case descriptions of the ten subjects are discussed below to provide information about the unique personalities which endorsed a given theme. The case descriptions also provided verbatim examples and quotes which allows the theme to be thoroughly examined in its original context. The power of the themes becomes more obvious when studied in this fashion and it is particularly

striking to learn that the group themes of the sample were yielded by individuals of such different psychologies and life histories.

Subject 1

"Tom" is a 46-year old, single, gay male currently self-employed in the service industry. A week before the interview, Tom had experienced a forced termination with his therapist of eight years since the therapist planned to move out of state for retirement. The transition was obviously very difficult for Tom, as he had formed a solid attachment with this particular therapist, and indeed, he displayed an idealizing transference for most of the interview.

Tom originally sought treatment at a long-term alcohol detoxification and rehabilitation facility. He experienced severe withdrawal symptoms and at his lowest point, finally asked himself, "Do I just blow my brains out and get it over with?" or "Shall I go into treatment?" Somehow finding the strength to carry on, Tom was referred for outpatient psychotherapy by one of the A&D specialists who hand-picked the referral for Tom. While the thoughtful referral may have indeed facilitated the positive experience that ensued, it is also true that Tom himself had been prepared and genuinely committed to therapeutic work since his hospitalization. "By the time I got to therapy in Knoxville...all this had already come out...so by the time I got to "Dr. Smith," I was pumped prime, I was rearing to go. I was up and running, and I knew what I needed to do." Although Tom clearly attributes his ultimate therapeutic success to Dr. Smith, he also concedes that timing and preparation were important factors.

In the initial phase of their therapeutic relationship, Tom purposefully tested Dr. Smith on several occasions to ensure Dr. Smith's skill and intelligence. The results were comforting: "I could never jerk him around. And there were times...I could tell, God almighty, he's two steps ahead." In addition to being intelligent, Tom also saw Dr. Smith as a caring, compassionate individual: "There was just so much empathy there. It didn't always calm me, but it was always apparent that he understood." Tom frequently sought to identify similarities with Dr. Smith to help make their alliance even stronger for the interview was peppered with comments such as "he was a middle-aged man, and I'm a middle-aged man..." and "like Dr. Smith my parents came from farm backgrounds too so I've always felt this real connection with the land... (Dr. Smith was retiring to a farm)." Dr. Smith apparently participated in some degree of measured self-disclosure as Tom knew specific details about Dr. Smith's decision to retire; yet he was not aware of more personal details such as Dr. Smith's religious orientation.

Over time, Tom clearly developed a solid therapeutic alliance with Dr. Smith. Their work together primarily focused on what Tom originally thought were gay issues but instead turned out to be "middle-aged men's issues" such as how his masculinity influenced his family-of-origin. One of the most therapeutically intense examples was when Tom had to learn, at age 43, how to become a self-reliant man capable of functioning well independently of parental control. In his own words, he had become his mother's "surrogate lover" and it

took intense daily sessions for Tom to recognize this, set boundaries, and enforce those boundaries despite his mother's intense despair and her manipulative attempts to maintain status quo.

Due to the intensity and pace of the therapeutic work, Tom occasionally "went off the deep end," and during such times Dr. Smith would reliably step in, provide support, and refocus Tom's attention. Although Tom repeatedly credited Dr. Smith for knowing exactly when to push and when to pull back, he would nevertheless become irate, despite his intellectualized understanding, during Dr. Smith's planned silences. "God damn it, I don't know what I'm doing. Will you please help me?" Tom would cry, only to hear in return, "What is it I'm supposed to do?" Yet, when Tom was almost near defeat, Dr. Smith would inevitably step in and provide ego strength until Tom restabilized.

In this therapeutic context, it is not surprising then that Tom and Dr. Smith were able to discuss religious issues in an extremely positive and proactive manner. This is particularly interesting given that Dr. Smith managed to do so without ever disclosing his own religious beliefs or orientation:

Well I don't especially know what Dr. Smith's religious values were, or what training he was brought up on, other than he once said that his father was very "Old Testament-oriented" and I never asked him but I thought that maybe that meant he was Jewish.

Religious issues were figural in this therapy for they were immediately relevant to this patient's personality and family dynamics: Tom's parents were

both fundamentalist Baptists. While Tom had decided years ago to become an atheist, and did so contentedly, Tom and Dr. Smith nevertheless jointly realized the significance of exploring Tom's Baptist heritage. Not the theology per se but rather the psychological ramifications of being raised Baptist in this particular family. Over time, Tom began to realize that whereas some of this heritage (particularly the theology) could be discarded, some of it was yet an important part of his identity:

One time we talked about how I missed the great hymns of the church and we talked about some of the hymns...and what Dr. Smith helped me do was to find my own individual beliefs rather than the stuff I was brought up with... There were times though that I had left the church for so long, and repudiated it so much that I still found myself, and still do, quoting passages of scripture...

And another example:

And I then realized that my spiritual life does not hinge on church services, Dr. Smith helped me clarify all of that. But that it was OK for these pieces of my life to come up and for me to realize that this was the environment that I grew up in, and that I'm always going to have that in the background, and that even if I became Hindu or Buddhist I would always have that dynamic.

In these examples, Tom obtains comfort from reciting scripture and from singing old hymns, and thus they are psychologically healthy and useful, even though

church-going and the attendant Baptist theology are no longer of assistance. But rather than divorce religion from his identity altogether, Tom is instead able to select what to retain and what to discard, making the religious experience his own positive experience rather than a negative experience imposed upon him by his Baptist parents. As such, this case is a prime example of how a therapist can foster a patient's self-acceptance and self-understanding using religious issues, without ever having to inappropriately and unethically debate ontological issues.

Subject 2

"Bobby" is a 37-year old single male who has been in a long-term, committed relationship for numerous years. He has a graduate school education and is currently employed in social services. Bobby appears years younger than his stated age, was meticulously groomed, and had a very quiet, deliberate demeanor. He seemed eager-to-please and spoke softly, formally and slowly as if he were carefully weighing every thought. He also often spoke in a detached style as if he were at times describing characters in novels rather than people he actually knew. When describing his mother, for example, he stated "*the mother*."

Bobby's most striking characteristic, however, was that he appeared extremely eager-to-please. He arrived on time, was very polite, attentive and labored to answer each question posed during the interview. At the end of the interview, he profusely thanked the interviewer for allowing him to participate and displayed interest in the project's findings, the interviewer's opinions on

managed care, and so on. He ended the interview by remarking "If you ever need any more information, if there's anything I can do, just call me. It was a pleasure to help you and I wouldn't have spent my lunch hour any other way." When the post-interview questionnaires were delivered, Bobby's was the first to be returned—and not only did he return it by fax, but he also sent the original by regular mail in case the original was also needed.

This intense desire to be helpful is particularly understandable given Bobby's history of childhood neglect. As a result of these early traumas, he had acted out considerably as a result, and in adulthood these themes were inevitably perpetuated in other relationships until he had the benefit of extensive psychotherapy. Despite having brief therapy experiences in his past, it wasn't until he entered long-term psychotherapy at a student training facility that he finally had the chance to explore his grief and loss and to also forge, for the first time, a strong positive relationship with a female—his student therapist.

As expected, given his circumstances, Bobby quickly developed a strong, idealizing maternal transference with this student therapist, "Sarah". At the time of the interview, their relationship had been terminated for two years because she had moved out-of-state. Bobby, however, still spoke of her in extremely positive terms, grieved her loss, and never identified any critiques of her therapeutic style:

She was a wonderful person. She is still a wonderful person... She looked at me, she listened to me, she challenged me whenever I

would say silly things... She was there whenever I needed her or even when I didn't. A strong sense of stability I found with her-- structure. She was always available by phone... But really just her presence. She sat up straight, she looked at me... She understood what I was saying.

In addition to being seen for the first time, Bobby also felt highly valued in this relationship for not only did this therapist accept his worst flaws, but he also felt valued by being able to teach her: "...wanting to learn what my lifestyle was and I was happy to tell her things that she did not know. She would say "Teach me, teach me. I don't know so teach me." He also enjoyed having the occasional opportunity to comfort her: "It embarrassed Sarah something awful so I had to soothe Sarah at that point and say its not really all that bad."

When this relationship ended, Bobby decided not to reenter therapy because he adamantly believed he would never find another therapeutic alliance as positive as this one had been. He instead currently relies on friends as a sounding board and for personal advice.

It was in part due to Bobby's intense cooperation, zeal and interest that originally blinded this investigator to the fact that Bobby did not actually meet the project's inclusion criteria. Although the telephone script was utilized, in which the nature of the project was explicitly described to the prospects (e.g., have you ever tried, successfully or not, to discuss religious issues with your therapist?) this particular patient slipped by and was incorrectly included in the data

collection. It was only during data analysis that it was determined that no religious content appeared in any of his materials other than the following explanatory comments: "I went regularly but never believed. There was too much bad going on to possibly believe that somebody is watching over me (laughs). And today as an adult I still have no religious affiliation."

While the project's inclusion criteria permits atheist subjects, the project does require that at some point of the therapy the patient at least attempted to discuss their atheistic belief system. With Bobby, however, this was clearly not the case:

I'm sure religious preference/background was on my assessment sheet but I can't recall it ever coming up... I've always been comfortable with my stance so there was nothing to talk about in that. When I quit going to foster care I quit going to church.

Although it is evident that tighter screening procedures would have been useful, this case is also an extraordinary instance when the patient also, unconsciously or not, presented himself in such a way as to gain acceptance into the project. Perhaps he had hoped to forge a relationship with the investigator of this project, a female therapist from the same program as his prior therapist. And perhaps he simply wanted to be helpful and to be heard.

Subject 3

"Randy" is a 28-year old, single male who is currently employed part-time in retail while pursuing his graduate education in social work on a full-time basis.

He has been in therapy on three prior occasions. His current therapy has lasted two years and he presently attends three psychotherapy sessions weekly.

Randy is a highly-educated and intelligent individual who is extremely invested in overcoming family-of-origin traumas—he was emotionally abused and neglected by both parents throughout his childhood and youth. These issues are clearly emotionally charged for him even today for although Randy is typically a soft-spoken individual, he becomes obviously agitated, anxious and angry when discussing his childhood. He has consequently spent considerable time, money, and effort attempting to resolve these unsettling experiences through various psychotherapy relationships. He strives to find a positive, emotive therapist to help correct these negative life experiences and has terminated several therapeutic relationships when this pervasive need was not met. For example, when discussing his prior female therapist he remarks: “I didn't want to go back. I guess I was feeling sort of disillusioned or disappointed and that would be real hard to tell her that...I knew I needed something I wasn't getting there.”

At the time of the interview, Randy was in his fourth therapeutic relationship and was going three times weekly despite having considerable doubts about the therapist's competence and genuineness:

...now with my new therapist like I'm not getting everything from him either and someone told me I should go to someone else and I'm not sure what to do...I don't feel like I trust him. And right now

I'm still aware that it could be better, that there's something missing...

With his current therapist, Randy appears to have a complicated transferential reaction in which he sees his new male therapist as someone very similar to himself. Consequently, he strongly identifies with this therapist—at times deeply caring for him while intensely disliking him at other times. This ambivalence is portrayed in the following two illustrations:

...I didn't like him and I don't feel like I trust him...I'm aware that he's not much of a presence. See I think he's a lot like me—he's introverted, timid and doesn't like confrontation and I've told him I want him to be more emotionally available and more present—like I want to be able to feel him...Like if he would bring more emotion into the session or somehow I would somehow know that he was being real...

and yet:

I'm also aware of an urge to want to help him, I want to help him be freer, which is something I want for myself, so I want it for him. ...I want to know how he's growing, it's important for me to know how I'm helping him, how I'm changing him...I hope that I do have something and that he benefits too.

