THERAPISTS WHO ADDRESS CLIENT RELIGIOUS BELIEFS IN THERAPY:

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Abstract

Research has reported that the majority of Americans view religion as being important in their lives, and can have a beneficial influence on a client’s mental health. However, fewer than half of therapists assess a client’s religious beliefs, and rarely is religion discussed in the treatment setting. This study attempted to address this rift between the importance of religious and spiritual beliefs of clients and the hesitance of therapists to discuss these beliefs by looking at psychologists who do address religion in their practice. In this qualitative study, the focus was to determine how these therapists work with a client’s religious beliefs. Twelve clinical psychologists, who identified themselves as addressing a client’s religious and spiritual beliefs in therapy, were interviewed about how they work with the client’s beliefs. These psychologists, between the ages of 44 and 64, whose clinical experience ranged between 9 and 34 years, were recruited from New Jersey and Pennsylvania through professional contacts. The interviews were semi-structured, with open questions designed to look at how the psychologists conceptualized religion and psychology, how they conceptualized bringing religion into therapy, how they worked with a client’s beliefs in therapy, and the ethical considerations surrounding addressing religion in therapy. Grounded theory was used to analyze the interviews and examine the major themes that emerged. From these themes, specific guidance was found from the various answers to the individual questions of the interviews. In addition, a more in depth qualitative analysis supported a theory in which therapists address a client’s beliefs by creating a collaborative dialogue between religion and psychology, similar to that discussed by Stanton Jones (1996). This emergent theory
suggests that religion can be brought into therapy via the client’s world view that includes
the client’s individual spiritual beliefs. The therapist acts as a representative of
psychology, namely the therapist monitors boundaries carefully to maintain this specific
role as the psychologist. Once these two roles are established, the collaborative dialogue
occurs when discussing those areas of the client’s life where the domains of religion and
psychology overlap. Finally, the psychologists interviewed also offered guidelines for
addressing religion in therapy.
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Chapter I

Introduction

Research that examines religion and psychology has returned consistent results over the past years. First and foremost is the importance religion plays in the lives in people as a whole. Gallup polls have consistently shown that more than half of Americans view religion as being very important in their lives. In 2007, Gallup polls have shown that 56% of Americans see religion as being very important, and 26% seeing it as fairly important (Gallup, 2008). Secondly, studies in religion and psychology reveal potential benefits for both mental and physical health. Religious activity has been found to be a predictor of coping with life stressors, psychological adjustment, and physical health (Hill and Pargament, 2003), increased satisfaction with life and a health care provider’s acceptance and participation in a client’s religious belief can prove beneficial (Koenig, 1990). Acceptance of religion has been gained in psychology, and 82% of surveyed APA members believe religion to be beneficial to mental health (Delaney, Miller, and Bisong, 2007). However, despite this acceptance, little more than half of APA members regularly assess a client’s religion or spirituality; (14% always assessing, and 37% often assessing) and little more than a quarter view spiritual or religious issues as regularly relevant to treatment (3% reporting always relevant, 23% reporting often relevant) (Delaney, et al, 2007).
Reflecting this rift within psychology, there has been both a resistance towards, and a push for, inclusion of religion in psychology. In contrast to the national rate of only 15% in 2003, 48% of surveyed APA members reported religion as being unimportant in their lives (Delaney, et al., 2007). In addition, 68% of psychologists surveyed feel it is inappropriate to pray with a client, and 55% felt it was inappropriate to use scripture in therapy (Shafranske, 1996, p. 366) despite reported utility (Koenig, H.G. 1990). The majority of graduate and post graduate training institutions do not offer direct training on issues of religion, spirituality and its integration with psychotherapy (Plante, 2007) with training directors reporting religion and psychology most likely being brought up in supervision, and after that religion is approached in reference to other training topics, most commonly diversity or ethics related courses (Brawler, et. al, 2002).

The hesitancy to directly work with and integrate religion into therapy is understandable and stems from a number of sources. First of all, religion is a politically charged topic that, along with its history of motivating and guiding the growth and development of society and fighting for social justice, has also been used to justify acts of violence and oppression. There is also a philosophical difference between psychology and religion. Psychology operates with a strong grounding within scientific methodology, a necessary component of which is the operationalizing of phenomena into clearly definable concepts. Religion exists in a realm of the unexplainable, vague, and paradoxical, in direct contradiction to psychology’s scientific determinism (Northcut, 2000).
Review of the Literature

**Historical overview of the relationship between religion and Psychology.**

The history between religion and psychology has been tenuous since psychology’s birth as a discipline. In his 1913 work *Totem and Taboo*, Freud saw the birth of religion through a primordial Oedipal murder. As totemistic animals represent God, and the psychoanalytic connections between fathers and God, Freud drew a connection between the ominous father head of Darwin’s primeval horde, murdered by his sons to subsume his power, and the ceremonial slaughter and consumption of revered animal totems (Freud, 1913/2005, p.123). “In this connection some features were formed which henceforth determined the character of every religion. The totem religion had issued from the sense of guilt of the sons as an attempt to palliate this feeling and conciliate the injured father through subsequent obedience.” (Freud, 1913/2005, p 124). His views of religion were carried forward into *Future of an Illusion*, where he becomes more critical of an illusion based on wish fulfillment, made dangerous as it perpetually acts as an immature defense, and serves only to infantilize human society (Freud, 1975). James Leuba called religious belief a form of psychopathology (Wulff, 1996), a sentiment shared by Albert Ellis, the famed founder of Rational Emotive Behavioral Therapy, (Marks, 2006). George Vetter saw religion as a vehicle of war, savagery, and corruption that originate from randomly reinforced behaviors arising in uncontrolled situations (Wulff, 1996). In general, the opponents of religion in psychology often view religion as unscientific, and therefore antithetical to the highly scientific view held by many psychologists (Slife and Whoolery, 2006).
Religion has had its defenders within psychology as well. Early on, attempts were made to mirror the Cartesian split between substance and spirit, granting psychology and religion their own separate domains of knowledge and practice (Nelson, 2006), where psychology focused more on the functional and observably evident facets of human experience (Hood, 1992), and religion maintained itself in the sphere of subjective human experience. William James argued that religion was a complex construct, representing “Man’s total reaction upon life,” (James, 1902/2010 p 174) and as such, should be sought out for examination in psychology. Carl Jung, contemporary of Freud, saw religion not as wish fulfillment, but as a “Numinosum” that exists outside of man, and influences him towards the religious, and argued that that it could not be a neurosis, because adherents normally do not show the demoralizations normally seen in neurotics (Jung, 1966). Instead, religion, for Jung, is a system that connects man not only with his unconscious, but with a universality that lies in that unconscious. “You try religion in order to escape from your unconscious. You use it as a substitute for a part of your soul’s life. But religion is the fruit and the culmination of the completeness of life, that is, a life which contains both sides.” (Jung, 1966 p 50). Winnicott and Pruyser developed an idea within Objects Relation theory that sees religion as a human construct that aids in the growth of the psychological human, one that has its own forms of reality testing (Wulff, 1996). Erik Erikson saw religion as society’s source of the trust, wisdom, and hope necessary for the development of ego strength (Wulff, 1996). Others have tried to argue that neither psychology nor religion are more accurate, but merely describe human experience from different perspectives. (Slife & Whoolery, 2006). Gordon Allport, though highly supportive of religion, also acknowledged the problems voiced by its critics, and sought
to find resolution between the two (Wulff, 1996). His resolution came from an analysis of the experiences of religious practitioners that lead him to develop a theory of religious motivation. Allport proposed that a person’s motivation for religious practice would affect how his or her beliefs would manifest upon the world. Those who are intrinsically motivated, or motivated to practice for the sake of practicing religion, and its process of development, would be more adjusted and show more positive effects. Those extrinsically motivated, or motivated by personal or social reward and need, would not see the same positive effects, and were more vulnerable to problems (Fallot, 1998b, p 17).

The rift between psychology and religion has some of its origin in the rifts that have appeared between science and religion. In a survey of university scientists, 34% reported not believing in God, 30% responding as agnostic, and 52% having no religious affiliation. Noted in this study, however, was that the beliefs held by the scientist, whether religious or non-religious, preceded their education, indicating that the study of science itself did not create the anti-religious views (Ecklund, 2007). More fundamentally, there is a philosophical divide between science and religion that stems from both the primary material they seek to investigate, and the very questions they wish to investigate. The examination of science focuses on the measure of empirical data, data based on objective external observation of the natural world, quantified in discreet units created by consensus. Religion, in contrast, focused on experiential data about the human condition, data based on subjective experience, and invoked by story and ritual (Barbour, 1990) or through a process of gradual experience (New York Academy of Sciences,
In addition, even though both religion and psychology seek to know the world around them, the fundamental question each asks is very different.

The net of science covers the empirical universe: what is it made of (fact) and why does it work this way (theory). The net of religion extends over questions of moral meaning and value. These two magisteria do not overlap, nor do they encompass all inquiry (consider, for starters, the magisterium of art and the meaning of beauty) (Gould, 1997).

And though these magisteria do not overlap, the domains of science and religion can often be invoked together, such as when discussing moral implications of scientific discoveries, and in the process involves a conversation that can be complex and difficult to negotiate (Gould, 1997). Given the difficulty in negotiating these two domains, there is a tendency to simplify the situation by choosing to reject one domain and look solely at the other. When one domain is afforded primacy over all ways of knowing, however, the split widens, either in the form of scientific materialism or in the form of biblical literalism (Barbour, 1990). This scientific materialism can takes on theories of reductionism and logical positivism. In reductionism, all laws of science and nature can be reduced down to component parts, such as chemistry or physics. In logical positivism, only empirically derived information can be considered meaningful (Barbour, 1990), because it is seen as fixed, absolute, and immune from subjective interpretation (Jones 1996). The medical materialism that James (1902/2010) and Allport (1922/2011) criticized is an offshoot of this scientific materialism, as the behaviors of religious leaders have been described as representative of medical conditions, while ignoring the more intangible benefits of what was brought about through the experiences of these leaders.

Take the example of George Fox, the founder of Quakerism, who was apparently psychopathic. Certainly he was eccentric, had visions, heard voices. But his powerful, if erratic personality has affected countless lives favorably. To be specific, think of the Friends Service Committee and all that it has done to
relieve human suffering. George Fox’s psychopathy was one of the psychological roots of his organization, but the value of the Friends Service Committee to mankind has nothing whatsoever to do with Fox’s queerness. (Allport, p10).

Biblical literalism sits as the opposite of scientific materialism, and comes into existence when an ideology attempts to reshape science into religious conformity (Barbour, 1990). The conflict created by scientific materialism and biblical literalism, however, both come from a misunderstanding of the roles and boundaries of science and religion.

I will suggest, that each represents a misuse of science. Both positions fail to observe the proper boundaries of science. The scientific materialism starts from science but ends by making broad philosophical claims. The biblical literalist moves from theology to make claims about scientific matters. In both schools of thought, the difference between the two are not adequately respected. (Barbour, 1990 p.4)

A final source of conflict comes from associations of religion with violence and oppression. There is a long narrative of an intersection between religion, politics, and violence throughout the world and throughout history (Wellman, 2007) and many seek to separate themselves from religion to separate themselves from this intersection with violence.

Just as psychology has not been wholly antagonistic towards religion, there have been movements within the larger field of science to reconcile its differences between it and religion. Reflecting the non-overlapping magisterial of Stephen Gould, the National Academy of Sciences has affirmed a respect for the separate domains of science and religion.

Scientists, like many others, are touched with awe at the order and complexity of nature. Indeed, many scientists are deeply religious. But science and religion occupy two separate realms of human experience. Demanding that they combine detracts from the glory of each. (National Academy of Sciences, 1999)
In addition, positivism has been heavily challenged within the field of science. Since the 1950’s there has been a growing awareness that data is not as objective or theory free as once believed, but rather is theory laden. Data is not only defined by theory, as the theory describes how and what characteristic is to be measured, but the data is also evaluated by the theory and the subjectivity of the researcher. Also in this growing awareness, is the understanding that observers are not separate from what they study, but rather affect what they study through the act of observation. Science, then, has come to be understood not as a purely objective window into absolute reality, in contrast to the subjectivity of nature, but rather is a discipline that wrestles with its own subjectivity and differs from religion in the aspects of reality it investigates (Barbour, 1990). Finally, although there has been a heavy criticism of the problems associated with religion, there are many who argue that it may not be accurate to levy the criticisms at religion as the sole progenitor of the problems, as those criticisms have failed to recognize that those attributed issues exist outside of the domain of religion as well. When disputing the claim that religion stems from problems in psychology and neurobiology, William James wrote:

According to the general postulate of psychology just referred to, there is not a single one of our states of mind, high or low, healthy or morbid, that has not some organic process at its condition. Scientific theories are organically conditioned just as much as religious emotions are; and if we only knew the facts intimately enough, we should doubtless see ‘the liver’ determining the dicta of the sturdy atheist as decisively as it does those of the Methodist under conviction anxious about his soul (p710).

Gordon Allport makes a similar argument, illuminating this point through the life of the rationalist philosopher Immanuel Kant,

Now a psychologist might point out that having a sunken chest and poor physical stamina, he was a failure physically and had few fundamental emotional satisfactions in life. Partly as a consequence, therefore, he evolved his famous
doctrine of ‘pure reason’ and said that emotions were nothing but ‘diseases of the intellect’ (Allport, 1922/2011, p 9-10).

With this in mind, James argues that the origins are not as important as the effects themselves “In the end, it had to come down to our empiricist criterion: By their fruits ye shall know them, not by their roots.” (James, 1902/2010p 714). Similarly, when addressing the intersection of religion, politics, and violence, Alister McGrath points out that the same problems exist in communist governments, governments that explicitly endorse atheism (McGrath, 2011). As such, though religion is vulnerable to violence as seen by history, it is not causal, as the same violence can exist without the inclusion of religion.

**The inclusion of religion and spirituality in psychology.**

Despite the rift that exists between psychology and religion, there are a number of reasons to include client religious belief in the therapy process. First and foremost is the fact that religion is a part of many people’s lives and to ignore this ignores a part of the individual. A client’s religious participation can provide information on his or her self-understanding, resources for strength, coping and recover, and cultural and community connections (Fallot, 1998a p 10), and this information can be lost if the therapist does not inquire. In addition, investigating the client’s beliefs allows the therapist to build an understanding of the client’s moral framework, worldview, struggles and inner reality, which can help to foster both empathy and rapport with the client (Bergin, Payne, and Richards, 1996).

Second, not working with a client’s religious beliefs can create a rift between therapists and the population in need of services. The perception that psychology ignores or pathologizes religious beliefs may drive highly religious consumers from seeking out
secular mental health services (Bergin, 1991). In addition, many potential clients are seeking out therapists of similar religious orientations, or who are explicitly willing to bring religion and religious resources, like prayer and scripture, into therapy (Tan, 1996). As a result, inability to address religious beliefs in therapy can not only drive individuals from support, but can also blind therapists to forms of support clients may deem important.

There is a lot of research within psychology that indicates connections between religious participation and positive mental health. Rodney Clark, in an attempt to establish a relationship between religion and psychopathology, found a negative correlation between the two, and decided that psychology needed to collect data about religion and mental health (Marks 2006). Subsequent research supported a positive relationship between both religion and physical health, a positive relationship between religion and mental health, has shown that religion could act as a buffer against psychological distress and mental illness, has provided empirical data for the benefits of religion, and encouraging and guiding further study in the psychology of religion (Ghorbani, et. al, 2000; Koening 1990; Marks, 2006). Further research has continued to support the benefits of religion in health and mental health, but has also begun both to analyze what factors lead to the increase in mental health and to understand phenomena of the psychology, religion and identity (Hill and Pargament, 2003). Gordon Allport, aware of both the problems found in the violence and prejudice reported by some in religion, and the benefits and social good done by religion sought to rectify the two polarized views (Wulff, 1996). Allport proposed that how one was motivated to participate in religion, either motivated extrinsically by external rewards or punishments,
or intrinsically through seeking religion for religion’s sake and therefor internalizing development and connection, could account for the discrepancy. As he developed and researched this, he found that those who were intrinsically motivated, showed better mental health adjustment (Fallot, 1998b) and further research has supported Allport’s theory that intrinsic motivation towards religion does tend to predict better psychological adjustment in individuals (Ghorbani, et. al, 2000). Even though there is limited research on specific therapies that integrate religious components, there is evidence to support some therapies, such as Christian and Muslim related CBT for anxiety and depression, and building evidence for other therapies, such as Taoist CBT, Christian devotional meditation and Buddhist CBT for anxiety, as well as others (Hook et al, 2010).

Finally, there are ethical considerations also support the need to address client religious belief within therapy. There are direct imperatives in the APA Ethical Principles of Psychology and Code of Conduct that advocate addressing a client’s religious beliefs. Principle E: Respect for People’s Rights and Dignity specifies that:

Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status and consider these factors when working with members of such groups. Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices. and as such directs psychologists to consider and respect a client’s religious belief system. Section 2.01(b), which deals with standards of competence, states that:

Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals…
directing psychologists to take research and other factors associated with a client’s religious identity into consideration, and to take steps to maintain an understanding of current related research and knowledge. In addition, Section 2.04 states that:

Psychologists’ work is based upon established scientific and professional knowledge of the discipline.

Research has suggested that religious participation is negatively correlated with psychopathology and can be supportive of mental health (Marks 2006), can promote psychological adjustment (Ghorbani, et. al, 2000) and buffer against stress and aid coping (Koening 1990). In addition, research has also suggested that that a religious treatment delivery system not only can improve the effectiveness of cognitive behavioral therapies, but may have a therapeutic value on its own (Probst, et, al, 1991).

Theoretical perspectives in addressing religion in psychology.

Building a construct for religion and spirituality.

The first issue in discussing religion in psychology is the task of developing a conceptual definition of religion and spirituality for study. As a scientific field, failure to accurately define religion and spirituality compromises the construct validity of the research done or the theory developed. If you cannot define a theoretical construct sufficiently, the research done will not accurately reflect the real world intended object or entity of study (Rogers, 1995). The attempts to accurately define religion and spirituality have been difficult, vague, and confusing (Fallot, 1998a). Part of the problem is that concepts like religion reflect more of a collection of ideas, rather than a single construct that can be easily simplified and reduced to a single operational definition, with a breadth
of variety similar to that of ideas like government (James 1902/2010). Because of this, different researchers have provided a number of definitions for religion and spirituality, definitions that include experiential domains, institutional domains, and various degrees of intertwining and separating religion and spirituality (Fallot, 1998a).

**Theoretical perspectives on the orientation of therapists who bring religion into therapy.**

There are a number of perspectives on how to bring religion into therapy. One of the first questions to answer involves how active religion will be when it is brought in. The integration of religion into therapy can be either implicit or explicit depending on a number of therapist and client factors. In the implicit application, the therapist respects, inquires about, and acknowledges the importance of the client’s religious life, and will discuss religious issues as brought up by the client. An explicit application focuses on actively bringing religion into therapy, and uses prayer, scripture, referral to religious groups, and other practices as appropriate for the client (Tan, 1996). The choice as to whether to be implicit or explicit depends on a number of factors, including proper match to client (Hook, 2010) and comfort level of therapist, and the two do not always have to be mutually exclusive (Tan, 1996). Research has consistently shown that matching is important when deciding to be explicit with religious integration. Religious integration has been found to be useful with highly religious clients, but less useful for those not highly religious, possibly because of the worldview of the highly religious individuals (Hook, 2010). With therapist characteristics, there are degrees to which one can be implicit and explicit, and therapist can fall along a continuum for which they are
comfortable integrating religion into therapy (Tan, 1996). Also with therapist characteristics, even though clients may seek out therapists who share their belief system as a way of fostering connection and understanding, a therapist does not actually need to hold a particular religious belief to be able to explicitly integrate it in therapy (Hook, 2010).

**Assessing religious belief in therapy.**

There are a number of ways to assess a client’s religious beliefs for the purpose of inclusion into therapy. One common way is to look at religion in the field of psychology has been through an ethnographic-style study of the traits of various religious groups. Numerous studies have attempted to understand the specific cultural implications of religious practice and can provide examples of how to understand the aspects of different religious groups and how they influence and interact with individual identity. Robert Lovinger, for instance has compiled a basic primer on specific denominations such as Judaism, Catholicism, Protestantism, Mormonism, Millenialists, Pentecostals, Evangelicals, Fundamentalists, African American Churches, and Islam (Lovinger, 1996). Similarly, Milagros Pena and Lisa Frehill studied Latina ethnic groups, to see how the image of the Virgin Mary has been elevated and identified with by women to aid them in finding strength and power in largely patriarchal hierarchies (Pena and Frehill, 1998). Jewish identity and experience has been examined to see how culture, environment, and themes like pride and meaning have come together to form identity (Friedman, Friedlander, and Blustein, Lo and Dzokoto, 2005). Islam has been looked at to both understand issues surrounding from cultural differences, as well as how status,
environment and culture interact (Ajrouch and Kusow, 2007; Hodge, 2005) Tanya Lockwood examined spirituality as an aspect of psychotherapy with African American clients (Lockwood, 1998). Within this collection of ethnographic information on religion and identity, there is a reminder that rather than project a single understanding of religion onto an individual, it is important to look at the interaction of the religion, and the individual’s own understanding and internalization of the various components of the belief (Yancey, 2001) It is an important concept within the multicultural framework of psychology that characteristics of a group cannot be generalized onto an individual, but that you understand the interaction of the larger cultural group and the individual self-perception. With the vast in-group and between group variations of identity, the salience of group identity, and the differences in both knowledge of and attachment to identity, “Ethnic identity, therefore, refers to the incorporation of group membership into self-perception.” (Yancey, 2001, p 191). Carried forward into religious groups as multicultural groups, the same need to assess the degree of ascribed religious identity applies.

The assessment of religious belief within the setting of psychology can also focus on the more individual aspects of the client. There are a number of conceptual frameworks that can be used for assessment, including diagnostic, experiential, and functional assessments. Diagnostic assessment focuses on assessing pathology in relation to religious beliefs. Even though pathology is not correlated with religious beliefs, there are many for whom their pathologies, such as obsessions or delusions take on religious components. When this happens, the primary issue is the mental disorder and should be treated as one would an Axis I disorder (Fallot, 1998b). The religious component here is conceptualized as secondary to Axis I disorder. The DSM-IV also allows for difficulties
that are based in religious practice, but not Axis I pathology. Changes in spiritual beliefs, relational conflicts with religious beliefs, questioning of beliefs, and other stresses and crisis related to spiritual practice can be coded as a “Religious or Spiritual Problem” (V62.89) (Fallot, 1998b). In addition, because having an Axis I diagnosis can lead to stresses in a person’s religious system, one can have both diagnoses, reflecting both the pathology and the spiritual stress and crisis. Finally, the cultural consideration allowed by the DSM-IV contextualizes many beliefs as being part of the larger religious culture, removing the judgment or stigma that could otherwise be applied (Fallot, 1998b). An experiential assessment looks at the specific religious beliefs of the individual client, and for signs that specific beliefs may reinforce pathology or provide strength and coping. These assessments focus on evaluating experiences according to models of mental health, such as Allport’s model of religious motivation (Fallot, 1998b). There are a number of assessments from different models that can be used to assess both the strengths and vulnerabilities of an individual, such as Kenneth Pargament’s three problem solving styles, and his “red flags” of religious maladjustment (Table 1) or Lovinger’s Markers of Pathology and Indices of Mature Adjustment (Table 2) (Lovinger1996). Finally, a functional assessment looks for the meaning and sense of direction and purpose in life found in the religious beliefs. These models assess the individual through self-report, behavioral priority, and commitment, and can tell a therapist not just what the person believes, but more importantly what meaning it gives to the client’s life and world view (Fallot, 1998b).
Table 1  
**Pargament’s Coping Styles and Red Flags of Religious Maladjustment**

<table>
<thead>
<tr>
<th>Coping Style</th>
<th>Red Flag</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Directing</td>
<td>Dimension: Wrong Direction</td>
</tr>
<tr>
<td></td>
<td>Scales:</td>
</tr>
<tr>
<td></td>
<td>1. Self-Sacrifice</td>
</tr>
<tr>
<td></td>
<td>2. Self-Worship</td>
</tr>
<tr>
<td></td>
<td>3. Religious Apathy</td>
</tr>
<tr>
<td>Collaborative</td>
<td>Dimension: Wrong Road</td>
</tr>
<tr>
<td></td>
<td>Scales:</td>
</tr>
<tr>
<td></td>
<td>4. God’s Punishment</td>
</tr>
<tr>
<td></td>
<td>5. Religious Passivity</td>
</tr>
<tr>
<td></td>
<td>6. Religious Vengeance</td>
</tr>
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<td></td>
<td>7. Religious Denial</td>
</tr>
<tr>
<td>Deferring</td>
<td>Dimension: Against the Stream</td>
</tr>
<tr>
<td></td>
<td>Scales:</td>
</tr>
<tr>
<td></td>
<td>8. Interpersonal Religious Conflict</td>
</tr>
<tr>
<td></td>
<td>9. Conflict with Church Dogma</td>
</tr>
<tr>
<td></td>
<td>10. Anger at God</td>
</tr>
<tr>
<td></td>
<td>11. Religious Doubts</td>
</tr>
</tbody>
</table>

(Lovinger, 1996)

Table 2  
**Lovinger’s Assessments**

<table>
<thead>
<tr>
<th>Markers of Pathology</th>
<th>Indices of Mature Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self-Oriented Display</td>
<td>1. Awareness of Complexity and Ambiguity</td>
</tr>
<tr>
<td>Use of religion as an exhibitionistic display or to serve other narcissistic needs</td>
<td>Recognition that the ambiguity and complexity of the human condition allows for interpretation within belief</td>
</tr>
<tr>
<td>2. Religion as Reward</td>
<td>2. Choice in Religious Affiliation</td>
</tr>
<tr>
<td>Frequent use of religion to attempt to meet every day, mundane needs</td>
<td>The individual recognizes that he or she has choice with which religious group he or she identifies, and has considered alternatives before choosing a group.</td>
</tr>
<tr>
<td>3. Scrupulosity</td>
<td></td>
</tr>
<tr>
<td>An obsessive and intense focus on controlling one’s impulses to avoid sin.</td>
<td></td>
</tr>
<tr>
<td>4. Relinquishing Responsibility</td>
<td></td>
</tr>
<tr>
<td>Either the individual accepts responsibility for events outside their control, or they refuse to accept responsibility for their actions</td>
<td></td>
</tr>
</tbody>
</table>
Table #2 - Continued

5. Ecstatic Frenzy
   Intense and idiosyncratic emotional expression not part of their religion’s regular practice.

6. Persistent Church-Shopping
   Could indicate problems forming relationships, narcissistic tendencies, or traumatic avoidance

7. Indiscriminate Enthusiasm
   Persistent and unwanted sharing of religious experience that violates social norms and impairs relationships and social interactions

8. Hurtful Love in Religious Practice
   Unnecessarily hurtful and damaging relationships that create confused definitions of love.

9. The Bible as a Moment-to-Moment Guide to Life
   Using the Bible (or other religious material) as guide for daily living, relinquishing agency and self-direction

10. Possession
    (Lovingier, 1996)

3. Value-Behavior Congruence
    An individual’s behaviors match the beliefs he or she ascribes to, such as practicing the positive behaviors they endorse, or avoiding behaviors they see as negative

4. Recognition of Shortcomings
    Recognition of one’s own imperfections, with a desire to improve without overly punitive guilt or shame.

5. Respect for Boundaries
    A mature individual may offer religious insight from experience, but he or she refrains from pushing beliefs on others.

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_Conceptualizing religious beliefs in the therapy setting._

When addressing religion in therapy, there are some general themes and issues to be mindful of. First and foremost is the need to understand and explore the content of religious beliefs and experiences. Religion can be a source of coping, problem solving, social networks, meaning, coherence, and social role models, as well as sources of more
tangible resources (Sullivan, 1998), all information that is useful within therapy. Religious imagery, likewise, can be investigated as source of information on the client’s internal world (Lovinger, 1996). Even when there exist delusions, cognitive distortions, or other pathologies that are seemingly connected to the client’s religious beliefs, it can be more useful to understand the content of these thoughts than to challenge them directly. “People with mental illnesses are rarely talked into, or out of, delusional beliefs. In fact, the sensitive exploration of these convictions may yield a great deal of information for assessment and service planning.” (Fallot, 1998a p 6-7). In addition, inquiry and understanding the beliefs may end up providing the support within therapy that allows the client to begin the self-inquiry that aids in the therapeutic change, as seen in the case of Olav, a psychotic patient from Norway.

By daring to engage with Olav’s psychic reality, as it was represented in his religious symbolization (e.g., as represented by the regular pictures that he drew during the vita program) – rather than dismissing his psychic reality as symptomatic or insane – allowed Olav to feel safe, respected, and even loved. In this context, Olav’s ability to mentalize flourished, and he began to let go of his defensive withdrawal from the world of intersubjective relating and his perniciously rigid, self-other representations. (Malitzky, p 124).

It has been noted in the literature that there will be times in therapy when a problematic belief does seem to be anchored to specific scripture. Even when such beliefs are scriptural, it is possible to collaboratively explore and challenge the beliefs. Robert Lovinger has offered a method that involves first exploring meaning of the text for the client early on, and ask the client to find the specific text. If the client cannot find the text, the therapist shouldn’t act surprised, but if they do find it, reading the larger passage surrounding the text can provide important contextual information to better understand the intended meaning of the text. The conflict or problem continues, sometimes
comparing the texts in different translations can give better insight. Finally, during this process, it may be necessary to also seek out sources of commentary and interpretation to better understand the text (Lovinger, 1996 p. 355). Resistance and transference are just as important in working with religion in therapy as it is with therapy in general. Initial resistance may come in the form of a fear of loss of their faith, or a distrust of therapy, and can be resolved early if the therapist is willing to validate and resolve the issues. If the child has been a victim of abuse, the client may be resistant to label the experience as abuse if they have created a religious defense against the abusive reality, or if they feel such a revelation would cause them to dishonor parents or authority figures (Lovinger, 1996). In addition, for clients dealing with anger, they may have difficulties discussing anger as it comes into conflict with religious imperatives towards forgiveness. When these issues do come up, examining the beliefs, including their originating context, can help to resolve issues. Transference as it comes up in therapy can be complicated by the client’s religious beliefs and experiences. Erotic transference, for instance can become especially problematic if the client holds conservative beliefs about sex. In these cases, it may be necessary for the therapist to bring up the issue, as it can drive the client out of therapy if it goes unaddressed (Lovinger, 1996).

Practical issues in addressing religion in therapy.

If one decides to explicitly integrate religion into psychology, there are a number of spiritual resources that can be brought into practice. Prayer can be brought into therapy to open sessions, close session, or at other times when appropriate. They can be said silently or spoken out loud, the therapist can pray with the client or for the client, and prayer can be specifically for healing, or can be internal and contemplative (Tan 1996).
When using prayer, it is advised that it be brought in only when concurrent with the client’s goals and care needs to be taken that the prayer is used in a meaningful and therapeutic way, and not in a way that may be superficial or act as a defense against exploring difficult issues (Tan, 1996). Whereas scripture can be brought into therapy implicitly as the client discusses it, a therapist can bring in scripture as a tool to resolve issues. And as noted by Tan, not only do clients who have strong beliefs often respond better to scripture based cognitive restructuring than challenges based on logic or evidence, but even Albert Ellis has noted the utility of scripture in creating positive personality changes (Tan, 1996 p 375). Referrals to spiritual resources can also be helpful for therapists who decide to explicitly integrate religion into therapy. Finally, therapists can support the client’s investigation of religious based social or support groups, or even counselors or therapy groups related to the client’s denomination.

Many existing theoretical orientations can have religion integrated into their therapies. There is some overlap between ideas in cognitive behavioral therapy and with man religious denominations. Religious themes of redemption, for instance, coincide with CBT’s value of examining current problems without heavy emphasis of the past (Propst, 1996). A developing knowledge about the self coincides with CBT’s focus on thought monitoring (Propst, 1996) and the theory of mindfulness that has become a major part of third wave therapies like DBT have been drawn from Zen religious practice (Swales and Heard, 2010). Scripture can be more useful to religious clients than secular rationality in challenging thoughts (Tan, 1996) and the use of religious imagery can be used as a powerful tool in the process of cognitive restructuring as well (Propst, 1996).
Finally, when initiating behavioral changes, invoking supportive and empowering religious constructs can act to increase motivation when making change (Propst, 1996). In psychodynamic theory, religion is integrated through its influence on both the individuals’ development and through the individual’s affective experience. The practical and symbolic structure created by religion creates an environment that guides and affects the child’s developmental progress (Rizzuto, 1996). According to Winnicott, a child begins life with an egocentric belief that they create and control the world, creating a purely subjective world view. During this phase, a responsive parent will create an environment that is constantly protective and responsive to the child’s needs, providing both safety and an initial organizing structure for the self of the child. As the child experiences more of the world, the parent begins to incrementally fail and frustrate the child’s instant gratification. Through this process the child goes from creating and controlling objects in the world, to having to seek out and manipulate objects, building an understanding of an objective reality that sits alongside their former subjective understanding. The child needs to learn to function in both their subjective and objective experiences, in order to build and maintain a self that is rooted both in an authentic self and a tested reality. To aid in the development of this dialectic, the child requires a transitional experience with transitional objects; objects the child does not subjectively create or control, but is still present and responsive to his or her needs. This object takes the place of the parent and provides the support to allow the child to act within and upon the objective reality of the world (Mitchell and Black, 1995 p 124-133). There are things, however, that are not tangible enough to be subject to the reality testing that occurs when negotiating the objective reality, and an understanding of these abstractions must be built.
through the child’s original creative processes. When the child tries to understand a spiritual concept like God, they do so through a constant re-elaboration on an internalized representation of God. Similar to the transitional object that replaces the parent, the primal representation of God is often formed when the child internalizes the parent as an abstract object. As the individual negotiates through developmental stages and conflicts that come when this representation is not in line with the realities of life, the child’s concept of God develops in kind (Rissuto 1996). In addition to this representational aspect of a client’s religious life, religion has a profound effect on the client’s affective life. In his early works on religion, William James felt that, for the purpose of psychology, religious investigation needs to focus on “the feelings, acts and experiences of individual men in their solitude so far as they apprehend themselves to stand in relation to whatever they may consider the divine” (James, 1902/2010 p723). Of importance to James in this understanding was the emotional component as religious ritual and representation was seen as a medium for evoking such emotion (Rizzuto, 1996). Religion was not a singular emotional state, but rather incorporated a full human emotional spectrum, as invoked by religious acts and objects (James 1902/2010). Psychodynamic therapy that integrates religion into the therapy focuses on these themes, both on the developing representation of God, and the conflicts that may emerge as the representation is challenged, and on the examination of the affective life of the religiously observant client. There are different ways to focus on these themes in psychodynamic therapy. One may implicitly bring it in by maintaining an informed neutrality, in which the client’s religious history is taken, and religious feelings worked with in reference to normal psychodynamic themes (Rizzuto, 1996) or more explicitly by encouraging deep
emotional experience, including religious based experience, to facilitate change
deepening the client’s capacity for experience (Mahrer, 1996).

Religion has been integrated into group therapy in a number of ways following a
number of theoretical orientations. Similar to individual CBT, religion and spirituality
can be explicitly integrated into cognitive group therapy by using religious teaching and
religious imagery to supplement cognitive restructuring and guided imagery (Hook, et al.
2010). Twelve-step programs like Alcoholics Anonymous explicitly integrate spiritual
components while staying away from specific religious traditions. The spiritual
dimension brought in seeks to get people to admit their own limitations and seek support
from a power outside of them for help in recovery, and specific religious dogma are left
out in order to avoid both authoritarianism and limiting access do to differing religious
memberships (Hopson, 1996) Even though there have been some criticisms about twelve-
step programs (Hopson, 1996), research has shown that the programs are efficacious
(Hook et al. 2010). Therapy groups that focus on discussing religious issues and
integrating scripture, prayer, and meditation, have been found to be possibly efficacious,
or efficacious when combined with medication (Hook et al., 2010). Even clients with
severe mental illness, such as bipolar disorder, Schizophrenia, and delusional disorder
can benefit from group therapies that focus on religious and spiritual beliefs. These
groups acknowledge and explore the importance of the client’s religious beliefs, but also
acknowledge and explore when beliefs are defensive or interfering and need to be
challenged. Within this context, the groups discuss important psychosocial topics like
hopelessness, psychosis, depression, etc., and the groups have been able to relate their
beliefs to their life situation (Kehoe, 1998).
Ethical Considerations

Ethical Concerns.

There are ethical concerns that one risks as when addressing religion within psychology. As Plante (2007) points out, mental health professionals who work with religious beliefs must be careful to protect against blurred boundaries and dual relationships, be aware of their own biases regarding religion and different belief systems, cannot assume expertise in a religious system even if they are members, and must constantly balance the respect for a client’s autonomy with the ethical and legal responsibility of protecting the clients and the people around the clients from harm and abuse. When using more explicit methods of integrating religion into therapy, Tan (1996) also warned of the potential for abuse when therapists inappropriately apply spiritual interventions and force values onto a client.

Guidance from the literature.

Acknowledging both the difficulties and the need to address religion within psychology, guidance for addressing religion in the therapeutic setting is also available in the literature. Using the APA’s general principles as a guideline, Yarhouse and VanOrman (1999) advocate understanding the individual meaning and significance of client beliefs, utilizing appropriate religious measures and efficacious integrative techniques, being explicit about goals and values in therapy with the client, maintaining familiarity with relevant community resources, such as local clergy and research, continuing to respect and maintain the client’s autonomy in the face of values disagreement, encouraging a full exchange between client’s religious beliefs and the therapist’s understanding of mental health and welfare to enable the client to make
informed decisions, and becoming familiar with relevant issues and policies within the community. Plante (2007) utilized APA guidelines to reminds us that they don’t require us to agree with a client’s beliefs as long as we treat them with respect, that we have a responsibility to be aware of the individual importance that religion may serve in a client’s life, that rules of integrity require us to be open and honest about our skills and limitations, that we need to maintain competence by seeking continuing education and consultation when working with religious clients, and that even though we need to maintain the rights and autonomy of a client, we have a duty to be concerned with protecting both the client and those in his environment from abuse and harm. When illuminating methods on explicit integration of religion into therapy, Tan (1996) noted that Nelson and Wilson have provided some guidelines for explicit integration:

It is ethical for therapists to use or share their religious faith in therapy (a) if they are dealing with clinical problems that would be helped by spiritual or religious interventions, (b) if they are working within the client’s belief system (as long as they do not impose their own religious values on the client), and (c) if they have carefully defined the therapy contract or informed consent agreement to include the use of religious or spiritual interventions and resources. (Tan, 1996)

Finally, specific techniques have been researched that aid in the integration of religion within therapy (Bergin, 1991), and conceptual frameworks have been offered to help reduce barriers to integration (Bergin, 1991, Kernberg, 2000, Northcut, 2000, Sanderson, Vandenberg, and Paese, 1999, Shafranske, 1996).

Purpose and Goals of the Current Research Study

The goal of this dissertation is to help address this discrepancy between reported client and therapist support for the benefits of religious participation, the reported utility and the lack of integration of religious themes within therapy with religious clients by
interviewing therapists who do integrate religious themes within their practice. It is hoped
that in studying therapists who do successfully address religion in therapy, a better
theoretical understanding about how religion can be addressed in therapy can be
developed and used to help address the discrepancy.

The main question to be asked in this research is:

“How do therapists work with religious beliefs in a therapy setting?”

To generate a more comprehensive answer to this question, additional research questions
to be explored include:

1. How do you conceptualize a client’s religious beliefs in your practice?
2. How often is Religion addressed in your practice?
3. How do you address religion in your practice?
4. Who is the one who generally begins the discussion of religion, you or your client?
5. How do you assess the spiritual and religious beliefs of your client? Do you use any
   assessment tools?
6. How do you assess the appropriateness of addressing religion with a particular client?
   Are there any specific methods or techniques you use when addressing religion in
   therapy?
7. Can you think of an instance or instances where a client’s religious beliefs have been
   complimentary to what we know about mental health? How has this been supported?
8. Can you think of an instance or instances where a client’s religious beliefs have been
   contradictory with what we know about mental health? How has this been resolved?
9. What are the ethical concerns surrounding addressing religion in Psychology in
   reference to The Ethical Principles of Psychology?
Chapter II

Methodology

The goal of this dissertation is to help address the discrepancy between reported client and therapist support for the benefits of religious participation and the reported utility and the lack of integration of religious themes within therapy with religious clients by interviewing therapists who do integrate religious themes within their practice. Because of the similarities in the themes of the research question, this study will be using the research design from Tonya Lockheart’s “An Exploratory study of Using Spirituality in Psychotherapy with African Americans” (1998) as guide.

Subjects

The subject pool will consisted of 12 licensed psychologists who are self-identified as addressing client religiosity within therapy. Because of the specific characteristics required of the subject pool, subjects came from an opportunistic sample drawn from personal contact and the “snowball” method to generate new subject contacts. Subjects were informed of the topic and research questions of the study prior to the interview.

Subjects were initially contacted by phone or electronic mail to ask if they would be willing to participate in the study. In this initial contact, the study, including research question and methodology, was explained to the potential participant. When the subject
agreed to participate in the study, an information packet was sent to the subject containing an information sheet on the study and a consent form. The consent form in the packet explained that the interview would be recorded, all information would be confidential, that participation is voluntary, recording can be suspended at any time at the subject’s request, and that consent can be withdrawn at any time in the study. These recruitment materials can be seen in Appendix C. Participation in this study was voluntary and unpaid.

Once a participant confirmed interest, an interview was scheduled. All interviews were conducted in person by the investigator. Before the interview began, the subjects were given a chance to clarify any questions about the study and their participation. The interview was recorded, but the recording would be suspended or stopped at any time during the interview process at the request of the interview subject. After the interviews, the recordings were transcribed by the investigator.

**Procedure**

Qualitative data was generated from the subjects through the use of semi-structured interviews. A predetermined set of questions was drafted, but participants were encouraged to speak as openly as possible. Within the questionnaire, there were some possible prompts listed, but these were only used if the participant needed to clarify a question, and were used as little as possible to prevent the questions from becoming too leading. After the main questions were asked, participants were given an opportunity to discuss any other thoughts related to the subject of addressing religion within psychology. This questionnaire is available as Appendix A.
The Interview Design

The interview was semi-structured, utilizing a questionnaire that consisted of three parts: Personal Beliefs, Addressing Religion Within Therapy Practice, and Ethical Considerations. The Personal Belief section focused on the how the participants personally understood issues surrounding conceptualizing and addressing religion in psychology. In order to address the problem of construct validity when addressing religion, the first question of the Personal Beliefs section directly asked for the definitions of religion and spirituality to determine how they would be conceptualized in the interview by the participant. The Addressing Religion Within Practice section focused on how the participants actually addressed religion within the therapeutic environment in more practical terms. The Ethical Considerations section asked the participants for guidance regarding navigating the ethics of addressing religion and psychology. In addition to the interview, there was a second questionnaire generated to collect demographic information about the participants’ background and beliefs. Since this second questionnaire was to be used solely for collecting demographic information, participants were asked not to identify their names on this form, and the results were not connected to the interview responses or transcripts. The author kept sole custody of these forms so as to not compromise the confidentiality of the participants. This questionnaire is available in Appendix A.
Analysis

The research methodology used to analyze and conceptualize the qualitative data was that found within Grounded Theory as described by Kathy Charmaz (2010). Grounded theory was chosen because it focuses on the unique demands made by a qualitative study. Qualitative studies contrast quantitative studies in that where quantitative studies test theory by applying preconceived categories to the data collected, qualitative studies attempt to build theory by generating categories as they emerge from the data collected (Charmaz, 2010). In Grounded theory, theory and conceptualization are developed while the data is being collected and analyzed (Fassinger, 2005). Grounded Theory is often utilized in qualitative research because it provides a rigorous structure to guide researchers and provide for the generalizability and reproducibility of the study (Lockwood, 1996). Grounded Theory has controls that allow for critical evaluation of the study, including the trustworthiness, authenticity, transferability, and dependability that, in qualitative research, is considered to be comparable to the principles of validity, reliability, generalizability and objectivity valued in quantitative research (Fassinger, 2005).