Randy has remained in this ambivalent relationship for two years because it is not yet clear to him whether these reactions are simply part of the complex

therapeutic process or if, in fact, it is yet another poor therapeutic match. While others have suggested that he move on to a new therapist, he nevertheless stays and wonders what therapeutic change should actually be like.

...it's not entirely nurturing...some people say that's what it should be...and I think well, I don't know if it is or not...I guess I'm wondering how do I ultimately end up getting better? Is it because I'm comforted or is it because I am frustrated?

This question has not yet been answered but it is clear that Randy is getting enough positive assistance in the relationship to keep him invested for two years thus far. In fact, the strength of the alliance, or at least the interest, may be stronger than Randy realizes: "I don't feel like I can connect with him very well, you know share this fantasy that we're connecting, that we're...I think I want to have this experience of feeling connected..."

Regarding the topic of religion, Randy has had considerable experience attempting to discuss this issue with his various therapists. Like other issues, his uncertainty about the topic, and his need for external fulfillment and approval, is always prevalent:

...Maybe it was inevitable after being in therapy for so long that I became agnostic...I didn't try to talk about it much in therapy because it wasn't really a therapy issue and maybe by then I didn't want to offend my therapist.

Randy first assumes that he must inevitably change to accommodate to the personality and expectations of his therapist. In addition, despite being curious, Randy never directly asked about his therapist's religious beliefs. Randy instead surmised that "it would surprise me a lot if he wasn't agnostic or atheistic but he never said anything but he never um said anything positive either." So it was based upon the fact that his therapist never proactively broached the topic, that Randy assumed that he was irreligious and reacted accordingly.

But assuming that his therapist was irreligious is only one factor. Randy also believed that the therapist would also not only debate his religious beliefs but that he would also inevitably destroy this belief system:

I guess I would feel a little bit defensive to bring up my beliefs...because it's not psychologically justifiable. I knew intellectually they wouldn't hold up but I didn't want to have to look at it...I didn't want to face a challenge and I guess if brought it up to question it, it would mean that I didn't really believe it.

He continues:

I felt like I couldn't talk to my therapist because I would have to face the fact that there is no real basis for religion, you can't justify it...and I didn't want to have to either...I resented having to justify something that gave me some sense of meaning...maybe I just don't like it when people try to talk me out of something I believe in and I just sort of thought why bring up something that depressing?

In his quest to repair childhood trauma, Randy seems reluctant to discuss religion in therapy because he feels it would inevitably be taken from him, thus adding to, rather than repairing, the void. Although it appears that Randy is not necessarily theologically invested in religion, it does seem that he protects his beliefs at least for their stabilizing value. As noted earlier, Randy assumes that any religious discussion would only offend his therapist, or upset him, so the topic religion is avoided in this relationship. Given Randy's psychological goal of merging with the therapist, along with his assumption that the therapist is irreligious, it is evident why he cannot easily discuss religion in therapy—to do so would only highlight their differences and thus destroy the fantasy of merging which he longs for at this time.

Subject 4

"Elizabeth" is a 45-year old, married female who is currently employed as a mental health aide. She has attended therapy on three occasions, attending one session per week, to discuss issues of depression, bulimia, and blended family relationships.

Her first therapeutic experience occurred while living on the west coast. She attended therapy for a few months at a free mental health clinic and despite her protests was assigned a male therapist:

The therapist was a man and I had a lot of trouble trying to explain my issues to him...he'd give me the feeling that I was silly or stupid. I was expecting more answers from him and he kept asking

me for answers. I felt put down but maybe that was the male/female thing. I always felt like he cut me off with a question or comment and I didn't always feel safe.

Within a few months, the therapist decided, without her input, that she was ready to move into one of his groups for group therapy as a type of promotion from individual therapy. Elizabeth was not ready or interested and it was at this time she decided to not only give up group therapy but the therapist as well. She explains that "I had never tried therapy before so I guess at first I thought, "Well, is this what it's supposed to be like?" Like many people of the sample, Elizabeth was not sure what therapy was supposed to be like and, as such, had no gauge against which to check her personal reactions.

Although she was reluctant to try therapy again after this negative experience, she soon began having such extensive relationship problems that she felt compelled to try again. Educated by her prior effort, this time she specifically insisted upon being assigned a female therapist, anticipating that she could form a stronger relationship with a woman. Her calculations were correct and Elizabeth obtained a greater benefit from this relationship because the therapist was also very proactive and goal-oriented (which Elizabeth desired). Over time, Elizabeth quit drinking, and began exercising, attending to her personal appearance, and writing in a daily journal. In this journal she rated her daily mood on a scale of 1-10 and explored patterns in her mood each

session with her therapist. The biggest gain, however, was that Elizabeth became much more independent and self-confident as a result of therapy:

Really she let me do most of the talking, she'd ask questions now and then, but I did most of the talking. For me, she was great because she made me feel like I was actually helping myself. I know that she did many things to get me started but she made it seem like it was my idea all of the time.

Elizabeth adds that another difference in this relationship was that the therapist was more invested in identifying and promoting her strengths rather than analyzing her weaknesses. This was a tremendous help as Elizabeth was in an abusive relationship where she was told that everything was her fault--from this therapist she instead heard everything that was "right" and responded quickly and positively to this new-found hope.

Although in her prior therapeutic relationship Elizabeth never attempted to discuss religious issues, she did so on one occasion with this therapist as she was in the process of deciding whether to join the Mormon church. The result surprised her somewhat in that the therapist's immediate response was "Do you really want the extra pressure of the Mormon church? Have you thought about this? Have you explored this thoroughly?" While Elizabeth found the questions helpful in that it made her think about the choice carefully, it was also notable to her that the therapist's assumption was that the church would inevitably create "extra pressure" rather than be a potential source of comfort or support. The

relationship with this therapist ultimately ended when Elizabeth moved to Tennessee, and with the exception of the above circumstance, she found it to be a wonderfully productive, life-changing experience.

The circumstance that brought Elizabeth to seek treatment in Tennessee was the tremendous grief she suffered when she experienced a miscarriage. Although religious issues were prominent in Elizabeth's mind, she was initially reluctant to bring up the topic with her therapist:

I talked about my belief in God, whether the miscarriage was "meant to be" and all that. After I lost the baby, at first we were going to try and have another one right away but then one day I woke up and something told me "No, you're not supposed to have a child right now--just wait." At first I was uncomfortable sharing some of that with my therapist, saying "yeah, God is talking to me, but yeah God was talking to me!"

Despite their otherwise positive alliance, Elizabeth was afraid, based upon past experience, that she might somehow be judged and that discussing religion would be a risky endeavor:

Now I have no idea what her religious beliefs were, but it still felt like it would be taking a risk to talk about these things. I just drew it out that that might happen so it took me a long time to get it out.

Once she ultimately took the risk, however, the results were extremely positive and the dyad had many productive sessions surrounding religion:

I always get the impression that she agreed with me, I almost felt like she had the same belief system I had, even if she doesn't! It was her body language and the way she spoke, it was like well she could be going to my same church for all I know. After I was finally able to break the ice with her, I felt much more comfortable... She never changed the subject like the others or interrupted me or asked why I would want to change. She never asked me why where I had to defend myself.

Although the therapist never explicitly self-disclosed her personal religious beliefs, and Elizabeth only assumed that they had similar beliefs, she did successfully convey her sincere interest. As a result, Elizabeth was able to explore new territory that had seemed off-limits with prior therapists. When contemplating her initial reticence to discuss religion, Elizabeth explained:

I guess religious beliefs are kind of private, hmm, that sounds weird... I don't want to have anybody try to convince me that I'm wrong. I don't think I felt strong enough about my beliefs for them to be up there. Its like someone could beat them up or they'd say "Oh I can't believe you believe this way, that's just ridiculous." I guess it's the basis of your belief system and you don't want that knocked down or your whole system will fall down.

Clearly, Elizabeth felt that she would be forced into an unwanted debate over religion if she brought up the topic and, like prior subjects, she also assumed

that she would fail the debate and would therefore lose her religious beliefs altogether if they were scrutinized. In Elizabeth's case, it took a serious event--the loss of a child--to risk testing these assumptions with her third therapist. Fortunately, on this occasion it was a positive and productive outcome.

Subject 5

"Sherrie" is a 46-year old, married female who works as a data entry clerk for a large corporation. Although she considers herself a quiet, shy individual in many respects, she nevertheless decided to participate because she had a stronger competing desire to help others. She speaks slowly with a deep Southern accent and, despite her claim of shyness, required little prompting to discuss her experiences at length.

Sherrie has been in psychotherapy on four occasions, with the longest experience lasting nine months. Like Elizabeth, she wanted to work with a female therapist but was instead assigned to a male.

I made an appointment with a woman, that's who I made my appointment with. But when I went, the woman was on vacation so I got a man. I didn't like the man. I was real mad about that because I just wanted to talk about myself and I didn't want a man.

But its funny because I ended up getting a man.

It was immediately evident that Sherrie was quite preoccupied with sex differences and, specifically, that she had an enormous unconscious preoccupation with sexuality and being swept away by sexual passions:

I was real scared about counseling because so many girls, I don't know, I mean I don't know how many, it's probably just girls that I know, but they've gone to bed with their counselor. So I didn't want that happening, but anyway I got a man...Anyway, I saw a man anyway. I wasn't worried about going to bed with him or nothing like that but I wasn't sure how talk to a man.

Sherrie clearly felt powerless and vulnerable to these unconscious fears and even when discussing them years later was obviously rattled by the memory of being assigned a male therapist.

Despite this unpromising context, Sherrie quickly developed a positive relationship with the male therapist and within the course of only a few sessions asked to attend therapy three times weekly. She was also reportedly pleased when the therapist never made any sexual overtures to her and soon felt safe and secure as a result. In time, Sherrie found therapy very helpful because the therapist "wasn't judgmental, he just listened. It wasn't really that he gave you an answer, or at least he didn't with me, but that he listened...we also talked about the fact that he was a man." She adds that he was also very tolerant of her behavior as "I was really talkative, nervous and excited around that time."

Within the context of this strong alliance, religion came up rather quickly because Sherrie had many religious concerns and described herself as "spiritually sick." She emphasized that she was the one who brought up religion "because I know he didn't." It was only after she described her spiritual sickness

to her therapist that she learned that he had been a minister for ten years. This fact greatly surprised her, particularly in light of his response that "it was very rare that when you're going to counseling that you would ever talk about God." This comment, particularly by a minister, really surprised the patient, and it was this memory that eventually prompted her to join our study.

Over the course of their work together, they did ultimately discuss religion, God and the therapist's ministry on some occasions. Sherrie notes that "He didn't act exactly warm when I brought up religion, but this is the situation he set up for me: it was more like it was OK if I wanted to talk about God." She also adds, however, that religion was at times a pressing issue, so that helped with her incentive to do so despite it being unusual to discuss religion in therapy.

Primarily, however, religion was not the focal issue--her problematic relationships were--so over the course of their nine-month therapy, religion was mainly discussed as a secondary concern:

I don't think it was a main topic, but it was just woven in there. The Baptist stuff has just been woven throughout my whole life so it did keep coming up, but it wasn't the reason I went there. I think I had a little child's religion...I didn't have my own relationship with God. It took time working through it. I don't really think he helped me with any of that at that time, its just the point that we were able to talk about what faith was because I was real gutted out about faith and think I had lost some.

Sherrie adds that her therapist's response was passive: "He never argued or nothing, he just listened. I don't even think he ever told me what kind of minister he was. I don't think he ever did that." With no real data to support her convictions, Sherrie made assumptions that they were both quite similar in their beliefs. "I don't think we were worlds apart on religion or spirituality though. I believe he believed in God though I never knew what religion or anything." Like many clients, Sherrie highlighted any perceived similarities to help strengthen the identification with her therapist.

After nine months of some progress, this particular relationship abruptly ended as Sherrie became more and more reluctant to discuss issues that her therapist reportedly insisted on discussing (e.g., childhood abuse). She began acting out as a result in ways such as mocking her therapist's clothing and even kicking him on one occasion (particularly interesting given her belief that she is shy). On the final day, Sherrie "turned into a little child" and told her therapist:

"I don't want to talk about it." And so I went to the window and told him if he did not stop talking about that I would jump out the window...He just hit that chord in me and anyway we just never got past it.

Therapy thus ended prematurely with these issues unresolved.

Sherrie now wishes at times that she had had the courage to continue in therapy and occasionally longs to consult him. In the meantime, however, she is attempting to analyze herself, particularly where religious issues are concerned.

As one example, she is currently attempting to keep her religious life strong and yet contained. In the past, Sherrie explains, she "got so spiritual that I could have left the planet" and consequently could not function for several days. She continues that she enjoys being joyful and emotional about religion because she was raised in a negative tradition; however, at times the emotionalism overwhelms her to the point of temporarily losing track of reality. To help contain these disruptive, chaotic feelings she feels she has to keep tight control of herself. And just as her therapist once helped her contain the intense sexual and aggressive feelings that once permeated their therapy sessions, Sherrie now has to contain any disruptive, intense religious feelings single-handedly.

Subject 6

"Rebecca" is a 45-year old married female who is currently employed in the field of education. Rebecca is an unusually bright, articulate woman with a bold, powerful demeanor. She was able to discuss her life experiences in remarkable detail, not only because she was well-read in psychology, but also because she is quite psychologically-minded. Rebecca has spent considerable time in self-exploration in both psychotherapy and in self-analysis. In fact, at the time of our interview Rebecca was in the process of deciding whether to give up her position to attend a counseling training program.

During graduate school, Rebecca attended psychotherapy for the first time at a medical school training clinic. The psychiatric resident worked under supervision and although Rebecca was aware of this requirement, she was

frequently dismayed to hear her case being discussed within earshot. Rebecca was also put off by the therapist's theoretical orientation (which she perceived as "depth therapy") since to Rebecca this meant that the therapy was totally non-directive with no goals or agenda. This perceived orientation ran counter to Rebecca's highly organized, pragmatic style and she repeatedly remarked "I need to have a purpose for being in the room." Although she believed the resident was a nice, well-intended, caring person, Rebecca was nevertheless frustrated with his apparent lack of skill, particularly that he never provided any feedback or psychiatric diagnosis. Like others of the sample, Rebecca was not quite sure what to expect from psychotherapy and how to judge the qualifications of her therapist.

It is clear that Rebecca did not feel comfortable in such a permissive environment and, as a result, never broached religious issues with him for fear of being misunderstood:

I can't remember anything that he said...except that I just had a sense, I had a feeling that if I brought up anything like that kind of experience he would just think I was crazy...it may have been the scientific feeling of the environment...maybe there was a medical feeling about him? It's just kind of just a fear...it felt like it was not a topic. And I mean he never asked about it either. I was just left with the feeling that this was outside of the boundaries of what it is that can be talked about.

Rebecca initially gives several reasons for her reticence to discuss religious issues: the therapist never asked, the environment was too medical (which apparently meant it was inevitably irreligious), she was afraid of being labeled, and she had an intuition that it was the wrong thing to do. However, after further consideration, Rebecca realizes that a major reason for her reluctance, if not *the* reason, was that she had already tested her therapist on another emotionally-charged topic weeks earlier—and the therapist had failed the test.

I think it was his attitude toward me when I told him that I had taken LSD when I was 18 or 19. Yeah, yeah. I think he might of have a reaction to that even though I wasn't involved with it at that time...the way he acted I thought, ooh, I'm not going to be able to tell him that I was ever in a college dormitory playing with a Ouija board (laughs).

As a result of these combined impressions and experiences, Rebecca never attempted to discuss her "unconventional" religious behaviors but later regretted this happenstance:

I do remember having a strong sense a couple of times that it would really help if I could talk about it...Actually it might have been a therapeutic resource that could have been drawn upon and that made me feel that maybe a strength that I had was being left out.

Years later, Rebecca returned to therapy after the death of a family member to both grieve and to better understand her family's complicated dynamics. On this round, however, Rebecca obtained a seasoned therapist--a male slightly older than herself. "His ease and ability to establish rapport with me was much stronger than the first. And I think he had acquaintance with a wider variety of models and techniques too."

As part of the exploration of family issues, Rebecca soon found that she needed to discuss religion, even her "unconventional" beliefs, for it was implicated in an unavoidable, specific way. And so to this therapist, Rebecca confided that she had once been a cult member and due to this membership had alienated several members of her family, the residue of which remained in present-day scenarios.

Initially I think he was really shocked that I had been in a cult. Um, and I felt a little bit like, um, maybe I shouldn't have brought this up...And I thought I shouldn't pursue it but then I said to myself "No, no, no this is what I'm here for, we really need to be able to talk freely about this..."

It was her bravery, then, that saved her for she realized that without discussing the cult--no matter how difficult or risky it felt--she would be short-changing herself and her family. But her bravery paid off immensely since this therapist, despite his apparent initial shock, was able to regroup and respond therapeutically. The unexpected result was that the therapist was able to

skillfully demonstrate the relationship between the dynamics of her family and the dynamics of the cult (e.g., "domineering male, weak women") and to help Rebecca understand, with self-compassion, her repetition compulsion.

If anything, this particular therapist was too curious for over time Rebecca felt that the therapist was taking up too much of her time with tangential questions. However, after the therapist apologized and explained that he wanted to learn from her, Rebecca was very pleased and this ultimately had a strengthening effect on their therapeutic alliance. As a teacher, she must have been particularly delighted that she had something to give back in return.

Rebecca's only regret during this time was that, due to her negative family dynamics, the religious issues inherently got a negative spin. She felt that positive aspects of religion were never discussed and that no one ever simply saw that "I'm a spiritual person who's on a spiritual quest and whether I'm guided or misguided, I'm always seeking."

At present, Rebecca is undergoing her third psychotherapy--this time with a female counselor whom she considers "judgmental...and abrupt." Unlike her last therapy, Rebecca is once again choosing to keep her spiritual quest outside of the sessions--a particularly ironic stance given that the program is based upon spiritual issues. Nevertheless, Rebecca feels put down and defensive with this therapist: "I feel if I say something, I better be prepared to back it up...I can't just feel it."

As a result of this misalliance, Rebecca's primary therapy now comes from her own readings and self-analysis. Just recently, for example, she discovered that despite her strong feminist orientation, she was nevertheless still intrigued by Catholicism and longed to participate in some of its traditions.

I just realized that "we're just having a hard time repudiating our upbringing. There's just sort of a comfort level with it...My inner child just likes going. It's a little girl who didn't get to go to church when she was a little girl.

Rebecca, just like Tom, is now in her 40's and is finally coming to terms with her upbringing. Rather than trying to suppress their heritage, both Rebecca and Tom have found ways to integrate their past and to incorporate as much or as little, as pure or as diluted, as they like into their identity. But the difference is that, after having a positive therapy experience, the two now have a choice.

Subject 7

"Nathan" is a 28-year old single male currently attending an undergraduate philosophy program. Nathan was born in the South but is not of the South. His dream is to move to the Pacific Northwest to live with like-minded liberals and to escape Southern Baptist prejudice and oppression. Nathan is a unique, engaging person who has something of a guru-following. During the interview, which was held at the artsy coffee house Nathan frequents, there were constant disruptions from admiring females and males alike. He knew most by name and was quite nonchalant about his following. He would not allow anyone

to interrupt for long, however, and after a few minutes would politely relegate them to the outside deck to wait until he completed his interview.

Like the proceeding professor, Nathan has also spent considerable effort to become more self-aware. Though a philosophy major, Nathan spends a vast amount of time reading psychology, and he spontaneously recommended several of his favorite books (e.g., *The Paradigm Conspiracy*, *When Society becomes an Addict*, and *The Road Less Traveled*) to the investigator.

In addition to reading, Nathan has spent considerable effort struggling to find a like-minded therapist. He had at least five therapeutic encounters in the past, all of which ended unhappily because of their mindless, textbook approaches which typically either emphasized medication or over-simplistic philosophies and goals. Nathan explains:

I've had quite a few different ones and most of them were real bad --BAD. Like now that I've had some good therapy, something to compare the others to, most of what I had was pretty bad.

Like other patients, it was only after Nathan had a new therapist(s) that he was better able to measure what therapy was supposed to be like. However, it does also appear that Nathan had an unusually difficult time in finding a good therapeutic match:

Most of what I had up to this point have been real dogmatic, real Christianized, they want you to see things their way... they just

immediately wanted to Christianize me, they wanted me to go to church and all that.

These statements clearly do not reflect others in our sample and it is notable that Nathan gave no specific example of being Christianized by a therapist. He instead provides examples only of being forced to church by his parents and being treated "horrible with people who were so-called Christians." In fact, the only therapy examples given were a series of descriptions of poor therapeutic alliances with prior therapists:

...she was really into behavior modification and it just didn't work for me...I started therapy with a guy who was 12-step oriented and all his answers were pat jargon 12-step answers. They didn't really give me any kind of insight, any kind of flexibility...I would go into his office for fifteen minutes about once a month and that was it and he would try to work out some kind of plan for me. I felt like meat!

Nathan never established enough tenure with any of these therapists to establish trust and, consequently, he never felt safe enough to discuss his religious and spiritual issues. His concerns were "That I would get shamed, or that they would try to impose their beliefs on me. So anyway, I just didn't even want to deal with it so I didn't go down that lane."

In contrast to these reports, Nathan's current therapist is described as a total opposite and much-needed soul mate for this Northwestern-bound young man:

He's got the uh kind of Western attitude, er the Northwestern attitude. He's real liberal, real open minded, he's kind of into the universe and he's not any kind of ideologist or anything like that, he's real open. He's been really loving, really caring and he seems to have an open mind.

The main difference, Nathan continues, is that the other therapists "haven't been where I need to go."

As is common to many of our sample, Nathan ultimately accepted this therapist only after a series of explicit tests to gauge his trustworthiness and credibility:

I think I did test him at first. Like I'd cancel appointments and not show up and stuff like that to see how he'd react. I really was testing him and uh he was always just laid back, real Zen-type, a really neat guy...he was more process oriented like "whatever happens, happens."

However, according to Nathan, this testing phase did not last long:

...almost immediately with this guy. I could talk to him, I could talk to him about ideology and patriarchal society and fundamentalist Christian bullshit and all that stuff where most of the guys, you know, you say anything like that to most of them and they don't want to talk to you...(He would) just listen. And nothing bothered him.