As outlined by Kathy Charmaz (2006), the analysis process in Grounded Theory approach occurs in four phases, with each level aimed at generating an emerging theory from the data as it is being analyzed. The first level the Initial Coding, in which the raw data is analyzed word-by-word or line-by-line, attempts to identify the themes of the responses made as they come up in the discreet segments. In analyzing the data in this fashion, the coder remains closer to the data while being less likely to lose objectivity while working with the data. In the second level, Focused Coding, the most frequent
codes from the initial coding phase are used to sift through the data to test the earlier responses and generate more refined codes. The third level is that of Axial Coding, in which core categories are synthesized through the sorting and organizing of the data from the previous coding phases. These categories help to create an organizing frame for the data of the study. The final level, that of Theoretical Coding looks to create connections between the coded categories in order to generate the integrative themes that will develop into a theory drawn from the data (Charmaz 2010). During the coding process, the categories developed are analyzed using a process known as “Theoretical Sampling.” In Theoretical Sampling, the data is used to refine categories, with the end goal of reaching theoretical saturation within the categories. A category is considered saturated when it no longer generates new insight into the data, and no longer reveals new information about the categories (Charmaz, 2010 p 113). Using this process, the theory that emerges from this analysis is thereby considered grounded within the collected data, giving the theory its name. (Fassinger, 2005).

Following the model presented in Grounded Theory, data was collected through interview and analyzed according to four levels of analysis. The interviews were coded line by line, generating a list of responses as drawn directly from the participant statements in the interviews. These statements were analyzed to determine which ones were most frequently used and were then used to create the more refined codes. The refined codes were then organized to create structural framework by creating categories based on the relatedness of the more frequent responses generated from the focused coding phase. Potential categories were thinned to create the list of categories and subcategories to be used for the study as part of the axial coding phase. Finally,
categories and subcategories were reanalyzed alongside the interviews to make sure they reflect the themes and concerns brought up in the interviews to create the final list of categories and subcategories in the theoretical coding phase. This final list of categories will become the global coding list that was applied to create the coding manual. Because some of the questions asked in the questionnaire, like “What training have you had in working with religious issues?” can draw more specific answers than represented by the global theoretical categories, common specific answers to these questions were added to the coding manual to be reported separately.

In the final analysis of the interviews, the specific answers to the specific questions were presented in order to reveal the specific ways the participants understood and addressed religion and spirituality within therapy. Next, the global categories themselves were examined to present the overall themes of the interviews. In doing so, the major themes commonly found throughout the interviews is presented in order to construct a theory of addressing religion and spirituality in therapy as drawn from the collective experience of the participants. Finally, during the interviews, participants were allowed to make additional comments. In the first interview, the participant spoke of needing guidelines, for addressing religion in psychology. In the subsequent interviews, the question of guidelines was asked as part of the additional comments portion. Because of the specific suggestions made about the guidelines, that section would not be coded, but the results are directly presented.
**Coders**

The coding process was undertaken by the investigator and three additional independent coders. The versions of the interview transcriptions that were used for the coding process had all identifying information, such as names and places of business, removed in order to maintain the confidentiality of the participants. The investigator coded all interviews, while the additional coders shared the interviews to code in an even distribution, where each of the three coders took one third of the transcripts. Coders were drawn from a pool of master level mental health clinicians who had an interest in religion and spirituality, and understood boundaries of confidentiality. Coders were given an introduction to the manual, and the coding process was explained to the coders. Contact was kept open between the coders to address any problems that may arrive during the coding process, but care was taken by the investigator not to unduly influence the coders.

**The Coding Process**

Coders were given transcripts of the recorded interview and copies of the coding manual. Prior to being given to the coders, the transcripts were checked to make sure there was no identifying information within their content, and care was taken to make sure coders did not receive the transcript of an individual known to them.

During the actual coding process, coder’s were given the following instructions:

1) Coders were to read the response to a specific question in the interview transcript.
2) Coders were then to read the possible responses listed to the corresponding question in the Coder’s Manual.
3) Using the subcategory descriptions listed with each possible response, coders were to apply the code most appropriate to the theme of the response section. Coders were allowed to use multiple codes.

4) Coders were instructed to continue this process through to question 20.

In addition, the following instructive paragraph was listed on the coder’s manual to remind the participants of the procedure:

Codes are differentiated in this manual by being bold, italicized, and underlined. For each question, read the participant’s response and code the themes that appear in the response. For instance, if, in question 1, the participant mentions that religion is related to interactions in the community, you would write “1.2.a” in the margin next to the response. Write down all the codes that apply, you will often have to use multiple codes. Many of the codes you will see will include the letter “G.” Just write down the code as it applies (e.g. 3.1.G5) in the margin like any other code.

If there was any question as to how a question should be coded, coders were encouraged to refer to the subcategory descriptions. If further clarification were needed, the author would be available for questions.

**Inter-rater reliability.**

Inter-rater reliability of the coding was determined in the analysis of the coding agreements and disagreements between the author and the independent coders. As used by Tonya Lockheart’s dissertation (1998), inter-rater reliability was determined by the formula cited in Miles and Huberman. In this formula, the reliability quotient is generated by determining the number of agreements and dividing it by the total number of agreements plus the total number of disagreements:

\[
\text{Inter-rater Reliability} = \frac{\text{Number of agreements}}{\text{Number of Agreements Plus Number of Disagreements}}
\]
Using this calculation, an inter-rater reliability quotient above 70% would be considered demonstrating high reliability.

When the interviews were returned, one of the sets of the transcripts showed a disproportionate amount of disagreement when analyzed for inter-rater reliability. These coded transcripts were analyzed to see the origin of the variations, and it appeared that the coder over-applied categories, to the point where the reason for many of the codes applied could not be determined by the investigator. One of the other coders was brought in to examine the disputed transcripts, and that coder agreed with the investigator about the irregularities. Because the codes were over-applied, there was concern that not only would it create too many disagreements to be reliable, but that real agreements could not be distinguished from chance agreements. These transcripts were then reassigned to a new coder. Once the coding was finished, there were 351 agreements among 480 total responses, producing an overall interrater reliability of 0.73125 or approximately 73%. With this result, the agreement between the investigator and the remaining coders was considered good.

**Presentation of Data**

The analyzed data has been presented in the results section organized in the categories of: Demographic and Background Information, Defining Religion and Spirituality, Therapists Beliefs on Religion and Psychology, Addressing Religion within Practice, Ethical Considerations, Global Themes, and Guidelines. Data is presented as both the frequency at which categories were endorsed, as well as examples from the
interviews to illuminate participant responses. When the interview responses were used, any identifying information was removed to maintain confidentiality.
Chapter III

Results I

Demographic and background information

Participant sample

The participant pool consisted of twelve licensed psychologists from New Jersey and Pennsylvania. Initially fifteen were contacted, with two not being available and one responding after the limit of twelve participants allowed by the IRB had been reached. This provided a response rate of 80%. Participants had been recruited through a snowball method; appropriate participants were recruited through the recommendations of participants. Of the participants, five of the participants had earned a degree of PsyD, five had earned a degree of PhD, and two had earned a degree of EdD. The participant’s experience as therapists ranged between 9 and 34 years: one participant had been practicing 9 years or less, four had been practicing 10-15 years, one participant had been practicing 16-20 years, three had been practicing 21-25 years, and three participants had been practicing 30-35 years.

Age and Gender

The age of the participants ranged from 44-64 years. Two therapists were of 41-45 years of age, one was 46-50 years of age, five were of 51-55 years of age, two were
56-60 years of age, and two were 61-65 years of age. In addition, out of the twelve participants, five were male (42%) and seven were female (58%).

**Ethnic, Cultural, and Religious Background**

The participants varied in their identified ethnic, cultural, and religious backgrounds. Of the twelve, nine were Caucasian (75%) and three were African American (25%). In addition, four identified as ethnically Jewish (33%), two as Italian (17%), one as Irish (8%), and three as having a mixed background (25%) which included some of those already identified.

When first designing the study, participants were asked about their religious background and upbringing. Of the twelve participants, two identified currently as Episcopal (17%), two identified currently as Jewish (17%), three currently as Baptist (35%), and one currently identified each as Quaker, Catholic, Methodist, Russian Orthodox, and nonspecific Christian (8% each). However, during the interviews, six of the participants (50%) noted that their religious beliefs have changed over the years. Of these six participants, two reported formerly being Catholic, one Episcopalian, one protestant, one Methodist, one Jewish who later converted to a non-Jewish denomination, and one Jewish who converted to a different Jewish denomination, with one participant exploring more than one religion before affirming his or her current religious identification.

Participants were asked to rate their level of identification with their religious upbringing on a scale from 1 to 10, with 1 being the lowest, and 10 being the highest. When the aforementioned participants, who identified a change in religious identity, asked if they should rate their original or current religious identification, they
were told to rate their current religious identification. Overall, all of the participants rated
their identification as 6 or higher, indication a strong identification with their religion,
with four participants (33%) giving their level of identification a rating of 10, two
participants (17%) giving it a rating of 9, two participants (17%) giving it a rating of 8,
three participants (25%) giving it a rating of 7, and one participant (8%) rating it as 6.
The further breakdown of these results of this can be seen in Table 3, categorized by
percentage of each response given. Participants were also asked to rate the importance of
religion in their personal lives, again on a scale of 1 to 10 with 1 being the lowest and 10
being the highest. Overall, all of the participants rated their identification as 7 or higher,
indication that they felt religion was important in their lives, with four participants (33%)
giving their level of identification a rating of 10, three participants (25%) giving it a
rating of 9, three participants (25%) giving it a rating of 8, and one participant (8%)
rating it as 7. The results of this question can be seen in Table 4.

Therapist Theoretical Orientation

The Participants also varied in theoretical orientation and treatment focus. Of the
twelve participants, seven as Psychodynamic (58%), three identified as Cognitive-
Behavioral, one identified as Family and Systems Oriented (8%) and four identified as
integrated or eclectic (25%) including an response to one of the other orientations. In
addition, of the twelve, three specialized in individual therapy (25%), three specialized in
children and adolescents (25%), three specialized in couples therapy (25%), two
specialized in marriage and family (17%), one specialized in eating disorders (8%), one
in group therapy (8%), and one referred to himself as having a general focus (8%).
Summary

1. Distribution of participant degrees:
   - PsyD: 42%
   - PhD: 42%
   - EdD: 17%

2. Distribution of years in practice
   - 9 years or less: 8%
   - 10-15 years: 33%
   - 16-20 years: 8%
   - 21-25 years: 25%
   - 30-35 years: 25%

3. Age distribution of participants:
   - 41-45 years of age: 17%
   - 46-50 years of age: 8%
   - 51-55 years of age: 42%
   - 56-60 years of age: 17%
   - 61-65 years of age: 17%

4. Gender distribution
   - Male: 42%
   - Female: 58%

5. Ethnic/Cultural identity of participants:
   - Caucasian: 75%
   - African American: 25%
   - Ethnically Jewish: 33%
   - Italian: 17%
   - Irish: 8%
   - Mixed background: 25%

6. Religious identification of participants
   - Episcopal: 17%
   - Jewish: 17%
   - Baptist: 35%
   - Quaker: 8%
   - Catholic: 8%
Methodist 8%
Russian Orthodox 8%
Nonspecific Christian 8%

7. 50% of the participants indicated that their religious beliefs have changed.

8. Therapist Theoretical Orientation
   Psychodynamic 58%
   Cognitive-Behavioral 25%
   Family and Systems Oriented 8%
   Integrated or Eclectic 25%

9. Therapy Specializations
   Individual therapy 25%
   Children and Adolescents 25%
   Couples therapy 25%
   Marriage and family 17%
   Eating disorders 8%
   Group therapy 8%
   General focus 8%

Table 3
Level of Identification with Religious Upbringing

<table>
<thead>
<tr>
<th>Level</th>
<th>Responses of All Participants</th>
<th>Responses of Participants Who Reported a Change in Religious Identification</th>
<th>Participants Who Did Not report a Change</th>
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Table 4
Importance of Religion in Own Personal Life

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<th>Responses of All Participants</th>
<th>Responses of Participants Who Reported a Change in Religious Identification</th>
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Bar chart showing the distribution of responses for each category.
Chapter IV

Results II

Defining Religion and Spirituality

In order to answer the problem generated in constructing a valid definition of religion and spirituality for the purpose of this study, participants were asked for their understanding of the terms. Though this question was not intended to create a comprehensive definition of religion and spirituality, the results will act as the conceptualization of religion and spirituality for this study. Eight of the twelve participants (67%) conceptualize religion and spirituality as being separate entities. One of the participants (8%) did not create a distinction between religion and spirituality.

Personally, I don’t make a distinction between the two in my life. I think when people identify with a religion; it’s sort of saying that their spiritual beliefs line up line up with the characteristics with that individual religion. (Interview 11)

Three of the participants (25%) conceptualize religion and spirituality as being intertwined.

Well, I think a person’s religion is based upon a particular area where they choose to identify with a specific religious organization, such as catholic, protestant, Episcopalian, Baptist, etc., etc. Spirituality is one’s relationship with the higher power and the degree to which it is in their lives. They are intertwined, but one could be a particular entity within a religious factor and not necessarily adhere to the doctrines it happens to have. Yeah, it has a slight distinction between the two. (Interview 3)

One participant (8%) conceptualized them as being separate and intertwined.

Religion is more connected with organizations that have evolved to bring people together in their spirituality. But sometimes can be a little devoid of spirituality at
There were a number of ways religion was conceptualized by the participants.

Eight of the twelve (67%) defined it as being related to organizational institutions.

I view religion as being more of an organized person driven entity that professes certain beliefs and faiths and what not, as more of a human organizational structure with certain rules and regs. (Interview 5)

Two of the participants (17%) defined religion as being based in community interactions.

And religion I think of as more organized, institutional, practice and a place of coming together and I guess I would say more institutionalized practices and opportunity for people to come together and act on their faith. (Interview 2)

Two of the participants (17%) defined religion as being a body of collected faith and knowledge. One participant defined religion as a medium of faith (8%).

Spirituality was also conceptualized in a number of ways. Five of the twelve participants (42%) defined spirituality as related to an individual’s personal expression of faith and belief.

I view spirituality as being more about how you live out what you believe. And something I think cuts across certain faiths, I think, whether it be Jewish, Christian, Muslim, or even other denominations, Buddhist… I think there is an element of spirituality that runs through all of those faiths that I think is rather consistent and positive in practice in the true sense of the word. (Interview 5)

Four of the participants (33%) defined spirituality as a relationship with a higher power.

I think I define spirituality as belief in a higher power. Something greater than one’s self that has some control and design in terms of how the world is organized and responsibility for how things work (Interview 2)

Two of the participants (17%) defined it as it being based on an individual’s personal experience.
Summary

1. The participants were asked if they make a distinction between religion and spirituality. Their responses were that religion spirituality were:

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<tr>
<td>The same</td>
<td>8%</td>
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<tr>
<td>Different from each other</td>
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<tr>
<td>Intertwined</td>
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<td>Different but intertwined</td>
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2. The participants were asked to define the concept of religion. Their responses indicated that religion is conceptualized as:

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<tr>
<td>Community based</td>
<td>17%</td>
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<tr>
<td>An organized institution</td>
<td>67%</td>
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<tr>
<td>A body of collected belief and knowledge</td>
<td>17%</td>
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<tr>
<td>A medium of faith</td>
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3. The participants were asked to define the concept of religion. Their responses indicated that religion is conceptualized as

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<tr>
<td>Personal expression of faith and belief</td>
<td>42%</td>
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<tr>
<td>Based on personal experience</td>
<td>17%</td>
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<tr>
<td>A relationship with a higher power</td>
<td>33%</td>
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Chapter V

Results III

Therapist Beliefs on Religion and Psychology

The purpose of this section is to look at how the participants conceptualize bringing religion and spirituality into therapy. This section is intended to examine what roles religion and spirituality can play in a client’s life, what roles they can play in therapy, and what are some of the benefits and problems that can arise. In addition, this section aims to look at the training participants have had in addressing religion in therapy, how they differentiate psychopathology from religious beliefs in the therapy setting, and how religious and spiritual beliefs are conceptualized in the therapy setting.

The participants in the study reported various roles for religion and spirituality in the life of their clients. Six of the participants (50%) reported that the importance varied from client to client.

I think it varies with the client. For some people it’s essentially important, and for some people, it’s not even on their radar. And so there is really a wide spectrum. And to even make the question more general: To what degree is religion or spirituality a part of a human being’s life? And also that runs the spectrum. It can be a source of… it can be an asset, it can be something that people draw from and it really helps them through, and it can be the opposite, I think people can feel oppressed by their religion. (Interview 9)

Four of the participants (33%) noted that religion and spirituality provided sources of positive psychological resources for their clients.

I think religious practice, and/or spirituality, can help ground a person in their lives, which can be chaotic, which can be disturbing, meaning their lives can be
that way. And it can help people deal with very disturbing affect, and the experiences that they go through every day. Some people deal with it by intellectualization, and they can go into their head, and have a lovely model for organizing their thoughts. And other people, I think, who are not as left brain, don’t use language in that way, can find religion and or spirituality holding in a way that language doesn’t allow them or that they don’t have access too. (Interview 7)

Two of the participants (17%) reported that religion and spirituality aided in the development of the client’s world view.

It is certainly part of their information, so it is part of their upbringing, their relationship to their families, their relationship to their community, their lack of relationship to a community. It is part of what guides them in making decisions, and sometimes this is in their awareness, and sometimes this is not in their awareness. (Interview 6)

Two participants (17%) reported that religion and spirituality connected their clients to others, and one (8%) noted that religion and spirituality can be a source of potential stress and conflict in a client's life.

The participants also reported several roles religion can play in therapy. Four (33%) participants reported that a client’s religious background can provide important information about the client’s world.

The way that a client makes use of spirituality can be really informative to a therapist, because what a therapist can learn from that is how a person thinks in relation to the world and many other things. (Interview 7)

Four participants (33%) saw the client’s religious participation as a source of potential positive resources.

Kind of what I alluded to that sometimes spiritual beliefs can encourage people to go further. I can remember back in graduate school and was working on the inpatient unit, I was working with a woman with agoraphobia, and she was a very spiritual woman. I did like the normal kinds of behavioral work with her with her agoraphobia. And in addition to the relaxation, I added a prayer dimension, to get her in touch with herself and her spirituality, and that really boosted her ability to make it through different steps, so that she was able to leave the hospital and function well. Kind of synergistically.
Two participants (17%) reported that religious identity, like ethnic or sexual identity, needs to be understood as part of the client.

I was thinking about that in some ways, and I liken religion to, for example, cultural background. It’s an aspect of someone’s life, maybe different than mine, but I think that working with basic principles within that culture, I see the same thing with religion. (Interview 5)

One therapist (8%) reported that the level of importance varies from client to client, and one (8%) reported that discussing a client’s religious beliefs can enhance the therapy process.

A number of potential benefits for addressing religion in therapy were reported. Four participants (33%) reported that addressing religion provides the therapist important information about the client’s identity and world.

I think it can be beneficial to understand the person, and understand the world and their concept and their upbringing, and their internal dynamics, and the way they relate to their world, so in that way, I think it can be really good, and it can be supported as I talked about (Interview 11)

Three participants (25%) reported that the religion provided sources of meaningful connection for clients.

Sometimes people are searching for something bigger than themselves, and sometimes people who are socially isolated, I will talk to them about joining a church or joining a synagogue, because that is a healthy family like environment, and that is more for religion than spirituality. And I wouldn’t ask that of someone who is more of the Universalist Unitarian mindset to go to a Roman Catholic Church and vice versa (Interview 9)

Three participants (25%) reported that discussing religion can directly enhance therapy.

I find religion and spirituality to be extremely helpful when you are working with somebody and you are at a loss. Strategies and techniques you use don’t seem to be connecting. Often times when I have run out of things to bring to the table in terms of the therapeutic intervention or trying to understand the person, I’ll ask
them about their faith, because one’s faith can tell you a lot about that person. In an extreme case that can be helpful (Interview 5)

Two participants (17%) emphasized that there might be a benefit, but that benefit depends on the clients own level of belief. One client (8%) reported that religion can act provide positive psychological resources for the client.

Religion can also hinder the therapy process in a number of ways. Four of the participants (33%) warned that addressing religion can be a hindrance if it does not match with a client’s beliefs.

I think that I is not beneficial when a person has had a bad experience with religion and is opposed by it or has been turned off by it, or somehow bringing that in… you end up losing the client (interview 10)

Four of the participants (33%) mentioned that some religious beliefs can interfere with therapy.

I think it can be a hindrance sometimes when that is all there is that is being discussed in the room. I think can be a hindrance when clients kind of conceptualize things as fate, or predestined, or feel they have no interactive power with their religion. It’s not kind of like a partnership with God, like kind of God controls everything about this, or like “I’m doomed” or whatever, when it slows down the process of their growth, or there is no way to talk about anything else or how it relates to the world, I think that can be a problem (Interview 11)

Two of the participants (17%) reported that religion can be a source of stress and conflict.