Just as Nathan constantly sought self-understanding and self-improvement, it was extremely significant that he quickly identified this same quality in his new therapist, thus cementing the promising relationship:

...He's constantly working on himself. You know there's never a certain point where you reach a plateau and you're Mr. Mental Health. And he's constantly working on himself, checking out new things, you know, evolving. And the majority of therapists that I've had bad experiences with in the past, it seems like they were set in their ways and they had done the book work but that's all they've done is the book work.

The therapist also promoted a strong alliance by minimizing any perceived power differentials in their relationship "He would share with me something similar that had happened to him. It made it more human, it made him more like we were a team, almost."

Once the relationship was solidly established, Nathan then began discussing his spiritual longings. They pursued these issues at some length and it was soon evident to Nathan that this particular therapist was skillfully therapeutic in the way in which he handled the topic: "You know the thing about it too was that he went to church and stuff too so he wasn't locked into any kind of ideal about what spirituality should be."

Rather than debating religious values, or imposing his own beliefs, this therapist not only accepted this young man "where he was at" but he was also

able to introduce Nathan to new horizons that seemed appropriate given the patient's personality and interests. As for Nathan, having the therapist gently nudge him to take some risks changed his entire life:

At one point he introduced me to the Native American spirituality. He pushed me to take some risks and try different things and try different rituals and stuff like that and actually he was the one who turned me onto like the Native American spirituality and through that I met some people and ended up going to South Dakota one summer with the Lakota Indians and that was one of the most spiritual things that ever happened. And it just changed me, it took me out of my little box that I didn't want to be in and I felt like it wasn't me, and he helped me get through that and find another way. And now, I have a spiritual life that's pretty open, pretty carefree.

This case is quite different from the others in that the client was clearly looking for a conversion experience—in this case away from the rigid, dogmatic faith in which he had been raised, toward a spiritual path more aligned with who he wanted to be. The suggested path was not the therapist's own path, so there was no imposition of values, but rather the chosen path was what the therapist and client jointly discovered might be most beneficial to the patient.

Nathan is similar to many other clients in that he is currently seeking a new religious identity. Nathan began by shunning all parts that he did not want

to accept--being Baptist and being Southern for example. However, unlike the others, Nathan did not choose to retain his religious heritage in any significant way. Rather than conforming to the rules of a particular religion, or to a particular therapist for that matter, Nathan instead identified the type of person he wanted to become, and then found a religion that best matched this choice.

Subject 8

"David" is a 26-year old, single graduate student who has been in therapy on two occasions for family and relationship problems. David is a quiet, shy individual who appeared slightly nervous during early portions of the interview. Although he visibly relaxed over time, David remained fairly quiet in his demeanor and primarily responded to questions rather than volunteering much in the way of spontaneous material. As a result, this interview contained more prompts than others and a more interactive style was required to promote and maintain rapport.

David's first psychotherapy experience occurred at age 17 when his parents realized that he had few friends in school. Wanting to boost his popularity, they entered him into therapy against his wishes, ostensibly to improve his social skills. This was a negative experience, not only because it was a forced relationship, but also because David did not feel therapy would be effective for social reasons:

I knew I didn't have many friends but I didn't think it was anything that therapy would be able to help... I guess I thought that therapy was for if I was having problems with myself.

Although David was at least somewhat content with himself, he nevertheless attended therapy on a weekly basis. However, David was a shy, passive patient and consequently did not--or could not--participate in a proactive fashion. As happened during this project's interview, David instead just sat in silence during the sessions hoping the therapist would say or do something--that someone else would take the lead: "I never wanted to talk. And the guy I worked with never talked either so we had a lot of sessions where we just sat there and looked at each other for a very long time..."

While it is common for patients to identify similarities with their therapist, in this case the similarities were perceived as detrimental--in David's eyes, they were clearly too much alike and someone needed to do the talking. Even with the passage of time, this relationship never improved. Although David conceded that the therapist was a kind-hearted person, he never felt that the therapist was genuine--"it always felt sort of fake" and additionally he became only more angry over time with the therapist's perceived lack of involvement: "He used to give me homework assignments, and I would do them, but then he would never ask me about them... It seemed like eventually he would have asked." It never occurred to David to take responsibility for his own treatment (e.g., at some point he could have turned in his homework without being asked or to discuss his

concerns directly with the therapist). His anger and resentment was instead suppressed and acted out in a passive-aggressive manner whereby David refused to participate at all.

Religion was, not surprisingly, never discussed during this relationship but this was not significant as religion was not a figural issue for David at that time. Ironically, this relationship ended as abruptly as it began: once David's father lost insurance coverage, David was forced out of therapy as quickly as he began.

David's next therapeutic encounter occurred at age 24 when he decided, without outside encouragement, to attend therapy for help with depression, struggles for independence and ongoing family conflicts. It is notable that David agreed to try therapy again after his abysmal initial experience; however, he strongly believed that his current issues were more appropriate and amenable to psychotherapy. The fact that it was his own idea this time was probably figural as well.

David approached this psychotherapy from a very different position--he knew he would have to participate to have a favorable outcome--thus suggesting some insight into why his prior treatment failed.

As expected given David's personality style, he found the initial days of this therapy difficult: "It was still tough because the guy still didn't talk a whole lot (laughs)." This time, however, David persisted and kept trying to overcome his anxieties when the therapist let him do most of the talking. The primary

difference in this relationship was that, when appropriate, the therapist did fully participate in the relationship. For example, there were times when the therapist became very proactive--asking questions, making "penetrating statements," being supportive, and providing interesting viewpoints. In particular, David enjoyed co-analyzing the transference and learning how unconscious forces motivate people.

David warmed considerably to this type of interest and developed a strong attachment and paternal transference to the older male therapist. Having grown up with a detached father, David unconsciously sought attention from males and was thus basking in the attention he received in this relationship. (This history also explains the negative transferential reaction that occurred with the prior therapist's distancing silences). While David never wanted to "hang out" with his new therapist, he did enjoy that they had several interests in common--notably skiing and disliking Rush Limbaugh.

During the same timeframe that David reentered therapy, he simultaneously became more involved in his spiritual journey. He began thinking about religion a great deal and, like many patients, became curious about his therapist's religious faith but never felt free to ask. "I didn't know if he was Christian or Jewish or agnostic or atheist." David also began listening to Christian musicians and on one particular occasion attended a Christian concert and was able to personally spend time backstage with the charismatic male singer. This incident had a powerful impact on David, not only on his religious

walk, but on his psychological journey as well. As noted earlier, David had felt neglected by his father and unconsciously sought a father replacement in other relationships. This singular attention paid to him by this famous male was therefore a thrilling and highly significant event for David:

I had gone to a concert by this Christian singer um where during this concert I really felt moved. I felt like my life was going the wrong direction. I really wanted to rededicate myself to Christ. It's interesting because during this concert the singer said "Anybody who wants to come back and talk to me during intermission can." It wasn't for autographs...and somehow I got the nerve to go back there, and I talked with him, and he prayed with me and it was a real important experience for me. And I talked about that in my session of therapy.

Despite the intensity of this event, David remembers that he was reluctant to tell his therapist. He attributes this reticence to one occasion when his therapist told him to read Yalom's psychotherapy casebook *Love's Executioner*. David reports that since religion is described as a psychological defense in this book, he assumed the therapist also felt that way. From this subtle event, coupled with his own attributions, David felt uneasy about discussing this issue. He added that he was particularly afraid that:

...he would think I was just being irrational, or clinging to something or looking for hope. I didn't have any fear that he was

going to tell me I was wrong, but that he just wouldn't endorse it or support it....

However, reality was somewhat different. Rather than debating the rationality of religion, David's therapist reportedly ignored the topic altogether: "...he didn't respond at all. Um, he didn't respond. I told him this all had happened and he didn't say a word...I guess I feel he just didn't understand..." While David had been braced for a debate, he was instead met with the same type of stony silence that had been so upsetting to him in his first therapy experience. The therapist did not apparently notice the transference aspects of the concert, or chose not to say anything if he did, but neither did he remark on any aspect of the event: "I mean he didn't have to say anything like "Well, I'm glad you came to find Christ." (laughs). I didn't expect anything like that, but he just didn't have to ignore it." As a result of the therapist's disappointing reaction, combined with his passive personality style, David simply choose to give up religious discussions altogether and he never mentioned the concert again: "I just let it go...I just went on after that and talked about something else...I probably didn't talk to him much about religion after that...I figured it would be awkward." David construes this decision as a great loss, particularly the realization that his therapist had failed him on this one occasion. David muses that:

I guess I felt I wanted to be able to bring up anything with him, I wanted to be able to discuss anything with him, that was important to me...For most people religion is a central part of their life and

how can you do good therapy without that being considered? I don't see how it could really be effective. I just think its important for therapists to really support their clients' spiritual or religious issues within reason... Obviously I know sometimes people can get real destructive, but I feel there's a big difference between Heaven's Gate and Presbyterians and I think people should realize that and do whatever helps people get better. Maybe use the religion to help the people get better.

While David's therapist had obviously been tremendously helpful in many other ways, there had been a great empathic failure on this one occasion. David continued on in psychotherapy with this therapist because he was, in fact, receiving a great benefit from their work; however, a large piece of his life remained unexamined in the therapeutic context.

Subject 9

"Irene" is a 37-year old married female with a high school education and is currently employed as a trainer/consultant at a local hospital. Irene is a street-smart, high energy individual who somehow manages to raise five children, maintain her marital relationship, and work several jobs simultaneously. Despite these multiple demands, Irene reports that she is happier now than she has ever been--she feels healthy and significant--and it clearly shows in her demeanor. Irene is bubbly, talkative, and is eager to share her experiences so others can learn from her mistakes. She is also brutally honest about herself and easily

divulges unflattering information about her past to demonstrate how far she has come today.

Irene has attended therapy over six times in her life, but has never stayed with one therapist for over seven months. She began therapy at age 13 for behavioral problems (fueled by drugs and alcohol) and was eventually sent to a boot camp facility out-of-state. By age 17, she had worked with several therapists but had never been honest with any of them:

I walked out the door the day I turned 18 and two hours later I was back into drug abuse. All I did was say the right things to get myself out when I was 18, so it did no good.

Irene next attempted therapy, by her own choice, many years later at age 33. She had become a chronic alcoholic, but never told her new therapist that important fact and instead used therapy to "get all her complaints out." Irene is presently heavily invested in spirituality, so in retrospect she found it notable that the therapist never asked about her religious beliefs:

The whole time I was going there, though, there was no spirituality discussed. Of course I was drinking back then so maybe she did and I missed it, but I really don't think so because I still remember how very shocked I was when I found out she was a reverend. I mean when I started there was no introduction or anything, we just started therapy.

Like many patients, Irene received little or no preparation for psychotherapy, nor did the therapist apparently self-disclose significant facts such as her clinical training and affiliations. Irene reports being truly stunned by this discovery.

She was a reverend! (laughs) and I didn't know she was a reverend. Like I had been going there for about seven months, you know, and one day I noticed she had business cards on her table so I grabbed one and it said "Reverend!" and I went, "Ohhh, the words I have been using," you know?