I think one needs to be extremely cautious just because someone expresses that religion is important in their lives, sometimes they can think they have been condemned because of what went wrong, whatever happened, whatever malady they are experience, or traumatic event, or whatever the case may be. And I think it’s a fine line, and you have to be astute enough to pick up when to bring in religious overtones into a particular session, because it could be detrimental to the client. And you have to be very, very careful (Interview 3)

Two of the participants (17%) reported that addressing religion can be dangerous when the therapist begins to push his or her beliefs in the therapy.
When asked about the line drawn between religious belief and psychopathology, the participants gave the following insight. Four of the participants (33%) that the differentiation between religion and psychology is a very nuanced determination.

As a psychologist, I have to take all the information I receive from a client into context. Example: Someone in their mid-40’s, who comes to me with depression, no history of any psychotic episodes in the past, and they feel that people from their past, loved ones that are deceased, sometimes they see or hear them in dreams, or they may actually see visions of them. I don’t dismiss that as being psychopathology, because I know people in my personal life who have had those experiences. My stepfather was a psychologist and had a very strong spiritual foundation in his life and believed that he did not necessarily preach in therapy. I listen to… most religions tell you to do good things. Treat yourself well and treat others well. If someone is saying “I hear voices and god is telling me to do…” something that seems pretty inconsistent with the faith, that’s a red flag. (Interview 5)

Four participants (33%) believed that beliefs are pathological when they interfere with treatment by supporting pathology.

That is really dealt with on an individual basis. I do believe that the breadth of religious experience is very, very large, and that breadth has to be tolerated. When that breadth becomes psychopathology, is when it acts in the interest of an underlying morbidity, such as anxiety, depression, paranoid delusional systems, and less in the service of the spiritual life of the patient (Interview 1)

Two of the participants (17%) stated that religion becomes pathological when it impedes the healthy functioning of the client.

It’s very interesting, because I have also worked with a lot of very chronically mentally ill people, and I never really thought about it this concretely, and I guess the line would be that it becomes pathological when the person stops growing, and stops living. When it impedes their ability to stop functioning, and impedes their ability to have relationships, and it impedes their ability to grow. Then I would say that would be pathological in terms of my definition. I don’t think that would be very concrete, but that’s where every person’s different. But that is where I would see it as pathological.

Investigator: when you say “grow” can you say a little more about what you mean by “growing?”

Participant: like continuing to develop as a person, like maybe its developing concrete skills like saying “hello” as see another person in the hallway, somebody who is schizophrenic to have interactions to take steps getting a job. For another
person, growth may be understanding their internal dynamics, their relationships, taking care of themselves, exploring their creativity, thinking about themselves. So stunting that, depending whatever their level is at, stunting that I would see that as a problem, and growth would be whatever trajectory (Interview 11)

Two of the participants (17%) stated that beliefs can be pathological when they are overly rigid.

Six of the participants (50%) reported that they had no formal training in addressing religion in psychology. Seven of the participants (58%) reported that their training in working with religious issues came from their own religious practice and experience. Two participants (17%) reported that they have taken formal courses in religion and psychology. Two participants (17%) reported taking continuing education classes that dealt with religion and psychology. Two participants (17%) reported consuming research that dealt with religion and psychology. One participant (8%) learned through consultation when faced with issues of religion and psychology.

Therapist conceptualized religion in the therapy setting in a number of ways. Five of the participants (42%) viewed religion as being part of the client, similar to ethnic or sexual identity. Four of the participants (33%) viewed the client’s belief as a source of important information on the client’s world.

I look at their upbringing, like if they were taught in a very formal way or if they had a formal religious education, then I look at in a way of looking at family dynamics when they were growing up, what the family system was, and how those formal beliefs actually played into family functions and what they believed. And the person took from it, what they agreed with, and didn’t agree with, how it functions in their life. I see it as a fluid component… component is too boxy. I see it as a fluid thing that streams through a person’s life, both consciously, and unconsciously (Interview 11)

One participant (8%) looked to see how the client’s beliefs could be brought in to enhance therapy. One participant (8%) assessed to see if the beliefs are consistent with
known psychological principles, integrated within the health of the individual or pathological.

**Summary**

1. When participants were asked about the role of religion in a client’s life, they responded that:
   - The role and level of importance depends on the client: 50%
   - Religion provides influence on identity formation: 17%
   - Religion is a source of positive psychological resources for client: 33%
   - Religion can be a source of harmful stress and conflict: 8%
   - Religion can connects the client to others: 17%

2. Participants were asked about the role religion can play in therapy. Their responses indicated that:
   - The level of importance depends on the client: 8%
   - Religion provides both information on client’s world: 33%
   - Religion can be a source of positive psychological resources for client: 33%
   - Religious identity, like ethnic or sexual identity, needs to be understood as being part of the client: 17%
   - Discussing client’s religious beliefs can enhance therapy: 8%

3. Participants were asked when addressing religion can be beneficial to therapy. In response, the participants noted:
   - The level of benefit depends on the client: 17%
   - Religion provides both influence and information on the client’s identity and world: 33%
   - Religion can be a source of positive psychological resources for client: 8%
   - Religion can connects the client to others: 25%
   - Discussing the client’s religious beliefs can enhance therapy: 25%

4. Participants were asked about when addressing religion in therapy can hinder the therapeutic process. The participant responses indicate that addressing religion can:
   - Be a hindrance if it is unimportant to the client or of the beliefs discussed are not matched to the client’s beliefs: 33%
   - Be a source of harmful stress and conflict: 17%
   - Hinder therapy when beliefs interfere with treatment: 33%
   - When the therapist pushes beliefs: 17%
5. Participants were asked how they differentiate a client’s religious beliefs from psychopathology when working with religion in therapy. According to their responses:

- Beliefs can be pathological when they interfere with treatment: 33%
- Religious beliefs can interfere with therapy when they are rigid and inflexible, or certain: 17%
- Religion becomes pathological when it impedes health functioning: 17%
- The differentiation between religion and pathology is a very nuanced determination: 33%

6. Participants were asked about the training they have had in working with their client’s religious beliefs in therapy. Participants reported that they had received training through:

- No formal training: 50%
- Specific courses in religion and psychology: 17%
- Personal religious practice and experience: 58%
- Continuing education: 17%
- Supervision: 17%
- Consultation: 17%
- Consuming research in religion and psychology: 17%

7. When participants were asked how they conceptualize the religious beliefs of their clients, they responded that:

- Client beliefs provides influence and information on client’s world: 33%
- Religious identity, like ethnic or sexual identity, needs to be understood as being part of the client: 42%
- Discussing client’s religious beliefs can enhance therapy: 8%
- They assess if the beliefs are consistent with known psychological principles: 8%
Chapter VI

Results IV

Addressing Religion within Practice

The purpose of this section is to gain some insight into the practical ways that the participants address client religious and spiritual beliefs in therapy. In this section, participants were asked about how often they address religion, how they address religion, who brings up the discussion, how religious belief is assessed, how they determine the appropriateness of addressing religion, and specific techniques or methods used. In addition, participants were asked to provide examples of when religious beliefs both complimented and negatively affected the mental health of the client.

The frequency at which participants addressed religion within their practice varied among the participants. Three of the participants (25%) reported addressing religion 10-20% of the time. One participant (8%) reported religion being addressed 20-40% of the time, one participant (8%) reported addressing religion 41-60% of the time, and one participant (8%) reported addressing religion 61-80% of the time. Two of the participants (17%) reported addressing it when the client would bring it up directly or indirectly. Two of the participants reported (17%) asking about religion beliefs directly during intake. Two of the participants (17%) reported addressing it if they know religion is important to the client.
When asked about how religion is generally addressed in therapy, participants reported a variety of ways they address religion. Five of the participants reported (42%) discussion religion as it was brought directly or indirectly by the client. Four of the participants (33%) reported utilizing clinical techniques such as asking questions, listening, and reflection.

I do talk therapy, so we talk. And I try to talk within the parameters of what they give me, so I work within the confines of what they tell me. Again, if someone comes to me specifically, and I ask them those questions, I’ll address it other ways. (Interview 12)

Two of the participants (17%) reported addressing religion as a means of uncovering information about the client’s identity and world view. Two of the participants (17%) reported praying for a client.

The people I have prayed with usually are the more religious, who are actively talking about it throughout the whole session. Usually they are feeling close to God, but, like in one particular case, he is going through a divorce and he can’t quite see his way clear to divorce his wife, but she is actively pursuing it, I will close the session with prayer, just bringing God’s presence into the session, but also as an encouragement. (Interview 10)

One participant (8%) reported addressing religion as it pertains to the current issues in therapy.

Participants varied on who introduced the topic of religion into the therapeutic process. Four of the participants (33%) wait for the client to bring up the topic of religion. Three of the participants (25%) will introduce the topic. Three of the participants (25%) reported that the topic of religion can be introduced either the therapist or the client in their practice. There are also a number of ways that religion is first introduced into the therapeutic environment. Two of the participants (17%) specifically ask about religion in intake. Two of the participants (17%) reported discussing it as the client brought it up.
Two of the participants (17%) reported they will introduce the topic if they think it can contribute to the current therapy.

The participants use a number of different assessment strategies when assessing a particular client’s religious and spiritual beliefs. Six of the participants (50%) reported having no formal assessment tool or process. Three of the participants (25%) ask about religion in a formal clinical interview. Three of the participants (25%) ask about the client’s beliefs as they come up in the therapeutic conversation. Two of the participants (17%) reported that they listen for and accept the client’s religious or spiritual beliefs, but do not assess them in any way. One participant (8%) reported looking for verbal clues in conversations. One participant (8%) reported looking for nonverbal clues in conversations. As for what is actually asked about when assessing the religious and spiritual beliefs of a client, three of the participants (25%) specifically ask about the client’s beliefs, three (25%) as about the beliefs of the client’s family, and if those beliefs are different from the client’s, two (17%) ask about formal religious affiliation, two (17%) ask about the client’s level of religious commitment, two (17%) ask about the role of religion and spirituality in a client’s life, one (8%) asks about the formation of the client’s belief system, one (8%) asks about the level of active participation, and one (8%) asks about the partner beliefs and if those beliefs are different from the client’s beliefs.

When determining the level of appropriateness of introducing the topic of religion into the therapy process, participants utilize a number of different strategies. Four of the participants (33%) reported using their clinical judgment to determine the appropriateness for a particular client.

The appropriateness is based on how helpful it can be in the therapy, if it is respectful of boundaries, or if in any way I feel it could be harmful for the patient.
or of it could be harm for any reason. The thing is “do no harm” the best principle is “what’s in the best interest of the patient” and to the degree that it answers that question is the degree to which I will use it: if it is beneficial to the patient, if it is respectful of boundaries, and it doesn’t impose my beliefs, it’s appropriate. If it meets those requirements it’s appropriate, and if it doesn’t meet that criteria, then I back off from that because I think that its less appropriate. (Interview 4)

Four of the participants (33%) reported waiting for the client to bring religion into therapy either directly or indirectly.

It had to do with the degree to which it is part of their everyday life and part of their history. For example, if a male comes in and tells me a great deal about growing up in the Catholic Church, I might follow that up and ask if he had any uncomfortable experiences with a priest. So I will follow up in that way, but really I’m waiting for the client to initiate (Interview 3)

Three of the participants (25%) reported that the appropriateness is based on the level of importance of religion or spirituality in a client’s life.

I might mention something, but generally I wait for them to bring it up. And then I assess their response. If it immediately strikes a chord, and they start talking more, then I allow them to talk about it, I don’t pursue it. And for whatever reason it doesn’t strike a chord, then we don’t talk about it at all. (Interview 10)

Two of the participants (17%) reported that the topic of religion is not appropriate if the client shows any signs of resistance or discomfort to the topic.

If the patient presents explicit resistance, I immediately back off. I don’t process resistance when it comes to exploring religion or spirituality. (Interview 1)

Two of the participants (17%) reported that the topic of religion and spirituality is not appropriate if those beliefs are part of the client’s pathology.

Participants were asked if there were any specific methods or techniques that they would use when addressing religion or spirituality in the therapy setting. Five of the participants (42%) stated that they did not use any formal methods or techniques. Two of the participants (17%) used specific techniques from religious practice in therapy.
Sometimes I have suggested to people to memorize a verse, or listen to religious music if I have decided in the combination that it seems appropriate, or those who just spend time reading scripture every day, or praying every day, I’ve suggested to people going on a retreat, where part of it would be a spiritual component, and part of it would be meditative. Where they just need to calm themselves down, and if the religious environment is calm and safe, then they stay within that kind of environment.

(Interview 10)

Two of the participants (17%) would introduce the topic and see how the client would respond. One participant (8%) would utilize limited self-disclosure. One participant (8%) would inquire about the level of expressed faith. One participant (8%) would use the therapeutic discussion to address issues related to religion and spirituality.

During the interviews, participants were asked directly about instances in therapy where a client’s beliefs were complimentary to principles of mental health. Participants gave response that were both direct narratives of the therapeutic experience, as well as responses discussing general thematic issues. A few direct narratives were given by the participants. Two of the narratives discussed issues relating to how therapists were able to use religious investigation to aid on identity formation. In the first of these narratives:

A client was raised in a mixed Christian/non-Christian household. The religious ambiguity is consonant with her identity ambiguity, and the beginning of Christian formation in that person represented identity consolidation and that identity consolidation has taken the form of choosing a particular religious Christian tradition, mainline Christian tradition, and then beginning the process of education for baptism, which has consolidated an identity separate from her family, which represented a very important individuation and separation activity.

(Interview 1)

Another participant offered another story of developing identity through religious investigation:

In one case, there is someone who I’ve worked with for a number of years. Really, he came in here when he was finishing college. His issues were so focused on identity, not knowing who he was, and feeling confused. And he was very open person, very creative, he was a writer, and he started quite recently using
new age kind of spiritual practices to tap his talents, his sort of right brained talents, because he was a very intuitive person. And that was really a really wonderful way of tapping resources to strengthen his sense of identity. And so here we are using, what we know in psychology is the connection of brain and body, and through the work that we did in focusing on his body, and telling in when he was stressed, he was able to open up and use some other resources and practice and learn some spiritual practices to further his development. And he did a sweat lodge, he trained in some kind of tarot reading, or something like that, and it really helped to connect him and open him up and it really served to connect him with his own development. This was a way for him to individuate, separate from his own family where there was… very chaotic. His father was a really tough guy and he was a very sensitive kid who was terrified by his dad who was a raging maniac, who was a very frightened man who raged a lot and terrified his kids. And he didn’t have a way as a sensitive person to identify or develop his own male identity. And through his opening up to this sense of spirituality, he was able to separate and individuate from his family origin while still maintaining contact with them. (Interview 7)

In another story, another participant described how bringing in religious themes, such as forgiveness, helped to contextualize an important therapeutic intervention:

A couple came in and they were really wanting to explore whether they would continue their relationship because the wife had had an overnight involvement with another man, as it turns out in reaction to the husband, she thought, having an affair with someone. The husband was operating with a double rule, and it was rather blatant. He was having fairly angry, and kind of shut down, and was ambivalent about even continuing or competing that initial session. It was apparent that he was struggling with the issue of forgiveness, though we had a discussion about forgiveness, and he took the lead in terms of taking about his own prior experience of wrongdoing in some major ways, that had nothing to do with affairs. But he talked about how his wife had forgiven him even, but of even greater importance was his sense that God had forgiven him. So we had spent a great amount of time talking about that experience and what was blocking him from forgiving his wife, and I would recall that there was discussion about ways of knowing, and how do you know when God is speaking to you, and his definition and his beliefs about these things, if I recall, there was some task along his line of praying for an answer, and kind of going inside and searching his own heart and exploring what God would want to do, and what was consistent and what was inconsistent, and the value that he placed on forgiveness, and what did it mean to him if God could forgive him, but he could not forgive someone else. Without preaching. It’s just exploring his own perspective of it, and he was able to make some real movement between the first session and the second session. It turned out that he had never had that discussion of forgiveness… forgiveness with himself, with anyone before. He had actually been incarcerated, and had been
working in a space where nobody had a clue about his background and so, it just opened up a lot of issues for him (Interview 2)

One interviewer offered an example of how discussing religious beliefs could help to challenge maladaptive beliefs.

I use to do crisis intervention and emergency mental health for a number of years, and often times we would go out to the homes of those in mental health crisis and I am thinking of this one particular case where this one woman did not believe in taking medication, that religion, her faith would heal her. Now there are some people with such a strong faith that that may be it, but if that weren’t the case, then we wouldn’t be there, if it wasn’t something going on that was problematic. And I remember asking that person their religion, and it was Christian, but I said “you know Jesus used medication to heal” and they said “how is that?” “Well, what is medication? By mouth or it could be topical. When he healed people who were blind, often times he spat in a paste and put it over their eyes and made them wash it out. That could be an example of a topical intervention, a medication. The medication we know it may be a bit more synthetic, but it is based on natural substances,” so there are instances where certain psychological practices, though this is more psychiatric, the notion that an intervention that can help change someone’s functioning like that is seen as consistent. (Interview 4)

Another narrative offered by a participant illustrated supporting a client’s belief can keep them connected to necessary psychological resources:

What we also know about psychology, is the case of the orthodox Jewish woman I mentioned, is that, again, brain/body, this is a very anxious woman who need lots of rules in order to survive in the world/ she needed lots and lots of structure, because I think she must have had some sort of non-verbal learning disorder, and I tried to have her follow that through, but it didn’t fit within her life to have that assessed. And so, what we know about religion is that it has a lot of rules, and for her it is very holding, because we say “this is what we do” and the rabbi says this and I do this and it really held her. And we know in psychology that there are certain temperaments and certain neurobiologies that require structure and she found something, she was born into it that worked for her. As an outside observer, I think it restricted her because of the way she… but it was also good for her because it was a structure for her, and it also gave her access to a community because she was a very nervous and hard to get along with person and she had a built in community through her synagogue. It was a beautiful thing. And so it helped to connect her. (Interview 7)
In addition to the narratives, there were some general themes of how the religious beliefs of the clients complemented known mental health principles. Six of the participants (50%) noted that religion provided a source of positive psychological resources for the client.

When it is a source of community, when it is a source of coping, and they feel very comfortable with their religious leader, to consult that person, and when it has happened that that person has even made a referral to me, perhaps, and is psychologically minded. If it’s good it can definitely compliment therapy. If it’s about being healthy, being strong, and finding a reason why they are suffering and it does not need to be despair, and does not need to be guilt and shame inducing, it absolutely can be beneficial (Interview 6)

Five of the participants (42%) reported that discussion the client’s religious beliefs were able to enhance the therapy. Four of the participants (33%) reported that the client’s religious beliefs connected the clients to a beneficial community. Three of the participants (25%) reported that the client’s religious beliefs provided important information and influence on the formation of the client’s identity and world view.

Participants were also asked about instances where a client’s religious or spiritual beliefs have contradicted what we know about mental health. The responses to this question also contained both narrative and general thematic information. In one narrative, a client was using his beliefs in a way that interfered with the therapy.

I’m thinking about one couple where… where there was some concern about the level of time and commitment to the relationship vs. quoting bible verses and the church and that kind of active involvement. The husband had asked for a Christian therapist, which is always a question to me of “what does one exactly mean by that?” And he walked through the door with his bible. And I recall this guy, and I think people can, in general, sometimes be selective of certain thing in the bible to justify his position. When again, folks can contextualize things to their advantage when there can be multiple way of interpreting… it’s not up to me to decide what is right and what is wrong. But then again create a forum where they can at least take a look at that and broaden their perspective on…come to better understand how they have gotten themselves locked into this one
Perspective. And look at the inconsistencies in their own value system, and their own actions. (Interview 2)

In a second example given by a participant, the religious beliefs of a client’s guardian were harming the development of the client.

I have had clients who lived in homes… I recently dealt with a 17 year old boy living in a foster home. The 17 year old boy had bulimia and was referred to me by a service agency. His sexuality was emerging, and when his preference had become known to his home placement, he was vilified by the woman living in the home who was also a minister, and, not my religious belief, but the religious belief of the home in which he was living, was very counter-productive to his mental health, and ego-syntonic expression of his sexual preference. (Interview 1)

In addition to these narrative examples, the participants reported general themes involving client religious or spiritual belief coming into conflict with mental health principles. Five of the participants (42%) reported instances where the client’s religious life was a source of stress and conflict for the client.

When they get into this whole scenario of excessive guilt or complicated guilt, and then they think again that they are being punished because of something that went on. So that could be a bit of a downer because one of the anchors that people may have held onto will suddenly become fleeting. Think about this, if one of your anchors or pillars begin to dissipate, that is not a pleasant feeling if there is a trauma that may have occurred in that person’s life. (Interview 3)

Three of the participants (25%) reported that the client’s religious beliefs were interfering with treatment.

If it’s reinforcing something that is just detrimental to the person, like a Christian scientist, or like a person other people might consider, medicine of the devil, and God’s going to heal this. And it not good to reinforce this, and it’s not in keeping with the faith tradition or the healing tradition or scripture. And you would try to point out that god gave us a brain, and reason and that the two can co-exist, and we have brains, and we have people who have developed this and they have done the research and have taken this are healed from this and I don’t think that’s what God intends at all. (Interview 12)

Two of the participants (17%) reported instances where a client’s beliefs were overly rigid and inflexible.
I think that people who are very rigid in their religious beliefs that they cling to them despite the fact that it torments them that would be contrary to mental health. (Interview 10)

One of the participants (8%) noted specific conflicts between sexuality and religion. One participant reported (8%) an instance involving a level of obsession that interfered with the client’s life. One participant (8%), reported cases of belief causing harm to self or others. One participant (8%) reported that religion and psychology conflicts where there is a misunderstanding of the religious beliefs.