Irene ended this relationship soon thereafter but denies that she terminated the relationship because of her discovery: "I knew I needed to turn to something but didn't feel I could go back to the psychologists because I had been seeing them since I was 13 and nothing happened there..." Irene also remembers feeling inferior to the therapists, though she admittedly always had low self-esteem. Nevertheless, she decided to look somewhere else for assistance and her search ended unexpectedly in a jail cell:

I woke up one day under the viaduct on Jackson by the National Cemetery...Not a good place for a woman to be in the daylight let alone at 3 or 4 o'clock in the morning waking up, going "How did I get here?" and wondering how I was going to get home...I was in a holding cell with four other women just as drunk as I was...and I was talking to this one little girl...and I asked "Do you have any kids?" and she said "Yeah, and I'm sure whoever's got them will

bring them back eventually"... And that's when things turned around for me. The walls came down and hit me like a brick...

After years of psychotherapy, it was instead a cellmate that had the greatest impact on this woman: "It was like a spiritual awakening for me...because I knew I had to get honest. It worked after all those years of therapy because here was somebody just like me who had said that and it really hit me." Irene had always felt inferior to her therapists and consequently the most therapeutic moment for her occurred only when a harsh dose of reality was administered by a peer in jail.

Desperate and scared about the prospects of losing her children, Irene returned to the Reverend to continue treatment. Upon her return, Irene discovered that the therapist knew she had been hiding alcoholism all along and became infuriated:

"Well if you knew, why in the hell didn't you ask me about it?" I was mad at her, Irene continues, but didn't say anything. So she (the therapist) was finally more proactive. But looking back on it now, it's like well I had to beat the door down to get her to come to me and why is that?...people are looking for guidance.

Irene's therapist immediately referred her to 12-step meetings which became a life-changing event for in this environment Irene received what she truly needed:

"For the first time, I found someone willing to confront me, to be honest with me and to tell me what I was doing wasn't right." In the 12-step program, Irene

continued her spiritual journey and utilized the spiritual emphasis to renew her life.

But now that I have more experience, I see this happening all the time, where people will come into (a 12-step program) and have spent thousands and thousands of dollars on psychotherapy and it doesn't help, but then they get what they need from a 12-step recovery program and all this program does is to help people learn how to lead a spiritual life.

Irene had been sober for many years at the time of the interview. She is currently married, happily employed, and is raising her children. She continues to explore her spirituality and is presently trying to find a church to join so she can practice religion on a more formal basis. Based upon her life experiences—her disappointment with psychotherapy and its apparent lack of spiritual awareness coupled with her shining success in the 12-step program—Irene was very eager to discuss the problems with psychotherapy and spent much of the remaining interview in passionate discourse:

You can just see them sitting in a therapy session where nobody wants to talk about God, nobody wants to cross over that line—why?... I think the therapist should lay the foundation by asking the client all the underlying issues about what's going on in your life. So all they're doing is asking questions—that's not crossing a line... Then you can bring it up later. Say "Now 30 days ago you

mentioned spirituality, do you want to bring this up now, do you want to know anything about it? I'm here to help YOU but I can't help you unless you tell me that you're looking for answers too."

Therapists need to help open doors and avenues too. I mean even in a court of law you can ask questions...

In her departing words, Irene discussed the issue of therapist responsibility in some detail:

(Therapists should) be bolder. To be able to bring up stuff and at least put it on the table to see if the client wants to address it. If they don't then you can go on to something else but at least you've brought it up. It's like your life is a big jigsaw puzzle that's not put together yet. The therapist would ask something like, do you want to work on this part now or should we work on putting these pieces together instead? But at least its been brought up regardless of which section the client chooses. Otherwise, the therapist is just there sitting upright in their chair, keeping silent, not really offering anything, not really doing anything...I might as well be talking to myself in a mirror all day if you're not going to talk to me.

Irene clearly believes that responsibility for discussing religion lies primarily on the therapist's shoulders and never once indicated that she felt it was the patient's responsibility to bring up topics of interest.

Subject 10

"Sue" is a 35-year old, single woman currently employed as a word processor. She has been in psychotherapy on two occasions, the last for two years at two sessions per week, primarily to repair her soured relationship with her mother before leaving town to pursue a new career.

Sue appears years younger than her stated age in both looks and demeanor. She has a childish naiveté about her, which was at times charming and at other times inappropriate given her age. She was strikingly nervous and at times expressed an inability to think of anything to say; again, the demeanor of an awkward teenager comes to mind.

She is also an extremely passive individual. Rather than seeking to take charge of her destiny, she instead floats through life, hoping that good fortune will come her way. She expressed a deep desire to become a country singer in Nashville and her plan for accomplishing this goal was "...if I could just move to Nashville...I would get discovered by a friend...without having to audition." She also "takes a lot of crap" at her workplace because she is totally unable to stand up for herself. A good portion of her therapy therefore revolved around issues of assertiveness and relationship management.

This trend toward passivity also appeared in the therapeutic relationship with her analytic therapist. She kept expecting him to *do something*, and when he did not comply she entertained thoughts of quitting therapy altogether. Quitting, requires a very firm proactive stance, however, and so she instead

"kept giving him one more chance." She added that, "I kept thinking something magical was going to happen"...and when it did not she wondered whether her therapist was competent, never pausing to consider whether she might also need to make personal adjustments. While some of this pattern may have occurred because the patient was not educated about what to expect in therapy, it is also true that given the overall content of the interview that passivity is indeed a pervasive character style for this individual.

The patient's relationship with the therapist was exceedingly complex and interesting. She had long been externally driven by the opinions and whims of others, particularly her opinionated mother, and she inevitably attempted to recreate this scenario, albeit unconsciously, in the therapy setting. For example, the patient constantly strove for the therapist's interaction, involvement, and opinions and when she was met instead with permissiveness and silence, she became infuriated with him. The patient was, as expected, unable to express her fear and hostility directly, so she instead expressed it indirectly by questioning the therapist's competence, expressing anger about relatively trivial issues such as his choice of magazines, and expressing doubts about his sincerity..."He'd sit there and pretend to be oh-so-interested and you could tell he was just trying to be his good therapist-self."

This hostility was fueled by the patient's low self esteem and utter conviction that the therapist felt superior to her. She was extremely sensitive to their educational and cultural differences and to illustrate her concerns she

remarked that when she began therapy, she did not know how she would ever be able to "carry on a conversation with a DOCTOR." She ultimately attempted to relate to him by becoming like him, so in therapy she attempted to borrow his own personality and interests. The issue with the magazines returns to mind:

I remember trying real hard to become interested in them, feeling like I was supposed to like these things. So I'd sit there and force myself to look at them and hating them all the while. I felt put down in a way, like it was yet another way that he was superior to me.

In this case, borrowing the therapist's identity was quite difficult for her as he was from such a markedly different background than herself and she was never able to do so contentedly.

But to only focus on the patient's hostility is to miss the fact that she was actually quite ambivalent about their relationship, for at times she even admired and wanted to be like her therapist; hence, her reticence to end the relationship despite her numerous complaints. This ambivalence was expressed in many ways, one example of which was her desire to minimize their differences:.

I wanted to feel a sense of family somewhere. I didn't want to accept that we were really worlds apart. He was fatherly to me... I wanted to create a scene where I felt more similar to him than I really was.

Many of these core therapeutic issues emerged, as expected, when the topic of religion was broached. The patient initiated the first conversation on religion for at that time she was extremely invested in church life and spoke of it

often. She noticed that her doctor did not respond except for silence but she nevertheless proceeded to discuss her religious beliefs for some time. She was curious about the doctor's religious beliefs but never felt free to ask, stating that it just didn't seem appropriate. Without factual information on his belief system to guide her, she therefore assumed that due to his "book learning" he would inevitably be irreligious. Indeed, she interpreted his silence on the topic to mean that he was not saved, and ultimately embarked on a personal evangelical spree in hopes that he would convert to her religion. This is an interesting twist for someone ostensibly too shy to even "carry on a conversation with a DOCTOR" thus suggesting either a subtle arrogance to her proclaimed weakness or perhaps a stronger competing desire to give something back to someone who seemed to otherwise have so much. The patient was quite consumed with being perceived as "dumb" or for not having the right words or intellect to effectively witness to him. Over time, when her tenacious efforts met only with the therapist's relentless silence, the patient soon began worrying that her religious discussions were boring him or even worse that he was being offended by them. Her need for an alliance was greater than her need to evangelize and given that she did not, really, want to do anything to jeopardize their relationship, she ultimately gave up these discussions altogether.

The patient's therapy ostensibly ended due to financial considerations; however, it was evident that it was really other factors that ended their relationship. While it is not clear whether the patient's continued internal

conflicts were a part of the demise, it is clear that external factors were implicated. Specifically, the patient was not receiving her critically-needed external support for attending therapy; in fact, her mother was explicitly sabotaging this relationship by instilling fears of the possibility of inappropriate sexual contact. The patient was also hurt that others did not notice the gains she had made and furthermore felt shame about telling her church friends she even attended therapy. To her, therapy was a sign of a weak faith for, according to her belief system, God should be the source of all one's needs.

In summary, this case is somewhat tragic in that the patient ended up where she began in many ways. On more superficial issues she admittedly made progress (e.g., assertiveness at work), but on other more potentially critical internal issues she seemed to be in as much in bondage as ever. For example, she never explicitly worked out the pervasive transference issues with her therapist; she never felt brave or proactive enough to broach his apparent lack of interest in her religious discussions; and most importantly, she was never able to find a way to forge her own identity rather than relying on the beliefs, desires and expectations of others. Perhaps it was that her needs were not genuinely getting met in therapy that she ultimately let others destroy the relationship and her quest for self-understanding.

Summary of Case Descriptions

Upon reading the ten individual case descriptions, it is evident that although the group reported similar themes, they were markedly different as

people, for this sample illustrated many differences in personalities, presenting issues (e.g., relationships, alcoholism, anxiety, attachment) and in how these issues were handled therapeutically (e.g., religion, additional psychotherapy, 12-step programs). The case descriptions also yielded information about the transference aspects of the therapeutic relationship and how the individuals' unique psychologies impacted their perceptions and interactions in the psychotherapy experience.

CHAPTER 6

DISCUSSION

Introduction

The purpose of this project was to learn more about how religious issues are dealt with in the course of ongoing psychotherapy. This exploratory endeavor is in the context of literature which suggests that religious/spiritual beliefs and practices are presently studied very little within the field of psychology, and then they are often seen primarily as a pathological phenomenon. This creates a special problem for people who would like psychological help but who feel that their religious belief system will be seen as pathological. By talking with patients who have had actual experience discussing religious issues (or not) with their therapist, the investigator hoped to better understand what the experience was like from the patient's perspective.

Methodology

Strengths of the Methodology

The literature review conducted prior to this study yielded a conflicting mass of information in which it was exceedingly difficult to ascertain whether therapists as a group upheld beliefs significantly different than patient populations, whether therapists actually demonstrate the alleged bias in clinical and nonclinical judgements with religious patients, and whether religious issues impact patients' perceptions of the psychotherapy process. The most serious criticism of these studies was the pervasive use of the analogue design in which,

typically, students and therapists imagined themselves in a psychotherapy scenario. To help remedy this situation, this exploratory project was designed to provide a unique glimpse into the real life experiences of individuals with actual psychotherapy experience rather than relying on the imagined scenarios found in analogue research projects. This study is also different from other studies of religious issues in that its philosophy and research methodologies are based upon the existential-phenomenological school of thought. In this paradigm, the purpose of the researcher is to learn and elicit information, rather than impose beliefs and test a priori hypotheses; therefore, the emergence of fresh, untainted data is deemed more likely. To the knowledge of this investigator, no other researcher has investigated this specific topic using this type of methodology.