As part of this question, participants were asked how they resolved these conflicts as they arose. Two of the participants (17%) reported resolving the conflicts by encouraging the client to engage in religious exploration.

I may do some investigation and talk to people and find out ways in which they can be more mentally healthy. Like in terms of homosexuality, there is… it’s sort of an opinion that the actual act, not being a homosexual, is sinful, but here are others who feel and those who don’t believe that, and most Catholics don’t know that this is more of an opinion than a fact that their son or daughter who is homosexual is going to hell. So sometimes its education, sometimes its faith, sometimes, its expanding the focus, sometimes its searching within themselves, if there is good leaders in the area they are familiar with, its having them have a conversation with a religious leader who help them explore it in a religious way. (Interview 11)

One of the participants (8%) noted that she remained respectful of the framework provided by the client’s beliefs, but that she also carefully challenged the beliefs.
Summary

1. Participants were asked about how often religion is discussed in their practice. They responded that:

   Religion is discussed:
   - 10-20% of the time: 25%
   - 21-40% of the time: 8%
   - 41-60% of the time: 8%
   - 61-80% of the time: 8%

   Religion is discussed if the client brings it up: 17%

   The client’s religious beliefs are asked at intake: 17%

   Religion is discussed if it is important to the client: 17%

2. Participants were asked about how they addressed religion in therapy. They reported that they:

   - Asked about the client’s beliefs in intake: 8%
   - Assessed the connection between the religious beliefs and the current issue: 8%
   - Assessed the client’s beliefs using good clinical techniques: 33%
   - Prayed for or with client: 17%
   - Looked towards the client’s beliefs for influence and information on client’s identity development and world: 17%
   - Discussed religion if the client brought it up: 42%

3. Participants were asked about who brings up the topic of religion in therapy, and how this is brought up. The participants responded that:

   - The therapist brings it up: 25%
   - Both the therapist and client bring it up in therapy: 25%
   - The therapist waits for client to bring it up: 33%
   - The client is asked about his beliefs at intake: 17%
   - The therapist will ask about the client’s religious beliefs if at a loss or if it can enhance therapy: 17%
   - Religion is discussed if the client brings it up: 17%

4. Participants were asked about how they assessed the client’s religious or spiritual beliefs in therapy. The participants reported that:

   - They had no formal assessment: 50%
   - They look for verbal clues: 8%
   - They look for nonverbal clues: 8%
   - They ask in discussions: 25%
   - They ask in formal clinical interviews: 25%
   - They remain open to hear and accept anything the client says, but they do not “assess”: 17%
When assessing, the participants ask about

<table>
<thead>
<tr>
<th>Topic</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Beliefs</td>
<td>25%</td>
</tr>
<tr>
<td>Affiliation</td>
<td>17%</td>
</tr>
<tr>
<td>Formation of belief system</td>
<td>8%</td>
</tr>
<tr>
<td>Level of participation</td>
<td>8%</td>
</tr>
<tr>
<td>Commitment</td>
<td>17%</td>
</tr>
<tr>
<td>Role in life</td>
<td>17%</td>
</tr>
<tr>
<td>Family beliefs, and if those beliefs are different from the client’s</td>
<td>25%</td>
</tr>
<tr>
<td>Partner beliefs and if those beliefs are different from the client’s</td>
<td>17%</td>
</tr>
</tbody>
</table>

5. Participants were asked how they determine if it is appropriate to address a client’s religious beliefs in therapy. Participant responses indicate that:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>The level of appropriateness depends on level of importance depends on the client</td>
<td>25%</td>
</tr>
<tr>
<td>They discussed a client’s beliefs if the client brings it up</td>
<td>33%</td>
</tr>
<tr>
<td>The appropriateness based on clinical judgment</td>
<td>33%</td>
</tr>
<tr>
<td>Discussing the beliefs is not appropriate if client shows discomfort or resistance</td>
<td>17%</td>
</tr>
<tr>
<td>Discussing the beliefs not appropriate if they are apart of pathology</td>
<td>17%</td>
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</tbody>
</table>

6. Participants were asked what techniques or methods they used when addressing religion in therapy. Participants responded that they:

<table>
<thead>
<tr>
<th>Technique</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used no techniques</td>
<td>42%</td>
</tr>
<tr>
<td>Used limited self-disclosure</td>
<td>8%</td>
</tr>
<tr>
<td>Assessed using discussions or interviews</td>
<td>8%</td>
</tr>
<tr>
<td>Assessed how the client responds to the topic of religion</td>
<td>17%</td>
</tr>
<tr>
<td>Looked for the level of expressed faith</td>
<td>8%</td>
</tr>
<tr>
<td>Used specific religious interventions</td>
<td>17%</td>
</tr>
</tbody>
</table>

7. Participants were asked to think up an instance or instances where a client’s religious beliefs have been complimentary to what we know about mental health. In addition to specific narratives, participants noted that religion compliments mental health by:

<table>
<thead>
<tr>
<th>Compliments</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing influence and information on client’s identity and world</td>
<td>25%</td>
</tr>
<tr>
<td>Providing a source of positive psychological resources for client</td>
<td>50%</td>
</tr>
<tr>
<td>Connecting the client to others</td>
<td>33%</td>
</tr>
<tr>
<td>Enhancing therapy</td>
<td>42%</td>
</tr>
</tbody>
</table>
8. Participants were asked to think up an instance or instances where a client’s religious beliefs have been contradictory with what we know about mental health. In addition to specific narratives, participants noted that religion came into conflict with mental health:

- As a source of harmful stress and conflict: 42%
- By interfering with treatment: 25%
- By being rigid and inflexible, or certain: 17%
- With issues involving sexuality and religion: 17%
- When beliefs lead to harm of others or self: 8%
- When there is a level of obsession that interferes with life: 8%

The contradictions have been solved through:

- Encourage religious investigation: 17%
- Respecting the framework provided by the beliefs and challenging carefully: 8%
Chapter VII

Results V

Ethical Considerations

This section was intended to look at the ethical issues that might arise when working with religion in therapy. Participants were asked about ethical issues involving competence, integrity, responsibility, respect for dignity and autonomy, concern for client welfare, and concern for social welfare.

Participants were asked about issues of competency when addressing client religious beliefs in psychology. Four of the participants (33%) reported that therapists need to be aware of their own limits when working with a client’s beliefs.

I think that to the degree that a therapist or psychologist… well I think that when one is doing therapy, with somebody, I think that I am doing psychotherapy, and that drives what I do. I think you have to be clear with your patient what your role is. When I am working with somebody, before I bring up anything to do with spirituality, I tell them I am a psychologist, I am speaking from the point of view of a psychologist. I am not a minister, not a preacher, I don’t profess to be an expert with special training in this area. So I make it clear to the person what my role is, and to some extent that speaks to a level of competence. So I lay the groundwork of that upfront. (Interview 5)

Two of the participants (17%) related religious identity to ethnic or sexual identity, and that religious competence was similar to maintaining cultural competence.

I think there is a duty on us to understand other cultures and religions, I mean this is not so different from just being culturally aware and culturally sensitive, so I can start with a basic background and curiosity, but then I also assume that each person’s interpretation of it is individual, or how are they, just because I may know a lot about Judaism, I don’t know what it means to someone else. I don’t know what flavor, or how to do it, so my duty is to be somewhat knowledgable,
and then somewhat respectful, than to learn from my patient of client what they understand of it. I had somebody from a very obscure sect a while ago and I had to look up what that was and where that originated and that was pretty interesting. So there’s that, the duty to be culturally literate. (Interview 6)

Two of the participants (17%) warned that therapists need to be careful of pushing their beliefs on their clients. Two of the participants (17%) warned against overstepping their boundaries as psychologists. Two participants (17%) mentioned the need for continuing education. Two of the participants (17%) reported the need to respect client beliefs. Two of the participants (17%) reported the need to seek supervision when needed. One participant (8%) stated that therapists need to be aware of their own beliefs. One participant (8%) reported that therapists should be open with clients about their level of competence. One therapist (8%) noted that therapists do not need to be religious themselves to inquire about a client’s beliefs. One therapist (8%) suggested that we need more guidelines for direction.

Participants were asked about issues of integrity when addressing client religious beliefs in psychology. Six of the participants (50%) advised that therapists need to be aware of their own limits.

A consequence of this interview is that I may do some more formal training in this area, because as supervisors know, we do not set off to do things that are inappropriate, but may meet certain decisions that that may set up, and I will have to take a look at myself and the ethical principle in understanding the issue so that I can maintain my role as a psychologist and am consistent in that role (Interview 5)

Three of the participants (25%) reported a need to encourage an environment of open and curious exploration.

I don’t know that I do anything different for religion that I do for any aspect, so I sort of try to create a climate in which things are to be spoken about in more of an open fashion, and they know there’s confidentiality, and things get discussed. (Interview 6)
Two of the participants (17%) reported the need to respect the rights of client to hold their religious beliefs.

I am always monitoring my own notion from my Quaker beliefs, are that of god in every man, and that takes a certain level of respect in every patient and a certain level of carefulness with them that is very obvious in my practice. I think there are times when the patients talk about things I disagree with so strongly that it is very difficult. There is one, and it’s a play-therapy one, where it is the whole issue of “do I have fake guns in here” and I do not. It’s a moot thing, but it matters. So that’s been an interesting issue. And with my orthodox patients, some of them are Israelis and I’m not nearly of supportive of the Israeli point of view, but they would never know that (Interview 4)

Two of the participants (17%) noted that psychology needs to be the primary focus in therapy and religion is only to be addressed when relevant.

First and foremost I am a psychologist in here, and that is my role. When I am in the room, I don’t think about psychology from a religious viewpoint, my conceptualization is that of a psychologist, and it has to be consistent with that. If I don’t see the fit, I don’t use it. If the spiritual or religious concept does not fit with the framework of the client therapist relationship and is not appropriate in that, I would not use it. Integrity, my commitment is to my role as a psychologist, not one’s spirituality based upon my spirituality. (Interview 5)

One participant (8%) advised that therapist need to be open with clients about their beliefs and biases. One participant (8%) urged the need to refer clients out if they cannot work with the client’s beliefs.

Participants were asked about issues of responsibility when addressing client religious beliefs in psychology. Two of the participants (17%) reported a need to maintain the safety of clients.

It’s about not allowing something unsafe to happen if you can intervene, it’s about doing something and not standing by and letting something happen if someone can get hurt as a human being. What is in the best interest of the patient? Do no harm. If harm comes into play, I think that most main religions profess to value to life, and we have a safety issue comes to a client, my belief is about how people should treat each other. (Interview 5)
One of the participants (8%) noted that failure to bring up the discussion of religion can serve to censor the topic. One participant (8%) warned that therapists need to be careful not to overstep their boundaries as psychologists. One participant (8%) reported that therapists need to understand the purpose of the religious beliefs in a client’s life. One participant (8%) reported that therapists need to remember that psychology is not the only source of mental health and change. One client (8%) noted that therapists need to take ownership of the therapeutic environment. One client (8%) reported a need to know the resources available to a client.

Participants were asked about issues of dignity and autonomy when addressing client religious beliefs in psychology. Seven of the participants (58%) reported a need to respect client beliefs.

I think religion can be used within religious circles to be used like a giant bat to beat people, a little bit. And that’s not being respectful. And you could, theoretically, use religion to say “I believe God is punishing you, because, you had the child out of wedlock”, and that would be completely inappropriate. You have to be respectful of the person as a human being, respectful of them because they are coming to you looking for help. So if you are going to use religion in that, the same way you would be respectful with psychology, you would have to be sensitive to where they are ate, what they are willing to hear, and where their functioning level is, so you are not using tot abuse power (Interview 9)

Two of the therapists (17%) reported a need to respect others as individuals. One participant (8%) noted that because the importance of religion varies amongst clients, there is a need to see if addressing religion matches the client’s needs and beliefs. One participant (8%) reported that therapists need to be careful not to push their beliefs onto clients. One participant (8%) advised that if a client shows resistance, they should move away from the discussion of religion. One participant (8%) warned about setting up a strict counselor/patient hierarchy within therapy.
Participants were asked about issues of the client’s welfare when addressing client religious beliefs in psychology. Two of the participants (17%) reported a need to assess if a client’s beliefs were creating a positive or negative effect on the client’s life.

Make sure that patients know that they are involved in groups in terms of spirituality know they are safe, and when they are trying new things. In religious institutions you can get involved with freaky people who want to control the patient. To help the patient learn good boundaries not to get re-involved, or if they do get reinvolved, explore the meaning and why in dysfunctional relationships. In terms of religion itself, religion itself is not bad, its more about the things that would put someone in danger, and help them explore that, and don’t let them go out and get hurt. Make sure they have good judgment, you know, your basic neurotic population. People who are psychotic can frequently bring up Christ or God issues, or borderline, or are dissociative, can bring up religion in a way that is disconnected, and they might do something in the name of God that’s detrimental to themselves. So you need to assess a person’s degree of psychological functioning, which is different than someone who is using religion in a meaningful way (Interview 6)

One of the participants (8%) noted that the client’s religious beliefs can connect them to community resources. One participant (8%) advised that before you bring religion into therapy, you need to determine if it will enhance the therapy process. One participant (8%) reported that there is a need to encourage an environment of open and curious exploration.

Participants were asked about issues of social welfare when addressing client religious beliefs in psychology. Five of the participants (42%) discussed the effect of the community connections provided by religious practice.

An example of a client that had some religious inclinations, or needed a coping strategy or needed something, there you might want to hook them up to a community there, or get them to visit their community church too. Also, a lot of the kids I work with feel awkward, they don’t fit in, they aren’t good at sports, they are on the autism spectrum, they don’t belong to those clique groups in school, sometimes those volunteer organizations or religious organizations, these are nice things for kids to do. (Interview 12)
Two participants (17%) warned against overstepping boundaries as psychologists, such as through public representation.

I have a responsibility as a psychologist to, if I am part of a religious group, and that part of a religious group is being interviewed on television or something, I have to be mindful of what I say and how that will reflect on me as a clinician, and I have to be mindful of that. And that could affect how I can be presented to the public if they see me on TV as being part of some healing practice, and they say “he’s a psychologist and I can go to him to be healed,” then that is inconsistent with a healing process (Interview 5)

One participant (8%) advised that there is a need to be aware of your own beliefs and biases. One participant (8%) reported that there is a need to protect the client from unsafe circumstances in the religious community. One participant (8%) discussed the need for psychologists to educate the community on issues of diversity.

Summary

1. When asked about Competence in relation to the ethic surrounding addressing religion in therapy, the participants responded:
   - Religious identity, like ethnic or sexual identity, needs to be understood as being part of the client. 17%
   - Addressing religion in therapy is dangerous when the therapist pushes beliefs 17%
   - Therapist should know and be aware of their own beliefs 8%
   - Don’t overstep your boundaries as a psychologist 17%
   - Know and be aware of your own limits 33%
   - Be open with client 8%
   - Seek continuing education 17%
   - Respect client beliefs 17%
   - Seek supervision 17%
   - You don’t need to be religious to inquire 8%
   - Psychology needs more guidelines on addressing religion 8%
2. When asked about integrity in relation to the ethic surrounding addressing religion in therapy, the participants responded:

- Know and be aware of your own limits 50%
- Be open with client 8%
- Respect client beliefs 17%
- Refer if there is a conflict 8%
- Encourage environment of open and curious exploration 25%
- Psychology needs to be the primary focus in therapy, religion is only addressed when relevant 17%

3. When asked about responsibility in relation to the ethic surrounding addressing religion in therapy, the participants responded:

- If you don’t ask about religion, you may censor the topic, and the client won’t feel like he has the permission to discuss it 8%
- Don’t overstep your boundaries as a psychologist 8%
- Understand the purpose of the beliefs for the client 8%
- Maintain the safety of the client 17%
- Recognize that psychology is not the only source of mental health and change 8%
- Take ownership of the therapeutic environment 8%
- Know the available resources 8%

4. When asked about respect for dignity and autonomy in relation to the ethics surrounding addressing religion in therapy, the participants responded:

- The level of importance of religion depends on the client and you need to see if it matches with the client’s beliefs 8%
- Addressing religion in therapy is dangerous when the therapist pushes beliefs 8%
- Respect client beliefs 58%
- If a client shows resistance, move on 8%
- Respect others as individuals 17%
- Don’t set up strict counselor/patient hierarchy or controlling environment 8%

5. When asked about client welfare in relation to the ethics surrounding addressing religion in therapy, the participants responded:

- Religion connects the client to others 8%
- First determine if discussing client’s religious beliefs will enhance therapy 8%
- Encourage an environment of open and curious exploration 8%
- Assess if beliefs are positive or negative 17%
6. When asked about social welfare in relation to the ethics surrounding addressing religion in therapy, the participants responded:

- Religion connects the client to others: 42%
- Know and be aware of your own beliefs and biases: 8%
- Don’t overstep your boundaries as a psychologist: 17%
- Protect your client from unsafe circumstances: 8%
- Educate community about diversity: 8%
Chapter VIII

Results VI

Global Themes

In addition to the specific answers to the specific questions of the questionnaire, the interviews were analyzed to determine the general common themes that emerged from the interviews.

Nine of the participants (75%) made a total of eighteen references to a client’s religious or spiritual beliefs providing both influence on and information about a client’s identity and world.

And so it can often be helpful to look at that and see “what does the person believe now?” as opposed to what beliefs were they fed as a kid, and in a sense, I would see it as in that scenario, a facet of separation and individuation. But what do I believe now? What do I believe as opposed to what my family believes or my school believes or something. So it can be helpful to clarify. I have a patient who was born into a Jewish family, was Jewish, but received almost no Jewish education or training, married a non-Jewish guy, converted to Catholicism, and her husband died, and now she is 67 years old and rediscovering Judaism. And so it has been very helpful to talk about “what do you believe,” “what do you want to do” “what is meaningful to you?” so it kind of depends. Sometimes people are searching for something bigger than themselves, and sometimes people who are socially isolated,

Included in this information and influence were the client’s beliefs, values, worldview and meaning, internal organization, guidance during upbringing, family background and dynamics, strengths, support systems, self-care and their connections to communities, others, and world.
Nine of the participants (75%) discussed themes a total of fifteen times that reflect that the level of importance of religion and spirituality depends on the individual client and you need to match the client’s beliefs with the proposed interventions.

There is a range, there are people who use it as a guiding principle, all the time, and it can definitely be a positive coping strategy for some people, it can definitely be a source of strength, a source of beauty, and source of connecting to others, community, it can be outside the community they were raised with but they can find a new community that is more accepting, so that there is community which I value greatly

Within this theme, there was an acknowledgement that religion may or may not be important to a client, the degree of importance differs between clients, there is a danger if the discussion is not in touch with the client’s life, that bringing up religion can hinder therapy if the client had a negative experience with religion, and that addressing religion can be beneficial if the client identifies it as important in his or her life.

Nine of the participants (75%) discussed a total of twelve times that a client’s beliefs can interfere with the therapy process.

If people go around telling they are god, I shouldn’t believe everything that they are saying. And if people say… the ultimate question for whenever a traumatic event occurs is “why me?” “why are you against me,” or “you must want to punish me for something… and so I want to see I want to see if there is any sort of psychopathology going on in terms of delusions, hallucinations, excessive amounts of guilt, excessive amounts of anxiety, depression, stuff like that. So I think you need to tease out the difference on how they are using their religiosity in terms of what is going on with them psychologically and emotionally.

Ways that these difficulties emerged in the interviews included beliefs that can support pathology, beliefs that can support resistance in the therapy, or beliefs that can monopolize the therapeutic discussion.

Nine of the participants (75%) reported a need to respect the client’s religious beliefs a total of eleven times.
That client might have different religions and belief systems than I do, kind of, just like they are different than I am in a whole variety of ways because I am not clones of my patients... being very respectful and open to hearing about their religious background, along with everything else, and how it functions and how it may not be functioning in their lives, to help them to reconcile that to help them in their growth process, without forcing them to believe in something that they don’t believe in, or not believe in something that they believe in.

This theme emerged in the interview in ways that warned against judging clients, mentioned the need to respect beliefs and conflicts, stated that clients had a right to their beliefs, and a reported a need to accept the client in the therapy.

Eight of the participants (67%) discussed ways in which a client’s religious or spiritual beliefs can be a source of positive psychological resources a total of fifteen times. The resources mentioned in this theme included support, coping, grounding, anchoring, strength, resilience, forgiveness, structure, a sense of good in the world, hope, and positivity.

With younger clients I work with, I work with adolescents, they believe in a certain higher power; they may have some type of a church affiliation. They may be practicing reading the bible or praying as a part of their coping strategies. I definitely see that in older clients, such as one older woman I have in my practice today, who has chronic mental illness, and has been in psychiatric hospitals numerous amounts of time, and has not been hospitalized in over 20 years, and attributes her resilience to her faith, her spirituality. So I think it can be very central to one’s life and to the therapy. I’ve often said that sometimes the more spirituality one may have the less spirituality they may tend to need. So I think that that really speaks to the role that religion and spirituality have

Eight of the participants (67%) referenced the how a client’s religious and spiritual beliefs and participation fostered connections to others a total of fifteen times. These connections included connections to a community, connections to others within the community, and connections to a higher power. In addition some themes noted that problems emerge when beliefs can disconnect others from the community. Finally, the
client’s belief and participation can reconnect the client, encourage pro-social behaviors, and connects people to community resources.

Eight of the participants (67%) discussed treating religious identity like ethnic or sexual identity a total of ten times. In this theme, the participants talked about how the religious identity needed to be accepted as being part of the client.