Critiques of the Methodology

As noted earlier, this project is considered *exploratory* in nature. It is intended as a pilot study for future research projects rather than as a final study from which any firm conclusions can be drawn. The results must therefore be interpreted only in this context, and though many interesting themes emerged that have co-validation with other research, they must technically be considered only hypotheses at this time. In this vein, the results are subject to the following criticisms:

Sampling bias. Due to the exploratory nature of this project, our subjects were convenience-sampled, rather than randomly-sampled, from newspaper advertisements and from flyers placed in the community. Our goal at this time

was to discuss this issue with as many volunteers as possible from any available source. Certainly, the ten self-selected individuals who responded to our request are unique in many respects; thus the generalizability of our findings must be carefully considered in light of the following issues.

First, as evident by the low rate of telephone inquiries, few people wish to call up someone, identify themselves as psychotherapy patients, and then meet a stranger at a public location to be tape-recorded while discussing intimate details of their religious beliefs and personal lives. The type of people willing to do so, then, would be considered exceptional: for example, it seems evident that very few of them would be considered shy, retiring personality types.

Our sample was also exceptional in other ways. First, our sample was entirely of Christian heritage. Although the group was diverse in other factors (e.g., marital status, educational level), they were strictly homogeneous when it came to having a Christian background--no Jews, Buddhists, Moslems or other world religions were represented in our study.

Whereas most studies of this ilk evaluate college undergraduates, our sample instead had an older group of individuals who ranged in age from 26-46. The limited age range of this sample suggests that those most likely to respond were still in school or early in their career process. Perhaps older individuals were too busy with their families or careers to participate, but another explanation, as posited by several individuals, was that they vividly remembered

what it was like to need subjects for school projects and simply wanted to help out.

The desire to help others likely stems from another striking finding: almost all of the individuals in this group were professionally active (either in school or in actual career choice) in social work, counseling, mental health or the helping/service professions. Not one of the respondents represented fields such as science, engineering or agriculture and, in fact, the one professional of the group (an adjunct English professor), was likely returning to school to obtain a counseling degree.

The group was also heavily invested in the research topic, as all of them had been in psychotherapy on numerous occasions (not one individual had only one psychotherapy experience), and many had tried various religions and denominations over the years. Thus the topic would have much appeal to these particular individuals, and perhaps because of their extensive experience, they felt that they could contribute to the project.

Clearly, our sample is biased toward young to middle-aged individuals in the helping professions who have enough a priori interest in religion and psychotherapy that they were willing to respond to the advertisement. It may also be true that this topic strongly resonated with their life experiences and thus they felt compelled to participate so that others could learn from their experiences--both positive and negative.

While future studies will clearly want to seek a more diverse and representative sample, for the purposes of our exploratory study the fact that our sample was skewed toward subjects with interest and experience in the area of investigation can also be seen as an asset. Since our goal was to talk with "real-life" patients, then why not evaluate patients who have had extensive experience to draw on—who have seen both good and bad instances of psychotherapy—and who can articulate these numerous experiences accordingly? Although this sample was obtained by accident rather than design, the information learned from them should be attended to carefully.

Criterion issues. Since the subject sample is self-selected, the research is also subject to criticism for criterion-related issues. Specifically, how does the investigator know what the patients meant when they volunteered to discuss "religious" or "spiritual" issues. Given that the whole crux of the project lies on whether the patient ever attempted to discuss religion/spirituality with their therapist, it is critical that we know that the patient's meanings of these words paralleled our expectations.

As noted earlier, there is no current consensus in the literature on how to best address this issue, and while some researchers propose specific, descriptive phrases (e.g., religion as defined by denomination) others posit that the best practice is to develop the most parsimonious description with the greatest generalizability possible (Spilka et al, 1985). Due to the exploratory nature of this study, we decided to be more inclusionary than exclusionary; the

consequence was that anyone self-identified as "religious" or "spiritual," regardless of their personal definitions of these terms, were accepted into the study *as long as they tried to discuss these beliefs with their therapist*. Our goal is to understand how any individual with any variety of religious or spiritual issues, regardless of idiosyncratic labels or content, fares in psychotherapy with a secular psychotherapist. We therefore permitted liberal inclusion criteria and, as such, included atheists in our project.

However, for those who desire a more "objective" measure of religiosity, this project does provide supplementary evidence to verify the patient's self-assertions. For example, over the course of the project, each subject was given supplementary surveys and questionnaires in which they provided "objective" data such as the valence of religion in their life, their religious heritage, their current religion/spiritual belief system, and level of participation in religious/spiritual activities.

In retrospect, it appears that a more hermeneutically-appropriate strategy could be been utilized to effectively explore this area and to be more in alignment with the philosophy and framework of our project. Specifically, we could have interviewed our patients about what religion and spirituality meant from their personal perspectives and subjected the material to thematic analysis along with the other interview material. Via this strategy, the meanings would emerge from the patients themselves rather than from some admittedly

superficial labels. Future projects could explore the use of this strategy in further detail.

Interviewer bias. A third area of criticism, although secondary to selection bias, is the issue of interviewer bias. To minimize the possibility that interviewer style and technique would bias data collection, the same investigator conducted each of the ten interviews so that any bias inadvertently introduced would be relatively the same across subjects (Hyman, 1975). However, while the use of Hyman's procedure greatly reduces the incidence of unintended bias in interviewing, it does not account for the fact that an investigator is only "relatively the same" across subjects. With each succeeding interview, investigators are inherently less naïve about the topic at-hand and must therefore consciously recognize their emerging assumptions lest they contaminate subsequent interviews. The field of phenomenological inquiry has already acknowledged this issue: interviewers are expected to "bracket" these assumptions so that interviewers might "grasp, rather than impose, meanings emerging from the dialogue" (Thompson et al., 1989). The difficult part, however, is that there is considerable debate on what bracketing is, and how to ensure that it is being accomplished effectively. Hence, the issue of interviewer bias is still a valid criticism.

Results

A literature review of religious beliefs and the psychotherapy experience was presented earlier to provide both a background and a direction for this

project. Based upon the findings of that survey, and the numerous critiques uncovered in both theoretical and empirical studies contained therein, the investigator of this project decided to tackle the topic from a markedly differently perspective—namely from an existential-phenomenological paradigm.

The specific technique chosen was a thematic analysis of transcribed interviews from actual psychotherapy patients, supplemented by a post-interview questionnaire and case analyses. It was hoped that this process would allow thematic material to emerge which sheds light on the confusing studies presented thus far. The analysis was indeed productive for it yielded many significant and intriguing themes on both general clinical issues as well as the focal point of interest—how religious issues are handled in psychotherapy. Although this project is exploratory in nature, many of the detected themes can be corroborated by external theoretical and empirical evidence, thus potentially attesting to probable concurrent validity.

It is important to note that all identified categories and sub-themes are to be interpreted strictly as coming from the patient's perspective. Therapists were not interviewed for this project, so any interpretations should be attributed to patients only. As but one example, when it is noted that a therapist responded negatively to a religious discussion, an objective observer may or may not rate the therapist's behavior similarly. However, while the therapist's perspectives are certainly informative, for the purposes of this study we are interested only in uncovering the patient's own "truth."

General Clinical Themes

Although the target of our study was specifically to address how religious issues are handled in psychotherapy, trends on certain general clinical issues consistently emerged and became too obvious to ignore. Many, of course, inherently overlap with religious concerns.

Patient naiveté. The first point that emerged is that patients are not initially sophisticated about what therapy can and cannot do for them; and consequently some enter therapy with unrealistic expectations about what will occur and what results to expect. For many patients, their only knowledge about psychotherapy stems from the media (Wylie, 1997); given that psychologists are rarely accurately portrayed in the media, incorrect stereotypes can be expected. When the patient's expectations are not met, the patient is then not sure whether the problem is the therapist's competence, themselves, or the therapeutic match. Typically, the patients changed therapists on multiple occasions until, by trial and error, they either modify their expectations or fall into a better match. For religious patients who suspect that their therapist is biased against religion, this must present a particularly confusing situation since the naïve patient (one with no prior experience) would not know whether to attribute any misalliance to their religious differences or to other factors. In fact, this very thing occurred in most of our sample and some individuals had been in therapy on more than six occasions as a result.

Adequate preparation for treatment seems to be the key factor in addressing this situation. Although some researchers (e.g., Hoehn-Saric, Frank, Imber, Nash & Stone, 1964; Heitler, 1976; Strupp & Bloxom, 1973) have long reported that patients who receive pre-therapy information and role induction strategies have better therapeutic outcomes than those who do not, it is rare for patients to receive such formal orientations.

The quest for similarity. The next clinical theme identified is that it is common for patients to want to be similar to their therapist in some tangible way. Many of our subjects, for example, actively sought to identify hobbies that they had in common with their therapist, and some individuals used these perceived similarities as a way to offer something back to the therapist. They reported that they seemed to enjoy great psychological benefit from being able to contribute--rather than just take--in the relationship. In summary, patients long for a therapeutic dyad which has a team approach, rather than a therapeutic relationship in which one party, presumably with superior abilities, simply assists the other.

Since these findings may be attributed to our sampling bias, further research needs to be conducted before firm conclusions can be drawn. Our subjects (most of whom were in social work or other helping professions) may have simply desired a more collegial relationship than would be the norm if a more representative sample of patients had been obtained. Despite this caveat, there is some evidence that other researchers have uncovered similar findings.

For example, the significance of empowering the patient is not lost upon Orlinsky (1994) whose research has indicated that patients who are actively involved in their own treatment have a greater chance of a success; indeed, the quality of the patient's participation is one of the most important determinants of psychotherapy outcome.

The therapeutic issue of self-disclosure is also central to this theme as our sample indicates that it is necessary that the therapist judiciously reveal some aspects of their life so that points of connection can be made. It is important, however, for therapists to know how to monitor one's decision to self-disclose (and indeed that it is a decision, not an impulse) so the requisite therapeutic neutrality is not destroyed (Bugental, 1987). Although boundaries are important and should be professionally maintained, they can hurt the development of a therapeutic alliance if they are held so rigidly that the patient cannot get any glimpse into the therapist as a "real" person.

Preferred characteristics of therapists. Our sample identified several sub-themes in their interviews that illustrated which traits were desirable in a therapist and which were thought to explicitly impact the psychotherapy process.

First, the group unanimously expressed a desire for a proactive therapist who consistently displays an active interest, participation and involvement with the client. Secondly, the patients describe a therapist whose personality is almost Rogerian in nature, since traits such as warmth, empathy and unconditional positive regard were often described as essential. A third

frequently identified trait was that the therapist must not only be trustworthy but also be able to withstand being tested by their clients as a means of proving their trustworthiness.

Preferred characteristics of therapists, as described by our sample, have been studied at length in the history of psychology by Carl Rogers. Rogers formulated a "process equation" of psychotherapy which reports that positive personality change was initiated by the therapist's attitudes more than his or her knowledge, theories or techniques (1961). The characteristics of empathy, genuineness and unconditional positive regard were thought to be the most salient characteristics which impacted therapy outcome--an assumption that was borne out by several studies (e.g., Truax, 1963; Truax & Carkhuff, 1967) but critiqued for methodological flaws by others (e.g., Marshall, 1977; Gladstein, 1977; Gurman, 1977). In addition, Rogers' own students conducted outcome research which found that clients are far more likely to consider the "core variables" (warmth, empathy, and unconditional positive regard) responsible for their therapeutic improvement than "theories and flashy technique" (Duncan, 1997).