Seven of the participants (58%) noted a total of thirteen times that a client’s religious beliefs can enhance therapy. Ways in which they mentioned how the beliefs aid therapy include how discussing the beliefs provide support, enhance rapport, aid in crisis intervention, help to foster exploration and openness, can aid in the extension of therapeutic concepts, and can help to reconnect the client to others. In addition, it was noted that discussing a client’s religious beliefs can provide opportunities for intervention through discussing spiritual themes like death, guilt, and shame, and though allowing challenges to pathological spiritual interpretations.

And I think in that context, it is useful and helpful in therapy, at the time. Especially for people who are religious, and the words that you choose, like if you have “psychology” here and “religiosity” here, you can choose to words that are more theoretical and neutral, and you can choose to use religious words. And for those people it is a huge benefit, and it’s a compliment if they are able to address that. And for some people I have had some clients who they have had therapists who say they are religious, or accepting of it, but the client felt like they were shut down, and they felt that their religious experience was viewed as psychopathology. And they need to feel like they can discuss that without being criticized or put in a category like they don’t belong in. and it’s a huge relief, and it builds trust an rapport, increases motivation, and the client feels understood at a deeper level. I don’t know if my religious understanding… it’s hard for me to sort the 2 out because they have been together for such a long time. Because my religious understanding informed the psychology. But when you have a religious client, and you see where they are coming from.

Seven of the participants (58%) reported thirteen times that they would discuss religious issues if the client brought it into the therapy session. The client could, however,
bring religion into the discussion explicitly through talking directly about it in the present
or previous sessions, or implicitly by making religious references, or wearing religious
accessories.

Seven of the participants (58%) discussed the need of therapists to know and be
aware of their own limits a total of nine times.

I think that likewise, if my own personal perspective/belief system doesn’t allow
me to be non-judgmental, to be open, to be a resource to a person because of their
religious beliefs, or practices, then I think it’s incumbent on me to back off from
taking that client on, and if it emerges in the process, to be accountable and not try
to work through those issues in the course of that person’s therapy, because that’s
not why that person is there. There are some choices about how direct one may be
and if my own issues are getting in the way to the point that I can’t focus on what
the client’s needs are or what the client is perceiving, if that’s the case. You know
the client might be more cognoscente than I might be, for example.

Five of the participants (52%) discussed how a client’s religious beliefs could be a
source of harmful stress and conflict a total of eight times. The stresses and conflicts
mentioned in the interviews included oppressive environments, cognitive distortions,
shame and negative self-image. The negative self-image mentioned included a sense that
the client was damaged, not good enough, inherently bad, or irreparably unclean or
condemned.

I think people come in with some religious beliefs about God, that he’s punishing
them, or that they have to do penance, and I don’t mean Penance in in a catholic
point of view, but they can never pay enough back, or they have a
misunderstanding of religion…
So yeah, in that sense, it would be contradictory, and it would be maladaptive. It’s
negatively affecting their adjustment, or that sort of thing. But I would say that it
was a wrong understanding of religion that’s affecting them. Like “if I just prayed
more, I wouldn’t be depressed.” As psychologists, we know that prayer can play a
huge role, but that’s not what depression is all about.

Four of the participants (33%) warned a total of seven times against therapists
overstepping their boundaries as psychologists. Within these discussions, participants
warned that therapist should not speak outside their roles as professional psychologists, should not inappropriately disclose, and should remember that their role as a psychologist continues outside the office.

Three of the participants (25%) warned a total of four times against the dangers of the therapist pushing his beliefs on the client. Ways therapists might push their beliefs include a direct pushing of beliefs on clients, judging clients based off of the clients beliefs, and allowing the quality of the therapy to suffer because of conflicts in belief systems.

Three of the participants (25%) referenced a total of four times that a client’s beliefs can be pathological if they are rigid and inflexible.

When people are very rigid, that rigidity serves a function to protect them, because they feel threatened, and they have good reason to feel threatened, because the world can be a scary place. So I think religious beliefs, and any beliefs can be pathological, or, I’m going to say “unhealthy” when they are overly rigid, so that is the thing I look for. How rigid are your beliefs, and therefore, how closed are you and that would be, what I would look for, and I would be careful because I think rigidity is influenced by different factors. One being your temperament and how you are wired at birth and the other is your reactions to the world, what your environment is like, if it is very frightening. People who are really frightened, like to have a lot of control. And if they were victims of terror as children, that might encourage them to have some sort of rigid control over their lives, and so those two factors, and I would want to explore that, and I couldn’t work with someone who was overly rigid to a degree, but I would try to understand it first, and see if we could get there, just in terms of seeing a connection, so I would work with the person on the fear and terror that underlies the rigidity in a supportive way, but if they then become abusive, which can also happen because they are so frightened, they give me nothing to work with.

Three of the participants (25%) suggested a total of four times the need to encourage an environment of open and curious exploration.
Two participants (17%) reported the need for therapists to educate themselves through continuing education and being familiar with the literature on religion and psychology.

Two participants (17%) warned that therapists need to be aware of their own beliefs and biases.

Two participants (17%) encouraged therapists to seek supervision where there are difficulties and conflicts in addressing religion in therapy.

Summary

1. The global theme that related that “The level of importance of religion depends on the client and you need to see if it matches with the client” was endorsed by 9 participants a total of 15 times.

2. The global theme of “Religion provides influence and information on client’s identity and world” was endorsed by 9 participants a total of 18 times.

3. The global theme of “Religion as a source of positive psychological resources for client” was endorsed by 8 participants a total of 15 times.

4. The global theme of “Religion as a source of harmful stress and conflict” was endorsed by 5 participants a total of 8 times.

5. The theme of “Religious identity, like ethnic or sexual identity, needs to be understood as being part of the client” was endorsed by 8 participants a total of 10 times.

6. The global theme of “Religion connects the client to others” was endorsed by 8 participants a total of 15 times.
7. The global theme of “Discussing a client’s religious beliefs can enhance therapy” was endorsed by 7 participants a total of 13 times.

8. The global theme of “Religious beliefs can interfere with treatment” was endorsed by 9 participants a total of 12 times.

9. The global theme of “Addressing religion in therapy is dangerous when the therapist pushes beliefs” was endorsed by 3 participants a total of 4 times.

10. The global theme that “Religious beliefs can interfere with therapy when they are rigid and inflexible, or certain” was endorsed by 3 participants a total of 4 times.

11. The global theme of “Religion is discussed if the client brings it up” was endorsed by seven participants a total of 13 times.

12. The global theme of “Know and be aware of your own beliefs and biases” was discussed by 2 participants a total of 2 times.

13 The global theme of “Don’t overstep your boundaries as a psychologist” was discussed by 4 participants a total of 7 times.

14. The global theme of “Know and be aware of your own limits” was endorsed by 7 participants a total of 9 times.

15. The global theme of “Be open with the client” was endorsed by 1 participant 1 time.

16. The global theme of “Seek continuing education” was endorsed by 2 participants 2 times.

17. The global theme of “Respect client beliefs” was endorsed by 9 participants a total of 11 times.

18. The global theme of “Seek supervision” was endorsed by 2 participants a total of 2 times.
19. The global theme of “Refer if there is a conflict” was endorsed by 1 participant 1 time.

20. The global score of “Encourage environment of open and curious exploration” was endorsed by 3 participants a total of 4 times.

21. The global theme if “Understand the purpose of the beliefs for the client” was endorsed by one participant 1 time.
Chapter VIII

Results VI

Guidelines

During the initial interview, the first participant mentioned several times how he felt there was a need for guidelines for therapists who address a client’s religious beliefs in therapy. In that interview, and the subsequent interviews, the participants were asked if they had any suggestions for guidelines as part of the open discussion after the questionnaire was completed. Presented is the list of suggested guidelines from the participants.

- Don’t contravene an established belief system unless it is counterproductive to mental health.
- Respect the dignity of the patient and the diversity of their background.
- Religion should neither be avoided nor gravitated towards in therapy.
- If resistance is encountered, defer questioning until a later time, if not indefinitely.
- Watch for countertransference.
- Own your own religious beliefs and values.
- Be objective in your intake.
- Evaluate and assess the client’s beliefs.
- Investigate the client’s beliefs with open ended sentences.
- Don’t impose beliefs implicitly or explicitly
• Take courses on religion and psychology.

• Consult as needed.

• Explore the meaning of the beliefs for the client.

• Look for opportunities to be intentional about assessment and addressing the issue as relevant to the therapy.

• See religion as part of the whole of human experience.

• Maintain competence.

• Be sensitive to the client.

• Understand and respect religious communities.

• Be conscious of how you decorate your office with reference to religious décor.

• Refer if there is a conflict.

• You don’t need to be religious, just respectful.

• Know your limitations and be upfront with the client and let the client choose.

• Failing to ask about religion makes the topic taboo.
Chapter IX

Discussion

This exploratory study was undertaken to address the gap between the importance of religion and spirituality in a client’s life and the hesitancy of therapists to work with a client’s religious and spiritual beliefs within therapy. Qualitative information was gathered via semi-structured interviews of therapists who self-identified as addressing client religious beliefs in therapy in the hopes of understanding how they work with the client’s beliefs. Twelve clinical psychologists from New Jersey and Pennsylvania, with an age range of 44-64 years and 9-34 years of clinical experience, were interviewed. The interviews were analyzed using the Grounded Theory model in order to generate theoretical data as it emerged in the interviews.

The data collected was analyzed for both specific guidance on issues involved with working with a client’s belief in therapy and global themes about addressing religion within therapy. Within the questions to gain specific guidance, the participants were asked questions about how they understood religion and addressing it in therapy, how they actually addressed religion in therapy, and the ethical issues involved in working with a client’s religious beliefs in therapy. From these responses, larger global themes emerged about how the psychologist addressed religious beliefs in therapy. Finally, the participants offered up guidelines for therapists who work with a client’s religious and spiritual beliefs.
Conceptualization of Religion and Spirituality

Noting the importance of having valid definitions for any research study, the questionnaire was designed to begin by asking how the participants defined the concepts of “religion” and “spirituality.” In doing so, the hope was to develop working definitions of the two concepts for the purpose of this study. Because this study was intended to look at therapists who address religion, the boundaries of this conceptual definition have to remain within that limit. Even though this question does provide important information on how to understand religion and spirituality, it does not provide a view that is exhausted in scope, and creating a more comprehensive definition will require a larger conversation incorporating many viewpoints.

Religion, in this study, was understood as existing in a larger sociocultural domain. The majority of the respondents (67%) described religion as being an organizational institution, reflecting a conceptualization that included systems, hierarchies, and a focus on a collective of people. Additional understandings offered included that religion was a community based entity, formed as individuals come together around common beliefs, and a collection of faith and knowledge, reflecting a sense of a tradition that people join for expression and guidance. This conceptualization places religion into a domain that is defined by the group, more than the individual, and as such, contains the rules, hierarchies, traditions, and collective experiences needed to establish a functional community.
Spirituality, in this study, has been given a more individualistic conceptualization. Five of the participants defined spirituality as an individual’s personal beliefs and expression of faith, four participants saw it as a relation between the individual and a higher power, and two participants defined it as being grounded in individual experience. This conceptualization grounds spirituality in the individual, reflecting an individual’s personal belief, relationship, expression and experiences in relation to faith and higher powers.

Religion and spirituality were conceptualized as largely distinct entities in this study. The majority of the participants (67%) defined religion and spirituality as being different from each other. Three of the participants, noted that there was a relationship between religion and spirituality, with one participant specifically noting that they were different but intertwined. This conceptualization reflects the view that religion and spirituality are different from each other, but can interact.

In Summary, religion and spirituality are two different constructs that can act upon a client. Religion focuses on the larger organizational aspects of a group, including structure, community and tradition. Spirituality focuses on the individual, and incorporated personal belief, expression, experience and relationships.

This conceptualization, which creates a strong separation between religion and spirituality, with religions as being a larger organizational construct, and spirituality being an individualistic construct, has been discussed frequently. Kenneth Pargament has been critical of this split, warning that this definition suffers from problems ungrounded study, polarization and loss of the idea of the sacred. Pargament (1997) describes this definition as being ungrounded in research, as the large majority of people consider
themselves both spiritual and religious, there is often little correlation in definitions of
spirituality among individuals reporting to be spiritual, and that the main groups reporting
a difference between religiosity and spirituality among themselves are the mental health
workers who produce the writings on the topic. The danger in polarization comes from a
tendency to separate religion and spirituality as institutional and individual, or as good
and bad. The criticism to the polarization lies in that it does not reflect the experiences of
many individuals, and ignores the concept of interrelatedness that is a part of many
religious and spiritual institutions. Finally, these definitions ground themselves in the
individual or the organizational and do not place a central focus on the sacred aspect
(Pargament, 1997). At the same time, there is a historical argument for having a
separation between the individual and institutional experience as represented by the
definitions of spirituality and religion presented. In his lectures, William James used a
definition that focused on the individual.

Religion, therefore, as I now ask you to arbitrarily take it, shall mean for us THE
FEELINGS, ACTS, AND EXPERIENCES OF THE INDIVIDUAL MEN IN
THEIR SOLITUDE, SO FAR AS THE APPREHEND THEMSELVES TO
STAND IN RELATION TO WHATEVER THEY MAY CONSIDER THE
DIVINE. (James, 1902/2010 p 722-723)

This definition was acknowledged to represent a small part of the field of religion,
formulated in acknowledgement of the vast complexity contained within the construct of
religion.

The field of religion being as wide as this, it is manifestly impossible that I should
pretend to cover it. My lectures must be limited to a fraction of the subject. And,
although it would indeed be foolish to set up an abstract definition of religion’s
essence, and then proceed to defend that definition against all comers, yet this
need not prevent me from taking my own narrow view of what religion shall
consist in FOR THE PURPOSE OF THESE LECTURES, or, out of the many
meanings of the word, from choosing the one meaning in which I wish to interest
you particularly, and proclaiming arbitrarily that when I say “religion” I mean THAT. (James, 1902/2010 p 720)

The separation between religion and spirituality created through the interviews might be better understood alongside James’ argument for his focus on the religion of the individual: Due to the vastness of religion, a more restrictive definition is adopted for the purpose of clinical utility. Since the origin of this definition emerged within context of the therapeutic environment, its separation of spirituality as being in the domain of the individual, and religion as being in the larger group, may reflect the clinical need to have a definition that creates a separation between the individual and social environment.

Within therapy, the psychologist works with the individual in the room, though the social environment is considered as an influence on the client’s life. In addition, creating these separations allow psychologists to identify clinically useful variables that can help to best guide clients in treatment. When Maslow researched the attainment of self-actualization, for example, he saw this occurring through “peak experiences” that were more individual and somewhat separate from the traditional religious experience (Wulff, p 63-66).

Because of this, even though the definitions of religion and spirituality may not reflect the totality of religion, and the complex interactions of the individual and the organizational within the whole of religion, it can be seen as valid within this very specific context of the therapeutic environment, as its validity comes from its clinical utility.
Addressing Religion and Spirituality in Therapy

Therapist Beliefs on Religion and Psychology.

The responses to the interviews offered some guidance to therapists looking to address a client’s religious beliefs during therapy. When asked about the various ways they understand addressing religion and spirituality in therapy, the participants offered a number of views of clinical interest. When asked about how they conceptualize the role of religion and spirituality in a client’s life, the participants noted that though the actual role will vary from person to person, religion and spirituality can be a source of positive support, can be a source of stress, and can have a strong influence on the development of the client’s worldview. When asked about the role religion can play in therapy, the participants discussed how inquiring about beliefs can provide information about a client’s background and world view, and can help provide information about the client’s positive psychological support. In addition, participants noted that addressing religion can be beneficial in therapy by providing connection to others, enhancing therapy by aiding in the building of rapport, motivation, exploration, intervention, etc. There were a few possible dangers in addressing religion in therapy, such as problems caused when religion is unimportant or aversive to the client; the religious beliefs interfere with therapy by supporting resistance, defenses, or pathology, or when the religious beliefs serve as a source of stress for the individual.

When asked about how the participants differentiate between religious beliefs and pathology, the most frequent response admitted it was a much nuanced decision, determined by clinical judgment. However, some guidance was given in that pathological beliefs often interfere with therapy by supporting pathology and resistance, leads to
rigidity, and impedes the healthy functioning of the client. These responses seem to suggest that the determination made as to when a belief is pathological is based on the way those beliefs affect the client’s functioning in therapy and life. As such the beliefs are not based on the thematic content, but rather the degree to which they impede the client’s functioning.

When conceptualizing a client’s religious beliefs, the two most frequent responses focused on understanding how the religious beliefs act to inform the therapist on the client’s identity and worldview. Five of the participants conceptualized the client’s religious identity as being similar to cultural identity, while four looked for more specific information on the client’s beliefs, values, sense of meaning, family background and dynamics, upbringing, etc. Conceptualization of a client’s religious beliefs, then, most commonly focuses on how the beliefs have played a formative role on who the client is as he enters therapy.

**Addressing Religion within Practice.**

The variety of methods used to address and assess religion within therapy as given by the participants indicate that there may be a variety of valid styles therapists can employ when addressing a client’s religious beliefs. Many of the therapists look for the client to bring religion into the therapy setting directly or indirectly during the therapy. Still other will ask at intake or structured interview. Others actively listen, and sometimes ask, during the therapeutic conversation. One third of participants wait for the client to bring up religious or spiritual beliefs in therapy, one quarter will introduce the topic most of the time and another quarter of the participants reported that religion and spirituality
was brought by both the therapist and the client. When asked about actual techniques used, the most common responses used focused on inquiry and discussion. Five participants reported not using any sort of technique. Two participants utilized specific religious interventions, such as prayer or scripture. When determining when to bring up religion or spirituality, one third determines the appropriateness of addressing religion in therapy through clinical judgment, one third felt it was appropriate if the client initiated the discussion, and one quarter assesses appropriateness based on how important they know religion to be in that client’s life. These responses reflect a number of different styles when addressing religion within therapy, and the application of a particular style appears to depend on both the client’s and the therapist’s comfort with discussing religion in the therapy session. Because the responses given by the participants were general in nature, more detailed information is needed about how therapists can match an intervention to a particular client.

When asked for clinical examples of when client belief complemented mental health principles, two participants related stories where they encouraged religious exploration to help the clients develop identity, one participant related a story in which therapy was facilitated through the exploration of spiritual themes, and one participant described an instance where the therapist used scripture to challenge a harmful religious beliefs. In these narratives, the participants illustrated examples of not only the religious beliefs helping the client in general, but of specific interventions they were able to apply to foster both mental health and the client’s religious understanding. The actual methods utilized by the therapists involved exploration and elaboration on the beliefs held by the
client. In only one story were beliefs challenged, but the challenge was made within the context of the client’s belief system.

**Ethical Considerations.**

In discussing the ethical considerations of addressing religious themes in psychology, some common themes arose. When asked about issues surrounding the ethical domain of competence, four of the participants reported a need to be aware of their limits when working with a client’s beliefs, two of the participants warned against pushing beliefs, two participants discussed a need to respect client beliefs, and two discussed the need to treat religious identity, like ethnic identity, as a part of the client. When asked about the ethical domain of integrity, six participants advised that therapists need to be aware of their own limits, three participants reported a need to facilitate an environment of open exploration, two participants reported the need to respect the client’s right to their beliefs, and two reported a need to keep psychology as the primary focus of therapy. When asked about the ethical domains of dignity and autonomy, seven of the participants indicated a need to respect client beliefs, and two reported a need to respect clients as individuals. Common themes in the responses to these ethical questions focused around the maintenance of boundaries as psychologists, and the need to explore the meaning of religion and spirituality in a client’s life.

In response to the question about the ethical concerns surrounding responsibility when addressing a client’s religious beliefs in therapy, two participants mentioned the need to monitor for the safety of the client. When asked about ethical concerns surrounding client welfare, two of the participants discussed the need to assess whether
beliefs are having a positive or negative effect on a client’s life. Finally, in response to the question of social welfare and ethics, five participants discussed the pro-social connections made available through religious affiliation, and two participants warned against overstepping boundaries.

**Emergent Theory of Addressing Religion in Psychology**

When examining the global themes that emerged throughout the interviews, a few trends emerge. First, some of the themes can be interpreted to show a trend in understanding the client’s religious and spiritual beliefs as they are brought in through the life and identity of the client. Second, many of the global themes discuss ways in which mental health and the client’s spiritual and religious beliefs interact. Finally, the other global themes can be seen to support the need to maintain the boundaries of Religion and Psychology as separate entities. From these trends, a theory of addressing religious and spiritual beliefs can be proposed, one that focuses on Religion and Psychology as separate entities that relate to each other through human experience.

The most commonly endorsed global theme was the belief that the client’s religious and spiritual beliefs provide both information and influence on a client’s identity and worldview. This global theme was endorsed by three-quarters of the participants in the responses to many questions throughout the interviews. This theme stated that the client’s belief inform the client’s world by influencing his beliefs, values, sense of meaning, internal organization, development, family dynamics, strengths, connections, self-care and support systems. A similar theme commonly endorsed stated that a client’s religious identity, like their ethnic or sexual identity, is seen as being part
of who the client, equating religious competency as being comparable to cultural
competency. This global theme was endorsed by two thirds of the participants and
appeared in the answers to multiple questions. Both of these responses reflect an
influence of religion and spirituality on the client. Finally, the second most endorsed
global theme was that of needing to understand the importance of religion and spirituality
to the individual client. Endorsed by three-quarters of the participants, and discussed
through several questions, this theme recognizes that a client’s level of belief and
commitment exists upon a continuum, and the client’s place upon this continuum needs
to be understood to understand the degree to which religious and spiritual beliefs affect
the client’s world view identity, if they affect the world view and identity at all. Within
the therapeutic context, if religion does come into therapy, it does so through its
representation in the client’s religious and spiritual beliefs as manifest through their effect
on the client’s world view.

The second emergent trend involves where psychology, religion, and spirituality
interact within the therapeutic context. Two-thirds of the participants reported that a
client’s religious and spiritual beliefs were a source of positive psychological resources
for the client throughout the interviews. Participants noted that the client’s religious and
spiritual beliefs provided hope, positivity, support, grounding, coping, resilience,
strength, and structure for the client. Seven of the twelve participants noted that
discussing a client’s religious and spiritual beliefs can enhance the therapy. Endorsed in
several questions throughout the interviews, the client’s beliefs can potentially provide
motivation in therapy, enhance support, fosters exploration and openness, can help to
explain therapeutic concepts, and can provide opportunities for intervention when at a
loss, dealing with spiritual concepts like death and shame, or responding to a crisis. Two-thirds of the participants reported that a client’s religious and spiritual beliefs influenced the connections a client has to others. In this theme, the client’s connections to community, other individuals, and a higher power are influenced by the client’s religious and spiritual beliefs, as well as connecting the client to important community supports and resources. Three-quarters of the participants also noted that a client’s religious and spiritual beliefs can interfere with treatment by supporting a client’s existing pathology, supporting resistance within therapy, and hindering therapy by monopolizing the therapeutic discussion. Finally, five of the twelve participants reported that a client’s religious and spiritual beliefs can act as a source of stress and conflict negatively impacting the mental health of a client, by supporting cognitive distortions, negatively affecting self-image, and creating oppressive environments. In these global themes, the emerging trend focuses on the interactions between religion, spirituality and psychology, as they mix within the client’s life and are brought into therapy.

Finally, a strong trend that emerged focused on the necessity for psychologists to maintain their boundaries when working with a client’s religion and spirituality. Three-quarters of the participants mentioned the need to respect a client’s beliefs. The participants advised that therapists need to accept and not judge beliefs, to respect beliefs when there are conflicts, and remember that clients have a right to their beliefs. Seven of the twelve participants reported that they only discuss a client’s religious and spiritual beliefs when the client brings it up in the therapy session. Seven of the twelve participants discussed the need for therapists to be mindful of their limitations as therapist. One-third of the participants warned against overstepping boundaries as
psychologists by speaking outside their role as psychologists. One-quarter of the participants warned against the dangers of pushing their beliefs onto clients, through endorsing of their own beliefs, judging clients based on belief, or allowing the quality of the therapy to suffer because of the client’s beliefs. Also endorsed by the participants were the needs for therapists to seek continuing education and be aware of their own needs and biases. Throughout these themes was a trend that focused on maintaining boundaries by focusing on their work as psychologists, and not imposing or condemning the client’s religious views. In this trend, religion and spirituality are treated as entities distinct from psychology, and the therapist’s role is to solely act on behalf of psychology.

When viewed along these trends, the analysis of the global themes points to a theory that involves religion/spirituality and psychology being distinct and separate entities. Religion and spirituality are brought in through the client’s spirituality, represented in the particular world view of the client. Psychology is brought in by the therapist. The two entities, though separate, interact with each other within the client’s life, and the therapy session is used as a constructive and collaborative dialogue.

This theory matches with the observations made by Stanton Jones in his discussion of ways religion and psychology has traditionally interacted with each other. Of the three interactional styles, mentioned by Jones, the critical-evaluative model, which scientific research is evaluated for the fit with religious presuppositions, the constructive model, in which the ideas from religion are brought in when they agree with the presuppositions of the scientific theory, and a relational model, which encourages a dialectical relationship between religion and science (Jones, 1996 p 134-137), the trends that emerged in this study seem to reflect the dialectical relational style he discusses. In
this model, there is both an acknowledgement of psychology and religion being separate entities, and an acknowledgement that they are overlap in through many of the fundamental experiences of being human. In this model, the boundary maintained between religion and psychology is not done through psychology being treated as a purely objective science, but by recognizing the biases that do exist within each person, a concept noted in boundary themes reported by the participants in the interviews.

If psychological research and practice are going to be maximally effective in understanding and improving the human condition, psychologists would be well-advised to explicitly explore the connections of their work with the deepest level of our human commitments. Even if we think about our religious beliefs as biases that we bring into psychological science and practice, we must come to realize first that such biases are intrinsic to our professional activities, in that it is our biases that allow us to perceive and understand anything at all, and the second, that the most limiting and dangerous biases are those that are unexamined and hence exert their effect in an unreflective manner (Jones, 1996 p141-142)

The overlaps between religion and psychology are acknowledged through mutual attempt to understand reality, explain experience, and make sense of human experience. (Jones, 1996 p 122-126). In the study, these areas of overlap, came together to help build the world view of the client, and served as the representation of religion and spirituality in the emerging theory. Finally, in this model, religion and spirituality become partners in a conversation. “The relationship between science and religion must be dialogical and not unilateral” (Jones, 1996 p 137). In the emerging theory from the study, there too existed a conversation between the client’s beliefs and the therapist’s expertise in psychology through the efforts of the therapist to understand the beliefs for the client, the acknowledgement and support of beliefs that support mental health, and the collaborative conversations used to resolve issues that negatively impact the mental health.
In conclusion, the trends that emerged from the analysis of the global themes seem to support a theory that therapists, who do address religious themes in therapy, do so by creating a collaborative dialog between the client’s spirituality and psychology in the therapeutic session. The client’s spirituality is represented within the world view of the client as he presents it in therapy. Psychology is represented through the therapist who works to maintain proper boundaries in order not to overstep his or her role as a psychologist. Once these two entities are established within therapy, the therapist acts to facilitate a collaborative conversation regarding those two areas of human experience in which both psychology and spirituality act upon the client.

Limitations of This Study

There were a number of limitations that affect the ability to generalize the results of this study. These limitations include the sample characteristics, limitations stemming from the study design and analysis, and potential investigator bias.

The two biggest difficulties presented from the sample characteristics include the limited size and the religious affiliation of the participants. The study sample consisted of twelve individuals, a sample far too small to allow for generalization. In addition, all participants rated the importance of religion in their lives as relatively high, ranging from 7 to 10 out of 10. In contrast, 48% of surveyed APA members reported religion as being unimportant in their lives (Delaney, Miller, and Bisong, 2007). As such, there is a large discrepancy between the participant sample and APA members as a whole in the area of religious importance. Because this is a study about addressing religious and spiritual...
belief within therapy, there is a direct effect on this importance on the subject matter of study. As a result, there is a possibility of bias in the results that may impact the findings.

There were also several aspects of the research design that threatens the generalizability of the results of the study. As a qualitative study that relied on semi-structured interviews, there were variations in the administration of the measure due to the open ended quality of the questions, the differences in the understanding of the questions and terms used in the study, and differences in the administrative environment caused by the rapport between the investigator and the participants. Because of this, despite the fact that same questions were asked during the interview process, there may have been variations in how the questions were understood and answered. The development of the coding manual was dependent on the subjective judgment of the investigator, and was vulnerable to his particular understandings, beliefs, and biases. When collapsing participant responses into the categories that were used for the codes, for instance, the investigator had to use his own judgment as to whether or not to combine or leave codes separate based on his interpretation of the meaning of the participant’s response. For example, the argument can be made that the global codes of “Addressing religion and therapy provides influence and information on the client’s identity and world” and “Religious identity, like ethnic and sexual identity, needs to be understood as being part of the client” could have been subcategories of the same code. Similarly, the codes of “Beliefs can interfere with treatment when they support psychopathology, support resistance to therapy or defends pathology, or monopolizes the therapeutic discussion” and “Religious beliefs can interfere with therapy when they are rigid, inflexible, or certain,” could have been joined under the same code. The decision to
leave these codes as separate was based off of the investigator’s interpretation of the participant’s responses that were judged to weigh the particular codes differently in each circumstance. Even though there was a good level of agreement (73%) among coders when the coding manual was used, the reliance on a single individual’s judgment may serve to limit the study.

Similarly, the coding process depended on the subjective judgment of the investigator and the additional coders. The possibility for error was illustrated by the results from one coder who may over-applied the categories in the coding process, potentially producing agreements that were more likely attributable to chance than accuracy in coding. In this study, the problem was compensated for by first seeking secondary confirmation of the over-application, and then reassigning the interviews to a new coder. Even though the new coding contributed to an inter-rater reliability that indicated strong agreement (73%) the fact that the problem occurred illuminated possible flaws in the coding instruction and training that may limit the generalizability of the study.

Finally, the data analysis and theoretical formulation were limited in generalizability by the subjective judgment of the investigator. As noted by Kathy Charmaz (2010), the qualitative design structure of grounded theory varies from more quantitative experimental designs in that grounded theory looks for codes and themes as they emerge from the data, quantitative designs test preconceived codes and themes (Charmaz, 2010 p 46-47). Because of this, in contrast to quantitative designs that test preconceived theories with pre-established standards for success or failure, the results of this more qualitative design rely more on the subjective judgment of those doing the data
analysis. As such, there is a natural limitation to this study based off of the potential bias introduced by the investigator’s subjective judgment during the data analysis and interpretation.

**Recommendations for Future Research**

For the purpose of this study, there are a few recommendations that could improve the study design for purposes of replication. First of all, due to the small sample size and the disproportionate representation of religiously oriented individuals in the sample, one recommendation would be to increase the sample size, and recruit participants who vary more according to the importance they give to religion and spirituality in their lives.

Next, in order to reduce the potential bias an error in the production of the category codes, future investigators would be advised have more than one individual handle the coding process. The use of multiple evaluators working collaboratively to create the codes could reduce this error by reducing the effect of individual subjective judgment. This won’t eliminate the error completely, but it would reduce the error create by any single individual.

Next due to the problems that emerged during the coding process, there are a few improvements to the coder training and coder procedure that could improve the design of the study. A more stringent training of the coders could have helped to reduce the error produced in the coding process. Since one must be aware of both false negatives and false positives when it comes to results in research, the training must be such as to produce both true agreement as well as true disagreement. In order to prevent false agreements
that could result in the investigator leading coders to agree during the coding process, the investigator focused more on creating clear coding instructions and remaining as neutral as possible when explaining the coding process to coders. As a result, there may have been a reduction in agreement amongst all the coders due to this training style. Improving the agreement without generating false agreement could be achieved by spending more time reviewing the coding manual with the participants as a group, clarify meanings for the categories before assigning the interviews to the coders. To directly answer the issue brought up by the problem in the coding process produced by over-application of categories, the following instructions could be added to the coding process:

1) When you are reading the participant responses and codable content, underline it and mark it with a number.
2) In the margin of the transcript next to the underlined content, write the code deduced as well as the corresponding number used to label the underlined content

The addition of these instructions would further ground the codes given to the direct content of the interviews, reducing the likelihood of repeating the problems caused by the one coder.

Replication of this study is advisable for a number of reasons. First of all, there are a number of noted limitations to this study that could be corrected as the study is replicated to produce more valid and accurate results. Secondly, the limitations caused by the small sample size could be controlled through meta-analysis of replicated studies. Next, the results of this study supported one of many possible theories on how psychologists address client religious beliefs in therapy, and future studies could either give further support, or could support another theory due to variations in sample characteristics or design improvement.
In addition to the suggestions for the replication of this study, there is guidance that can be drawn for future study that can be drawn from this study. The theory supported from this data is that the therapists interviewed, who address client religious and spiritual beliefs in therapy, do so by treating the psychology and spirituality as separate entities in a collaborative dialog. In this conversation, religion and spirituality is represented by the worldview of the client, and psychology is represented by therapist who monitors boundaries to make sure he or she does not acts as more than the psychologist. The resulting dialog discusses the areas where both psychology and religion/spirituality interact with the person’s life, partnering to enhance therapy. As a theory, this is rather raw and abstract, and further development will be needed to make it more concrete, operational, and testable. In doing so, this theoretical development would be able to further support the theory, and to draw clinical application from the theory.

In addition to the emergent theory, there are a number of additional findings in this study that can be followed up on by future research and clinical training.

First, to answer the issue of construct validity, a provisional definition of religion and spirituality was developed for the study. This construct defined the two as separate constructs, with religion being an organizational group built around beliefs and traditions and spirituality being an individual experience and expression of faith and belief. As previously mentioned, however, this is a definition that may be valid in the context of clinical utility, but may not truly incorporate an accurate understanding of religion and spirituality. As such, future research could focus on building a more developed understanding of religion and spirituality. In addition, because of the clinical context in which this particular definition is found, clinicians could work to further develop the
construct within therapy by inquiring about how clients themselves define and understand the concepts.

Half of the participants interviewed reported that they had no formal training in addressing religion and spirituality in psychology. One sixth of the participants reported some formal training in school, and another sixth reported continuing education courses. The most frequently reported training (seven out of twelve) comes from the participant’s own religious experience, training that is not available to non-religious therapists. These results suggest that there may be a deficit in the training and competence that needs to be addressed within the field of psychology. Future research could confirm whether the deficit exists, and what the real need is for education on religion and psychology. If these results do prove to be consistent within the field, then it would be recommended to that courses on religion and psychology be added to graduate and continuing education curriculum.

Similarly, half of the participants reported that they did not use any formal assessment tools when addressing religion in therapy. One quarter utilized clinical interviews, and another quarter would ask when they felt it appropriate in the therapeutic discussion. Because of this, it is also recommended that included with the increased education, there be a special focus on assessment, both in the use of possible formal assessment tools, and the specific assessment strategies that can be used when working with a client’s religious beliefs.

The participants frequently acknowledged the need to match the degree to which religion and spirituality is brought into therapy with the client’s actual level of belief. Little information, however, was revealed about how this might be done. Rather, many
participants relied on clinical judgment, or waited for the client to being religion into the sessions. Even though there is a risk of harming a client by addressing religion when it is not appropriate, there is also a risk of censoring religion by not being intentional in giving permission to bring it into the therapy.

I think it’s good to give people permission to address religion in therapy, and maybe having that on the intake is a good thing, so that if you have a client who then is religious, and you’ve asked the client, you’ve given them permission. Just like we have questions sometimes about sexual orientation, or about work, or about family constellation, and when you think about family constellation, there is a lot of information about connection I would miss. So it puts the question on the table and they know they can bring it up if they wanted to. (Interview 10)

Because of this, it is recommended that educational curriculum discusses both methods for assessing the level of client religious participation and belief, but also how to match those beliefs with appropriate interventions.

Finally, several participants noted in the interviews the need for guidelines when addressing religion in therapy. Many participants made suggestions regarding the guidelines they believe should be given to therapists. It is the recommendation of this study that formal guidelines be developed addressing client religious beliefs within therapy.
REFERENCES


APPENDIX A

Interview Questions

Demographic Information:

Age: ____  Gender: M/F

Professional degree:  Year attained degree/years in practice: ____

Theoretical Psychotherapeutic orientation: _______________________________
__________________________________________________________________

Treatment specialty/focus: ____________________________________________
__________________________________________________________________

Ethnic/cultural background: ___________________________________________
__________________________________________________________________

Religious/ spiritual background.:  

    Religious upbringing: _______________________________________________
__________________________________________________________________

Level of identification with religious upbringing

1  2  3  4  5  6  7  8  9  10

Importance of religion in own personal life

1  2  3  4  5  6  7  8  9  10
Questions

Personal Beliefs:
How do you define religion and/or spirituality, and do you make a distinction between the two?
What do you feel is the role of religion and spirituality in a client’s life?
What role can religion play in Therapy? When can addressing religion be beneficial?
When can addressing religion be a hindrance?
What line do you draw between religious belief and psychopathology?
What training have you had in working with religious issues?
When dealing with a client’s belief, how do you conceptualize their religious beliefs in a therapy setting?

Prompts:
Do you conceptualize it pragmatically, do you accept them, or do you see is as a reality?

Addressing Religion within Practice:
How often is Religion addressed in your practice?
How do you address religion in your practice?
Who is the one who generally begins the discussion of religion, you or your client?
How do you assess the spiritual/religious beliefs of your client? Do you use any interview or assessment tools?
How do you assess the appropriateness of addressing religion with a particular client?
Are there any specific methods or techniques you use when addressing religion in therapy?
Can you think up an instance or instances where a client’s religious beliefs have been complimentary to what we know about mental health?
Can you think up an instance or instances where a client’s religious beliefs have been contradictory with what we know about mental health? How have you addressed these?

Ethical Considerations

What are the ethical concerns surrounding addressing religion in Psychology in reference to The Ethical principle of Psychology?

A) What are the ethical concerns surrounding addressing religion in Psychology in reference to Competence?

a. What are concerns?
   i. training
   ii. Meaning
   iii. Goals in religion and therapy
   iv. Sensitivity
   v. Efficacy of treatment with religiously diverse clients

b. How do you address these concerns?
B) What are the ethical concerns surrounding addressing religion in Psychology in reference to Integrity?
   Prompts:
   a. What are concerns?
      i. How and when do you discuss personal values?
      ii. Explanation of expectations?
   b. How do you address these concerns?
C) What are the ethical concerns surrounding addressing religion in Psychology in reference to Responsibility?
   Prompts;
   a. What are concerns
      i. Awareness of resources
   b. How do you address these concerns?
D) What are the ethical concerns surrounding addressing religion in Psychology in reference to Respect for dignity and autonomy?
   Prompts:
   a. What are concerns?
      i. Informed consent
      ii. Considering client views and values
   b. How do you address these concerns?
E) What are the ethical concerns surrounding addressing religion in Psychology in reference to Concern for Client’s Welfare?
   Prompts:
   a. What are concerns?
      i. Variant conceptualizations of welfare
   b. How do you address these concerns?
F) What are the ethical concerns surrounding addressing religion in Psychology in reference to Social Welfare?
   Prompts:
   a. What are concerns
   b. How do you address these concerns?
Dear Dr.____________________

I am writing to invite you to participate as a subject in my dissertation study examining the addressing of clients’ religious beliefs in therapy. The purpose of this study is to take a balanced look at the benefits and potential problems that arise when therapists address religious beliefs in therapy by looking at the clinical experiences of therapists who do address religion in therapy.

You are being invited because you have been identified as a therapist who does address religion within therapy when deemed appropriate. Should you agree to participate in this study, I will be asking to meet for an initial interview that would last for up to 2 hours to ask about your experiences. As I will be using the Grounded Theory approach to the data analysis, additional questions may arise that may lead to a follow-up interview. Interviews will be recorded with permission, though the recorder will be shut off temporarily or permanently at your request.

All information derived from the interviews will be kept in strict confidentiality, and at any time you can discontinue participation or withdraw consent. In addition to questions about your clinical experience, there will be questions collected for demographic reasons, including questions about religious orientation. You will not be excluded for any responses to questions about your gender, ethnicity, religious orientation etc.

Finally, in order to find a suitable subject pool, the study is using the snowball method to identify possible subjects, where one identified subject helps to identify other subjects. Though this is in no way required, and will not affect your participation in the study, if you happen to know of other therapists who address a client’s religious beliefs within therapy, it would be helpful to the study to suggest them as a participant.

If you have any questions, please free to contact the principle investigator:
Zachary Maichuk

[Personal Contact Information Removed for Publication]

Thank you in advance.

Sincerely,

Zachary Maichuk, PsyM
Information Guiding the Study

Research into religion and psychology has returned consistent results over the past years. First and foremost is the importance religion plays in the lives of people as a whole. Gallup polls have consistently shown that more than half of Americans view religion as being very important in their lives. In 2007, Gallup polls have shown that 56% of Americans see religion as being very important, and 26% seeing it as fairly important (Gallup, 2008). Secondly, studies in religion and psychology have a lot to say about the potential benefits for both mental and physical health. Religious activity, has been found to be a predictor for coping with life stressors, psychological adjustment, and physical health (Hill and Pargament, 2003), a better satisfaction with life and a health care provider’s acceptance and participation in a client’s religious belief can prove beneficial (Koenig, 1990). Acceptance of religion has been gained in psychology, and 82% of surveyed APA members believe religion to be beneficial to mental health (Delaney, Miller, and Bisono, 2007). However, despite this acceptance little more than half of APA members regularly assess a client’s religion or spirituality (14% always assessing, and 37% often assessing) and little more than a quarter view spiritual or religious issues as regularly relevant to treatment (3% reporting always relevant, 23% reporting often relevant) (Delaney, et. al, 2007). The goal of this dissertation is to help address this discrepancy between reported client and therapist support for the benefits of religious participation, the reported utility and the lack of integration of religious themes within therapy with religious clients by interviewing therapists who do integrate religious themes within their practice.
References [to the recruitment material]


Consent to be interviewed

I, ________________________________ consent to be interviewed as part of this research study to investigate the experiences of therapists who work with the religious beliefs of their clients in therapy. As a participant, I will meet with the investigator for an initial interview lasting up to two hours, in which I will be asked about my experiences working with clients and their religious beliefs. Should additional questions come up during data analysis, I may be asked to participate in a follow-up interview.

I understand that participation in this study is completely voluntary, and that I am free to withdraw my consent at any time without penalty. I understand that I can choose to not answer questions and still be allowed to participate in the study. I give permission to be tape recorded by the interviewer, and understand that I can ask to have the tape recorder temporarily or permanently turned off at any time, and that I can withdraw my consent to be recorded at any time.

I understand that strict confidentiality will be kept in references to the interviews and all information from the interviews. I understand that I will be asked for basic demographic information, including gender, ethnicity and religious orientation, but that I am not required to give any personal information about myself I do not choose to give, nor will I be asked for any identifying information about my clients, and all names or identifying information from the interview will be removed after the completion of data analysis.

I acknowledge that I have received a personal copy of this form and have kept it in my personal records.

I understand that should I have any questions about the study, or my participation in the study, I can contact the principle investigator mentioned below:

Zachary Maichuk
[Personal Contact Information Removed for Publication]

If you have any questions about your rights as a research subject, you may contact the IRB Administrator at Rutgers University at:

Rutgers University Institutional Review Board for the Protection of
Consent to be Recorded

I, ___________________________________________ consent to be recorded during the research interview(s). I understand that the recording may be stopped temporarily or permanently at my request, and that I can withdraw my consent at anytime without penalty and still be allowed to continue participation. I understand that should I choose to stop the recording, I will still be allowed to continue to talk and proceed with the interview without penalty.