As part of Rogers' considerable influence, researchers began to explore the notion that therapists with certain characteristics had larger therapeutic effects than therapists with certain techniques (Lambert & Bergin, 1994). In a 1980 study, for example, Hartlage & Sperr asked 60 VA outpatients to endorse their perceptions of "ideal therapist characteristics" on a 128-item checklist and

then to describe their own therapist using the same list. The patients were also asked to rate their overall satisfaction with their treatment. Of the 60 patients, 80 percent noted that an "ideal" therapist was one who made a good impression, was frank, honest and appreciative. Three-fourths felt that a therapist should be self-respecting and able to care for himself, and two-thirds felt that therapists should be firm, cooperative, friendly, self-confident, assertive and respectful. In addition, those who felt that their therapist displayed these qualities also tended to endorse greater treatment satisfaction. These results again suggest that the personal qualities of therapists can have a demonstrable effect on how well therapists meet their patients' expectancies and thus potentially impact outcome.

Related to this, Luborsky (1975) found that the single most significant therapeutic factor uncovered was the patient's experience of having a positive relationship with the therapist. Although other factors (e.g., renewal of hope, acquisition of self-understanding) emerged, it was the patient's perception of having a healthy, positive relationship with a therapist that mattered most (Luborsky, Crits-Christoph, Mintz & Auerbach, 1988).

Although a solid therapeutic alliance is clearly more predictive of psychotherapy success than either technique or diagnosis, it is important to realize that it is what the *client* thinks about the relationship—not what the therapist thinks—that counts (Duncan, 1997). A 1986 study by Orlinsky succinctly illustrates this power of this theory: empathy as perceived by the client significantly predicted a positive therapeutic outcome in 22 out of 31

studies, whereas empathy as perceived by the therapist predicted success in only 2 out of 17 studies.

Summary. Our sample reports themes which indicate that an ideal therapeutic experience is one in which the patient is educated about what the therapy experience should be like, where they are assigned to a therapist who has at least some similarities to themselves, where both the therapist and the client are actively involved in the treatment process, and where the client perceives the therapist to be a warm, empathic, trustworthy individual who has the clinical skills to withstand tests by the client. These variables seem to be the essential ingredients not only for a positive psychotherapy experience but also, based upon the aforementioned research by Orlinsky, the essential ingredients for a positive psychotherapeutic outcome.

How Religious Issues are Handled in Psychotherapy

While themes that pertained to general clinical issues are the necessary foundation for a solid therapeutic alliance, effective and skillful management of various religious themes were also deemed important to our sample

Religious discussions are necessary for effective treatment. Our sample strongly indicated that the exploration of religious issues within treatment is considered a necessary aspect for effective psychotherapy. This trend appeared, not only in the thematic analysis, but also on the post-interview questionnaire where it received 100 percent endorsement. This universal agreement was particularly surprising given that it was endorsed by the group's

atheist, agnostic and humanistic subjects. Although this fact initially appears counterintuitive, it begins to make sense when one considers that even if people do not currently ascribe to a given theology or religious practice, understanding their religious heritage is often an essential aspect of understanding their current psychodynamics.

Although the subjects had multiple reasons for feeling that such discussions are essential, several patients said they perceived their religiosity as a support and a resource that they could tap into during times of despair. Subject 1, for example, converted to atheism but still found it comforting during times of stress to sing old hymns and to recite memorized Bible verses. The theology per se was not of particular salience to him, but the reminder of how these religious practices can be used to self-soothe and to create a sense of greater well-being were highly significant. This finding is supported by research reported by Hadaway & Roof (1978) where religion was found to be a better predictor of well-being and life satisfaction than any of the following factors: number of friends, marital status, education/income, health status, race and age. So while the life satisfaction implications of religion are not newsworthy, what is new from our sample, and should be tested in future research, is that the remnants of one's religious heritage may also be an unexpected source of strength and well-being in certain instances.

It is difficult to discuss religious issues. Although our sample strongly believes that religious issues *should* be included in psychotherapy, finding the

courage to do so seems to be another story. With only a few exceptions, most of our sample initially endorsed some reticence to discuss religious issues despite having a strong desire to do so.

In reviews of studies which included religious clients as variables, Worthington (1991) found that religious clients can be reluctant to engage in psychotherapy for a variety of reasons, including fears that they would be misunderstood, misdiagnosed or have their religious values changed. While our sample mirrors Worthington's findings, it also contributes some novel points of consideration:

- (a) *Fear of being mislabeled* - First, consistent with Worthington's findings, many patients indicated a fear that if they discussed religious beliefs they would be labeled crazy or irrational. This was particularly true of individuals who were engaged in very conservative religious practices (e.g., speaking in tongues) and very unusual religious practices (e.g., playing with an Ouija board). It was only after the therapist had been tested, and proven reliable, that most patients ultimately took a risk and discussed the issues despite their hesitancy.
- (b) *Societal taboos* - Others expressed an initial reluctance to broach spiritual issues because of an unarticulated belief that it was somehow taboo to discuss religion even in psychotherapy. Although some of the sample had read the works of Freud and his

unfavorable view of religion, for the most part the clients obtained the belief that this topic was taboo from the current American zeitgeist. One patient, for example, felt reluctant to discuss religion simply because there was a "medical feel" to the environment, the basis of which was never articulated. Another patient made vast assumptions about her therapist and his belief system primarily based upon the art magazines she disliked in his waiting room. From this, the patient then began noticing other cultural differences (including religiosity) which, given that most patients desire to create similarities, had a distancing effect on their relationship. For many of these clients, it was not the therapist's error of commission, but rather omission, that perpetuated this sense of taboo. In the post-interview questionnaire, for example, 88% reported that their therapists never asked about their religious beliefs; therefore, by default, they assumed the topic was off limits. Only 63% ever fought against this apparent taboo and brought up religious issues themselves.

- (c) Protection of the therapeutic relationship - Another point of consideration is that patients are reluctant to discuss religion because they do not want to risk damaging the therapeutic relationship, which in some instances was otherwise positive. Several members of the sample expressed concern that they would

offend their therapist by discussing something that the therapist perceived as rude or that ran counter to their beliefs. Carter (1993) writes that "society is wary of anyone who takes their religion too seriously" (p. 8) and this trend apparently plays out even in the therapy setting where clients anticipate that irreparable harm might occur if they inadvertently offend their therapist.

(d) Spiritual illiteracy - In 1979, Gallup reported that Americans are "spiritual illiterates" (Carroll, Johnson & Marty, p. 115) while Koshmin & Lachman, in 1993, noticed the same trend in their decade, reporting that "religion prospered while theology went bankrupt" (p. 46). What is evident is that although Americans are outwardly religiously-oriented, many individuals cannot discuss more than the most basic tenets of their religion's theology. Consequently, it may be that patients do not try to discuss their beliefs because they are afraid that they cannot effectively debate such issues with their therapist. In the post-interview questionnaire, for example, 38% of the respondents endorsed this item in support of the same theme that had already been obtained during the interview.

(e) Lack of practice - Related to the above issue, even if a patient was prepared to intellectually articulate their belief system, it is likely that such discussions are still avoided since in our society, patients have little opportunity to practice sharing their beliefs with others. Berman

(1990) writes that although we live in an ostensibly religious nation, "discussions about personal, moral and spiritual beliefs are seldom encouraged" (p. 5). As a result, most patients would inevitably feel odd bringing up their belief systems as they have had little opportunity to practice such discussions and to learn how to effectively articulate their beliefs.

Patients want to know about their therapist's beliefs. Although the literature review yielded conflicting evidence on whether or not patients' perceptions about their psychotherapy experience were influenced by knowing the therapist's religious beliefs, our sample unanimously wanted to know what those religious beliefs were. In addition, on the post-interview questionnaire, 63% of the sample stated that they would better be able to trust a therapist with religious beliefs similar to their own, while 75% stated that if given a choice they would prefer to work with a therapist who shared their religious beliefs. The therapeutic use of self-disclosure is again at issue in this theme as there are controversies about whether a therapist should reveal personal issues such as their religious orientation. Of our sample, it was evident that only rarely did therapists explicitly divulge this information--in fact, even the two therapists who happened to also be ministers did not initially reveal this to their patients. For example, one patient became so distraught after accidentally discovering that her therapist was also a minister that she immediately quit therapy in shame of the four-letter words she had been using. When accurate information was not

available, the patients tended to fill in the gaps with their own assumptions and acted upon these beliefs accordingly.

How therapists respond to the presentation of religious issues. Although the literature review yielded inconclusive results about how therapists respond to the presentation of religious issues, this sample almost unanimously indicated that therapists are seen by the patient as having considerable conflict in this realm. As noted earlier in Table 19, only one individual of our sample reported having only positive experiences when discussing religious beliefs with his therapist. In contrast, four individuals reported only negative experiences, while the remaining four reported having both positive and negative experiences over the years. The end result is that a substantial majority of our sample (8 out of 9) have experienced negative reactions when discussing religious issues at some time during their therapeutic journey.

(a) Positive responses - Although only five individuals reported ever having a positive experience with any therapist, it is helpful to examine what a "positive experience" meant to this small group. First, the therapist expressed interest in the topic by asking questions and then tying the answers into other aspects of the patient's psychology. It was noted that in these instances the therapist never asked "why" questions, which typically puts patients on the defense, nor did they interrupt the patient or change the subject. Instead, the therapist listened, asked relevant follow-up questions, and was careful not to

impose their own belief systems. These therapists were obviously sensitive to religious issues which, according to McMinn's research (1991), is highly significant because therapists who are deemed sensitive to religious issues are seen by religionists as being more likable, more trustworthy and more likely to be consulted by the individual in the future.

(b) Negative responses - In contrast, eight patients provided illustrations of negative encounters such as the therapist sounding defensive, assuming that a given practice is pathological, never asking about the patient's religious beliefs, attempting to convert patients away from their beliefs, changing the subject when religion is brought up, and most commonly, avoiding the topic altogether. These findings indeed hint at the "repression of religion," that Kung discussed in 1990.

Summary. Our findings indicate that patients believe it is very important for religious issues to be discussed in psychotherapy, not only because this topic is inherently valued by the patient, but also because they feel such discussions are essential for favorable therapeutic outcomes. This belief transcends theological orientations, and it was most noteworthy that even the atheists and agnostics of the sample ascribed to this same belief.

Despite this strong interest, our sample expressed great difficulty accomplishing this task. First, they found it disconcerting that their therapist never asked about their belief system and, consequently, assumed that the topic

was taboo, even in a confidential psychotherapy session where the concept of free association is supposedly valued. In addition, patients came with their own unspoken fears and assumptions, many based on societal expectations, that it is inappropriate and unwise to bring up these topics in psychotherapy. To do so, our patients report, is to risk being mislabeled as irrational or crazy, to inevitably become entangled in a religious theological debate, or to harm the therapeutic relationship in some unspoken fashion.

As a means of minimizing these possibilities and allaying their fears, each person in our sample indicated a desire to know something about their therapist's religious orientation. According to our sample, very few of the therapists self-disclosed their religious orientation. It was particularly striking that the two therapists who happened to be ministers did not disclose their religious alliance. Although there is much discussion in the psychoanalytic literature about the judicious use of self-disclosure, some of the literature suggests that carefully monitored self-disclosure may be helpful—and clearly it is desirable to our patient population.

Finally, our findings indicate that the vast majority of our patients had experienced a negative encounter discussing religion on at least one occasion: eight out of nine patients reported having such unpleasant experiences. Although these reports do not inevitably suggest that therapists are biased against religion, it does strongly suggest, from the patients' perspectives, that therapists have considerable difficulty when this issue is brought up.

Implications for Future Research and Practice

The first task of future investigations should be to determine whether our finding, hermeneutically-derived from a small unrepresentative sample, that patients wish to discuss religious issues in psychotherapy (and furthermore feel that they could do so more effectively with similar therapists) generalizes to a more representative population. Since this project was exploratory in nature, a convenience-sampled population was acceptable for our purposes; however, the interpretive value of our findings was limited. Future studies should therefore explore whether our identified themes generalize to different populations.

Given such confirmation, the next research goal would be to determine if gratification of these wishes is ultimately in the patient's best interest. This step is critical since, despite studies which proclaim the primacy of patients' perceptions, further research may instead reveal instances where gratification does not necessarily equate with a more effective therapy. Indeed, many analytic therapists would report that some measured degree of discomfort is at times necessary to promote intrapsychic exploration and growth. In this sense, unexamined gratification might even inadvertently retard the patient's development.

A strategy for assessing these issues in future projects would be to develop and implement a training program in which therapists are taught how to professionally address religious issues in psychotherapy. To determine the effectiveness of this training, the randomly-assigned therapist-patient dyad

would be observed and evaluated over a period of time to see if the training had any perceivable impact on factors such as psychotherapy process/outcome and patient satisfaction. In addition to being assessed by observation, the patient and therapist would also periodically submit to interviews and/or be asked to complete surveys in which they assess their experience. A control group of untrained therapists would be needed to prove that any detected effects could be attributed to the training experience (and ostensibly the subsequently-acquired religious sensitivity and skill in the psychotherapist) rather than intervening variables.

This methodology is advantageous for several reasons including the fact that other variables (including potential confounds) can be controlled for and examined in this setting. Therapist experience, for instance, is a critical characteristic which has not yet received attention in the literature and it well may be that the negative experiences reported by our clients primarily occurred when they were matched with inexperienced, rather than religiously insensitive, therapists.

Two possible positive outcomes seem likely as a result of this proposed venture. First, by educating therapists, future religionists may enjoy an enhanced psychotherapy experience which, in turn, could potentially parlay into improved therapeutic gain. While therapeutic gain is a highly desirable outcome, a second possible result is that, from our extended efforts, we also

increase knowledge and understanding of the psychology of religion, thus promoting valuable theoretical gains for our profession.

Concluding Remarks

It is evident from this study that the investigation of how religious issues are dealt with in psychotherapy is an exceedingly complex process. However, by using a methodology that is uncommon in this specific literature, several new perspectives emerged and seem worthy of consideration in future research endeavors.

The momentum of this interest should be maintained for Worthington (1991) reports that psychotherapists will increasingly have to deal with religious issues in the upcoming years. His reasons include the belief that religionists are becoming more vocal about their beliefs and practices, that there is an influx of immigrants entering the United States with strong religious beliefs, and, finally, that the increasing cultural diversity within the United States demands greater tolerance in general.

According to Moore (1994), religion still has a future in America, even if it is compartmentalized and in some contexts marginalized. It must also be remembered that while many Americans only pay lip service to religion, there are nevertheless many who are genuinely committed to it and whose faith is extensively integrated into their lifestyle.

In 1993, Kosmin & Lachman predicted that endorsements of religious beliefs would rise during the 1990s as we approached the new millennium with

all its attendant hopes and fears. They were proven correct as early as 1994, as Kantrowitz had already documented a sharp escalation of national spiritual interest using the cultural marketplace as a barometer. In that year alone bookstores were filled with best-selling religious works while a spiritual novel, *The Celestine Prophecy*, remained on the New York Times best-seller list for most of the year. In addition, a foreign language album of Gregorian chants sold 2.8 million copies; attendance at religious retreats skyrocketed; and 58% of the baby boomers reported that they yearned to experience spiritual growth (Kosmin & Lachman, 1993). In the scientific realm, rapid growth is also expected as at this time in history the research of physical, biological and psychological scientists are yielding evidence for a biological basis of religion (e.g., Hooper & Teresi, 1986; Waller, Kojetin, Bouchard, Jr., Lykken, & Tellegen, 1990; Porush, 1993).

It is clearly evident that religion is very much alive in America—not necessarily in the traditional ways of old, but in ways which are “dynamic, creative, relevant, and continuously developing” (Kosmin & Lachman, 1993). Given that we indeed seem to be the “religion-soaked nation” that Bloom described (1993, p. 30), it seems irrefutable that this national passion indeed demands more understanding from the psychological community.

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APPENDICES

APPENDIX 1

Sample Community Advertisements

PSYCHOTHERAPY RESEARCH PROJECT

VOLUNTEERS NEEDED!!!

Volunteers are needed immediately for a new research project, Religious Values and the Psychotherapy Experience, being conducted at the University of Tennessee. Candidates must meet the following criteria:

1. Minimum age of 18 currently and at the time of psychotherapy.
2. Must have attended psychotherapy for at least 3 months.

GOAL:

The goal of the study is to better understand the relationship between the religious views of clients and its impact (if any) on the nature of issues discussed in therapy, satisfaction with the therapy experience, and upon the overall course of treatment. Other therapist/patient differences will also be addressed.

METHOD:

If you agree, you will be asked to participate in a one-hour meeting. Meeting times and locations will be arranged at your convenience. **YOUR IDENTITY AND RESPONSES WILL BE KEPT ANONYMOUS and CONFIDENTIAL.**

POTENTIAL BENEFITS:

These results may ultimately be used to improve the quality of the training and continuing education of psychotherapists. A brief summary of the project's results will be made available to interested participants upon request after completion of the project.

APPENDIX 1 (continued)**CONTACT:**

If you are interested in participating or need further information, please contact Ms. Castellani at _____. Leave a message on the machine and your call will be returned promptly.

THANK YOU! WE APPRECIATE YOUR HELP!

APPENDIX 2**Classified Newspaper Advertisements**Traditional newspapers:

UT RESEARCH PROJECT. Volunteers needed for psychotherapy research project. Any adult who has religious/spiritual beliefs and who has been in secular psychotherapy for 3+ months is eligible. Confidential. Call Jodie Castellani at _____.

Non-traditional newspapers:

UT RESEARCH PROJECT. Ever talked to your therapist about religious/spiritual issues? If so, call Jodie at _____ to discuss your experience. Confidential.

APPENDIX 3

Telephone Script for Screening Volunteers

Hi, I'm Jodie Castellani, I'm returning your call about my research project. How did you hear about my project?... I'm a student at the University of Tennessee in Knoxville (and I'm here in Memphis for one year working on my clinical internship). The project that I advertised is part of my dissertation research and is required to complete my degree. What I'm interested in doing is interviewing people with religious/spiritual beliefs who have been in therapy in hopes of better understanding what the experience of discussing these issues in therapy was like for the client. I'm not interested in details of your private life—so I'll need just the general gist of why you attended therapy, then I'll go in depth about your religious views, and then I'll ask what of this nature was discussed in therapy (or not discussed) and ask you to provide as much detail as possible about this experience. Then, I'll also ask for some basic demographic information. I am required to tape the interview so that I can make a transcript of our session, but the transcript won't have any identifying information in it, and the tape will be erased immediately after the transcript is complete to ensure your confidentiality. You're welcome to review the transcript if you want. I expect that it will take about an hour of your time and I'll be happy to meet you at whatever time or public location is convenient for you. Are you interested?.... (questions were then answered that hadn't already been presented)... OK, let's set up a time... Thank you so much...

APPENDIX 4

Religious Issues in Psychotherapy Questionnaire

This questionnaire is being conducted in partial fulfillment of a dissertation project being conducted at the University of Tennessee at Knoxville.

If you have any questions, please contact Jodie Castellani at ____ or Dr. Alvin Burstein at _____. Please forward your completed questionnaire by March 20th.

DIRECTIONS: Please circle the letter which **BEST** describes your views. For the purposes of this study, please assume that the question is referring to secular psychotherapists unless specifically noted otherwise (e.g., "Christian counselor"). If no answer seems to match your beliefs, please choose the one that is the **CLOSEST** match. If you have had more than one therapy experience, please answer the question based upon the **MAJORITY** of your experiences rather than one particular experience. (SA=Strongly Agree, A=Agree, N=Neutral/No Opinion, D=Disagree, SD=Strongly Disagree).

1	I consider my religion to be the single most important part of my life.	SA	A	N	D	SD
2	If given a choice, I would prefer to work with a therapist who shares my attitudes on religion.	SA	A	N	D	SD
3	For therapy to be truly effective, religious beliefs should be discussed at some point of the treatment.	SA	A	N	D	SD
4	From my personal experience, I find that most therapists are atheists.	SA	A	N	D	SD
5	I would better be able to trust a therapist who had religious beliefs similar to mine.	SA	A	N	D	SD
6	Therapists are generally well trained and skilled in handling religious issues that arise in therapy.	SA	A	N	D	SD
7	In my own therapy (or therapies), I personally raised religious issues for exploration with my therapist.	SA	A	N	D	SD
8	From my personal experience, I find that most therapists are very receptive when clients bring up concerns involving religion.	SA	A	N	D	SD

APPENDIX 4 (continued)

9	From my personal experience, I find that most therapists routinely ask about their clients' religious beliefs.	SA	A	N	D	SD
10	I would feel very pleased if my therapist spontaneously asked about my religious faith.	SA	A	N	D	SD
11	I wanted to bring up religion more frequently in therapy but did not for fear of the therapist's reaction.	SA	A	N	D	SD
12	Therapists tend to see religious beliefs as neurotic.	SA	A	N	D	SD
13	I did not bring up religion in therapy more often because I did not want to debate religious issues with the therapist.	SA	A	N	D	SD
14	The more therapists and clients have in common, the greater the chance for a good therapeutic outcome.	SA	A	N	D	SD
15	From my personal experience, I find that most therapists are accepting of any topic the client brings up and generally do not attempt to change the subject.	SA	A	N	D	SD

VITA

Jodie Sutton Castellani was born in Oliver Springs, Tennessee on August 4, 1961. She moved to Saudi Arabia with her family at age four, and attended private day schools in Ras Tanura and Abqaiq, Saudi Arabia during elementary and junior high. In 10th grade, she returned to the United States to complete her high school education at Chatham Hall, a girls' boarding school in Chatham, Virginia, where she graduated in 1979. During the 1980s, she worked at various national and international firms, and then entered the University of Tennessee at Knoxville where she graduated with a BA in psychology in 1990. In 1992, Jodie was admitted to the doctoral program in clinical psychology at the University of Tennessee in Knoxville and, in 1997, completed a pre-doctoral internship at the University of Tennessee Professional Psychology Internship Consortium in Memphis. She graduated in May 1999 with a Doctor of Philosophy degree in Psychology. Jodie is currently employed in crisis intervention at Overlook, Inc., a division of Covenant Behavioral Health, in Knoxville, Tennessee.