Signature: _________________________________    Date: __________ ___
APPENDIX C

Coding Manual

Coding Manual Instructions:
Codes are differentiated in this manual by being bold, italicized, and underlined. For each question, read the participant’s response and code the themes that appear in the response. For instance, if, in question 1, the participant mentions that religion is related to interactions in the community, you would write “1.2.a” in the margin next to the response. Write down all the codes that apply, you will often have to use multiple codes. Many of the codes you will see will include the letter “G.” Just write down the code as it applies (e.g. 3.1.G5) in the margin like any other code.

Question 1: How do you define religion and/or spirituality, and do you make a distinction between the two?
1.1) Religion and spirituality are:
   1.1.a) The same
   1.1.b) Different
   1.1.c) Intertwined

1.2) Religion is:
   1.2.a) Community based
   1.2.b) An organized institution
   1.2.c) A body of collected belief and knowledge
   1.2.d) A medium of faith
   - means of expressing faith
   - means of training in faith

1.3) Spirituality is:
   1.3.a) personal expression
       - own practice
       - own expression of faith
       - internal beliefs
   1.3.b) based on personal experience
   1.3.c) a relationship with a higher power

Question 2: What do you feel is the role of religion and spirituality in a client’s life?
2.G1) the role and level of importance depends on the client; there is a need to see if it matches with the client
   - may or may not be important
   - degree of importance differs between clients
   - can be dangerous if archaic and not in touch with the client’s life
   - can be a hindrance if there is a negative experience associated with religion
   - recognize that meaning and significance differ from person to person
2.G2) Provides influence on identity formation
- beliefs  
- values  
- worldview and meaning  
- internal organization  
- guides upbringing  
- Family and background and dynamics

2.0.3) source of positive psychological resources for client

- hope and positivity  
- sense of good in world  
- support  
- grounding/anchoring  
- coping

2.0.4) Source of harmful stress and conflict

- cognitive distortions  
- oppressive environments  
- negative self-image (sense of being damaged, not good enough, inherently bad, irreparably unclean or condemned, etc.)

2.0.7) connects the client to others

- connects client to a community  
- connects client to others within a community  
- becomes a problem when it disconnects client from others

- can aid in reconnecting client to others  
- can encourage pro-social behaviors  
- religion connects people to community resources  
- connection to higher power

Question 3: What role can religion play in Therapy?

3.1) importance in therapy

3.1.0.1) level of importance depends on the client: there is a need to see if it matches with the client

- may or may not be important  
- degree of importance differs between clients  
- can be dangerous if archaic and not intouch with the client’s life  
- can be a hindrance if there is a negative experience associated with religion  
- recognize that meaning and significance differ from person to person

3.1.0.2) Provides both influence and information on client’s world

- beliefs  
- values  
- worldview and meaning  
- internal organization  
- guides upbringing  
- Family and background and dynamics

3.1.0.3) source of positive psychological resources for client

- hope and positivity  
- sense of good in world
3.1. G5) Religious identity, like ethnic or sexual identity, needs to be understood as being part of the client.

3.1. G6) If you don’t ask about religion, you may censor the topic, and the client won’t feel like he or she has the permission to discuss it.

3.1. G8) Discussing client’s religious beliefs can enhance therapy
- provide motivation
- enhances rapport
- provides opportunities for intervention
-- dealing with spiritual concepts
like death, guilt, and shame
-- aids in crisis intervention
-- enhances pathological religious interpretations
-- provides direction when at a loss
-- helps to foster exploration and open conversations
-- can help to extend therapeutic concepts
-- client feels disconnected

3.1. a) Religion should never be part of therapy

3.2) When can addressing religion be beneficial?
3.2. G1) Level of benefit depends on the client: need to see if it matches with the client
- addressing religion can be beneficial if the client brings it up as important
- may or may not be important
- degree of importance differs between clients
- can be dangerous if archaic and not in touch with the client’s life
- can be a hindrance if there is a negative experience associated with religion
- recognize that meaning and significance differ from person to person

3.2. G2) Provides both influence and information on client’s identity and world
- beliefs
- values
- worldview and meaning
- internal organization
- guides upbringing
- Family and background and dynamics
- strengths
- connection to community/others/world
- Support system
- self-care

3.2. G3) Source of positive psychological resources for client
- hope and positivity
- sense of good in world
- support
- grounding/anchoring
- coping
- resilience
- strength
- forgiveness
- provides structure

3.2. G7) Connects the client to others
- connects client to a community
-connects client to others within a community
-becomes a problem when it disconnects client from others
-can aid in reconnecting client to others
-can encourage pro-social behaviors

-religion connects people to community resources
-connection to higher power

**3.2.G8** Discussing client’s religious beliefs can enhance therapy
-provide motivation — religious interpretations
-enhances rapport — aids in crisis intervention
-provide opportunities for intervention — provides direction when at a loss
--dealing with spiritual Concepts like death, guilt, and shame — helps to foster exploration and open conversations
--challenging pathological — can help to extend therapeutic concepts

**3.2.a** can aid in identity development

3.3) when can addressing religion be a hindrance to therapy

**3.3. G1** it can be a hindrance if it is unimportant to the client, or of the beliefs discussed are not matched to the client’s beliefs
-may or may not be important
-degree of importance differs between clients
-can be dangerous if archaic and not intouch with the client’s life
-can be a hindrance if there is a negative experience associated with religion
- recognize that meaning and significance differ from person to person

**3.3 G4** Source of harmful stress and conflict
-cognitive distortions
-oppressive environments
-negative self-image (sense of being damaged, not good enough, inherently bad, unclean or condemned, etc.)

**3.3 G9** beliefs can interfere with treatment
-supports psychopathology
-supports resistance to therapy or defends pathology
-monopolizes the therapeutic discussion

**3.3 G10** Addressing religion in therapy is dangerous when the therapist pushes beliefs
-pushes own belief system
-judges client based on beliefs
-quality of therapy suffers because of client beliefs

**Question 4: What line do you draw between religious belief and psychopathology?**

**4. G7** beliefs can be pathological when disrupt the connections with others
-connects client to a community — becomes a problem when it disconnects client from others
-connects client to others within a community — can aid in reconnecting client to others
can encourage pro-social behaviors

-can encourage pro-social behaviors
-religion connects people to community resources
-connection to higher power

4.G9) beliefs can interfere with treatment
-supports psychopathology
-supports resistance to therapy or defends pathology
-monopolizes the therapeutic discussion

4.G11) religious beliefs can interfere with therapy when they are rigid and inflexible, or certain

4.a) religion becomes pathological when it impedes health functioning
-impedes growth
-Interferes with life

4.b) religion becomes pathological when it interferes with the self
-causes harm to self
-causes one to sacrifice too much
-loss of self to beliefs

4.c) the differentiation between religion and pathology is a very nuanced determination
-depends on the client
-not due to disagreement of beliefs
-no absolute rules

4.d) a belief is pathological when a subjective or experiential claim is taken for an objective or empirical claim

Question 5: What training have you had in working with religious issues?

5.a) no formal training

5.b) specific courses in religion and psychology

5.c) generalized training to focus on all aspects of a client’s identity

5.d) personal religious practice and experience

5.e) continuing education

5.f) supervision

5.g) consultation

5.h) consuming research in religion and psychology

Question 6: When dealing with a client’s belief, how do you conceptualize their religious beliefs in a therapy setting?

6.G2) Provides influence and information on client’s world
-beliefs dynamics
-values strengths
-worldview and meaning connection to community/
-internal organization others/world
-guides upbringing Support system
-Family and background and self-care

6.G5) Religious identity, like ethnic or sexual identity, needs to be understood as being part of the client.
6. G7) how do beliefs connect the client to or disconnect the client from others

- connects client to a community
- connects client to others within a community
- becomes a problem when it disconnects client from others
- can aid in reconnecting client to others

- can encourage pro-social behaviors
- religion connects people to community resources
- connection to higher power

6. G8) discussing client’s religious beliefs can enhance therapy

- provide motivation
- enhances rapport
- provide opportunities for intervention
  -- dealing with spiritual concepts like death, guilt, and shame
  -- challenging pathological religious interpretations

- aids in crisis intervention
- provides direction when at a loss
- helps to foster exploration and open conversations
- can help to extend therapeutic concepts
- client feels disconnected

6.a) are beliefs consistent with known psychological principles
- are the integrated or pathological?

Question 7: How often is Religion addressed in your practice?
7.1a) 10-20%
7.1b) 21-40%
7.1c) 41-60%
7.1d) 61-80%
7.1e) 81-100%
7.2.G12) discussed if the client brings it up
- can be brought up directly
- can be brought up indirectly
- if client has mentioned religion is important previously principles
7.2a) asked at intake
7.2b) discussed if it is important to the client
- is it helpful to client
- are certain techniques like prayer and scripture helpful?
7.2d) clients come in seeking a therapist based on religious orientation

Question 8: How do you address religion in your practice?
8.a) brought up in intake
8.b) connection between religious beliefs and current issue is assessed
8.c) assess using good clinical techniques
- asking
- listening
- reflection
8.d) praying for client
8. G2) look for influence and information on client’s identity development and world and how religion has impacted this
- beliefs
- values
- worldview and meaning
- internal organization
- guides upbringing
- Family and background and dynamics
8. G8) Can discussing client’s religious beliefs can enhance therapy?
- provide motivation
- enhances rapport
- provides opportunities for intervention
  --dealing with spiritual concepts like death, guilt, and shame
  --challenging pathological religious interpretations
8. G12) discussed if the client brings it up
- can be brought up directly
- can be brought up indirectly
- if client has mentioned religion is important previously principles

Q9: Who is the one who generally begins the discussion of religion, you or your client?
9.1.a) Therapist brings it up
9.1.b) both therapist and client bring it up in therapy
9.1.c) Therapist waits for client to bring it up

9.2.a) asked at intake
9.2.G8) ask about client’s religious beliefs if at a loss or you think it can enhance therapy
- provide motivation
- enhances rapport
- provides opportunities for intervention
  - dealing with spiritual concepts like death, guilt, and shame
  - challenging pathological religious interpretations
9.2.G12) discussed if the client brings it up
- can be brought up directly
- can be brought up indirectly
Q10) How do you assess the spiritual/religious beliefs of your client?

Interview/assessment tools?

10.1.a) no formal assessment
10.1.b) look for verbal clues
10.1.c) look for nonverbal clues
10.1.d) ask in conversation/discussions
10.1.e) ask in formal clinical interview
10.1.f) be open to hear and accept anything the client says, but not “assess”
10.1.g) assess only if beliefs are pathological

10.2) when assessing, ask about

10.2a) beliefs
10.2b) affiliation
10.2c) formation of belief system
10.2d) level of activity/participation
10.2e) commitment
10.2f) role in life
10.2g) family beliefs, and if those beliefs are different
10.2h) partner beliefs and if those beliefs are different

Q11: How do you assess the appropriateness of addressing religion with a particular client?

11.a) never appropriate to inquire
11.G1) level of appropriateness depends on level of importance depends on the client: need to see if it matches with the client
- may or may not be important
- degree of importance differs between clients
- can be dangerous if archaic and not in touch with the client’s life
- can be a hindrance if there is a negative experience associated with religion
- recognize that meaning and significance differ from person to person

11.G6) If you don’t ask about religion, you may censor the topic, and the client won’t feel like he has the permission to discuss it.

11.G8) appropriate if discussing client’s religious beliefs can enhance therapy
- provide motivation
- enhances rapport
- provide opportunities for intervention
- dealing with spiritual concepts like death, guilt, and shame
- provide direction when at a loss
- helps to foster exploration and open conversations
- aids in crisis intervention
- can help to extend therapeutic concepts
-client feels disconnected

11. G12) discussed if the client brings it up
- can be brought up directly
- can be brought up indirectly
- if client has mentioned religion is important previously principles

11.a) appropriate if related to themes of the conversation

11.b) appropriateness based on clinical judgment

11.c) not appropriate if client shows discomfort or resistance

11.d) not appropriate if part of pathology

Q12: Are there any specific methods or techniques you use when addressing religion in therapy?

12.a) no techniques

12.b) limited self-disclosure

12.c) identify available resources

12.d) assess using discussions or interviews

12.e) assess how the client responds to the topic of religion

12.f) see what has worked in the past

12.g) look for level of expressed faith

12.h) specific religious interventions are used

- scripture
- religious music
- prayer
- centering
- religious retreats

Q13: Can you think up an instance or instances where a client’s religious beliefs have been complimentary to what we know about mental health?

13.G2) Provides influence and information on client’s identity and world

- beliefs
- values
- worldview and meaning
- internal organization
- guides upbringing
- Family and background and dynamics

13.G3) source of positive psychological resources for client

- hope and positivity
- sense of good in world
- support
- grounding/anchoring
- coping

13.G7) connects the client to others

- connects client to a community
- connects client to others within a community
- becomes a problem when it disconnects client from others

- can aid in reconnecting client to others
- can encourage pro-social behaviors
-religion connects people to community 
-connection to higher power 
**13.G8** discussing client’s religious beliefs can enhance therapy 
-provide motivation 
-enhances rapport 
-provide opportunities for intervention 
--dealing with spiritual concepts like death, guilt, and shame 
--challenging pathological religious interpretations 
-aids in crisis intervention 
-provides direction when at a loss 
-helps to foster exploration and open conversations 
-can help to extend therapeutic concepts 
-client feels disconnected 

**Q14**: Can you think up an instance or instances where a client’s religious beliefs have been contradictory with what we know about mental health?  
**14.1.G4** Source of harmful stress and conflict 
-cognitive distortions 
-oppressive environments 
-Shame without forgiveness 
**14.1.G7** beliefs cause rejection, isolation, or disconnection from others 
**14.1.G9** beliefs can interfere with treatment 
-supports psychopathology 
-supports resistance to therapy or defends pathology 
-monopolizes the therapeutic discussion 
**14.1.G11** religious beliefs can contradict therapy when they are rigid and inflexible, or certain 
**14.1.a** issues involving sexuality and religion 
**14.1.b** beliefs lead to harm of others or self 
**14.1.c** when there is a level of obsession that interferes with life 
**14.1.d** when there is a misunderstanding of religion 
**14.1.e** there is no real contradiction 

**14.2: Resolving the contradiction** 
**14.2.a** perspective taking 
**14.2.b** reality testing and orientation 
**14.2.c** encourage religious investigation 
**14.2.d** connect to better leadership 
**14.2.e** introduce new interpretations 
**14.2.f** respect the framework provided by beliefs and challenge carefully 

**Q15**: What are the ethical concerns surrounding addressing religion in Psychology in reference to The Ethical principle of Competence in Psychology?  
**15.G5** Religious identity, like ethnic or sexual identity, needs to be understood as being part of the client. 
**15.G10** Addressing religion in therapy is dangerous when the therapist pushes beliefs
- pushes own belief system
- judges client based on beliefs
- quality of therapy suffers because of client beliefs

15.G13) know and be aware of your own beliefs

15. G14) Don’t overstep your boundaries as a psychologist
- don’t speak outside of your professional role
- don’t inappropriately disclose
- remember that your role as psychologist continues outside the office, such as in your public image

15. G15) know and be aware of your own limits

15. G16) be open with client
- beliefs
- competence
- biases

15. G17) seek continuing education
- continuing education
- be aware of literature

15. G18) respect client beliefs
- don’t judge
- respect beliefs and conflicts

15.G19) don’t generalize beliefs

15.G20) seek consultation

15.G21) Seek supervision

15.G22) refer if there is a conflict

15.G10) Addressing religion in therapy is dangerous when the therapist pushes beliefs

15.a) focus on more than the negative

15.b) you don’t need to be religious to inquire

15.c) we need more guidelines

15.G23) encourage environment of open and curious exploration

Q16: What are the ethical concerns surrounding addressing religion in Psychology in reference to The Ethical principle of Integrity in Psychology?

16. G5) Religious identity, like ethnic or sexual identity, needs to be understood as being part of the client.

16. G15) know and be aware of your own limits

16. G16) be open with client
- beliefs
- competence
- biases

16. G18) respect client beliefs
- don’t judge
- respect beliefs and conflicts

16. G22) refer if there is a conflict

16.G23) encourage environment of open and curious exploration
16.a) Psychology needs to be the primary focus in therapy; religion is only addressed when relevant
16.b) know client expectations
16.c) understand and maintain confidentiality

Q17) What are the ethical concerns surrounding addressing religion in Psychology in reference to The Ethical principle of Responsibility in Psychology?
17.G6) If you don’t ask about religion, you may censor the topic, and the client won’t feel like he has the permission to discuss it.
17.G10) Addressing religion in therapy is dangerous when the therapist pushes beliefs
- pushes own belief system
- judges client based on beliefs
- quality of therapy suffers because of client beliefs
17.G14) Don’t overstep your boundaries as a psychologist
- don’t speak outside of your professional role
- don’t inappropriately disclose
- remember that your role as psychologist continues outside the office, such as in your public image
17.G16) be open with client
- beliefs
- competence
- biases
17.G23) encourage environment of open and curious exploration
17.G24) understand the purpose of the beliefs for the client
17.a) duty to warn and maintain safety of the client
17.b) recognize that psychology is not the only source of mental health and change
17.c) inquire about the level of comfort with talking about religion
17.d) take ownership of the therapeutic environment
17.e) know the available resources

Q18: What are the ethical concerns surrounding addressing religion in Psychology in reference to The Ethical principle of Respect for dignity and autonomy in Psychology?
18.G1) level of importance depends on the client: need to see if it matches with the client
- may or may not be important
- degree of importance differs between clients
- can be dangerous if archaic and not in touch with the client’s life
- can be a hindrance if there is a negative experience associated with religion
- recognize that meaning and significance differ from person to person
18.G10) Addressing religion in therapy is dangerous when the therapist pushes beliefs
- pushes own belief system
- judges client based on beliefs
- quality of therapy suffers because of client beliefs
**18.G18**) respect client beliefs
- don’t judge
- respect beliefs and conflicts
- clients have a right to their beliefs
- accept client

**18.G22**) refer if there is a conflict
**18.a**) if a client shows resistance, move on
**18.b**) respect others as individuals
**18.c**) look at the interaction of person and beliefs
**18.e**) don’t set up strict counselor/patient hierarchy or control environment

Q19: **What are the ethical concerns surrounding addressing religion in Psychology in reference to The Ethical principle of Concern for Client’s Welfare in Psychology?**

**19.G1**) level of importance depends on the client: need to see if it matches with the client
- may or may not be important
- degree of importance differs between clients
- can be dangerous if archaic and not in touch with the client’s life
- can be a hindrance if there is a negative experience associated with religion
- recognize that meaning and significance differ from person to person

**19.G7**) connects the client to others
- connects client to a community
- connects client to others within a community
- becomes a problem when it disconnects client from others
- can aid in reconnecting client to others
- can encourage pro-social behaviors
- religion connects people to community resources
- connection to higher power
19.G8) determine if discussing client’s religious beliefs will enhance therapy
19.G9) avoid beliefs if they interfere with treatment
   -supports psychopathology
   -supports resistance to therapy or defends pathology
   -monopolizes the therapeutic discussion
19.G10) Addressing religion in therapy is dangerous when the therapist pushes beliefs
   -pushes own belief system
   -judges client based on beliefs
   -quality of therapy suffers because of client beliefs
19.G14) Don’t overstep your boundaries as a psychologist
   -don’t speak outside of your professional role
   -don’t inappropriately disclose
   -remember that your role as psychologist continues outside the office, such as in your public image
19.G15) know and be aware of your own limits
19.G24) understand the purpose of the beliefs for the client
19.G23) encourage environment of open and curious exploration
19.a) assess if beliefs are positive or negative
19.b) monitor for the safety of the client

Q20: What are the ethical concerns surrounding addressing religion in Psychology in reference to The Ethical principle of Social Welfare in Psychology?
20.G7) connects the client to others
   -connects client to a community
   -connects client to others within a community
   -becomes a problem when it disconnects client from others
   -can aid in reconnecting client to others
   -can encourage pro-social behaviors
   -religion connects people to community resources
   -connection to higher power
20.G10) Addressing religion in therapy is dangerous when the therapist pushes beliefs
   -pushes own belief system
   -judges client based on beliefs
   -quality of therapy suffers because of client beliefs
20.G13) know and be aware of your own beliefs and biases
20.G14) Don’t overstep your boundaries as a psychologist
   -don’t speak outside of your professional role
   -don’t inappropriately disclose
   -remember that your role as psychologist continues outside the office, such as in your public image
20.G18) respect client beliefs
   -don’t judge
   -respect beliefs and conflicts
- clients have a right to their beliefs
- accept client
20.a) protect your client from unsafe circumstances
20.b) educate community about diversity
20.c) understand cultural influences
APPENDIX D

List of Global Themes

G1) level of importance depends on the client: need to see if it matches with the client
- may or may not be important
- degree of importance differs between clients
- can be dangerous if archaic and not in touch with the client’s life
- can be a hindrance if there is a negative experience associated with religion

G2) Provides influence and information on client’s world
- beliefs
- values
- worldview and meaning
- internal organization
- guides upbringing
- Family and background and dynamics
- strengths
- connection to community/ others/world
- Support system
- self-care

G3) source of positive psychological resources for client
- hope and positivity
- sense of good in world
- support
- grounding/anchoring
- coping
- resilience
- strength

G4) Source of harmful stress and conflict
- cognitive distortions
- oppressive environments
- negative self-image (sense of being damaged, not good enough, inherently bad, irreparably unclean or condemned, etc)

G5) Religious identity, like ethnic or sexual identity, needs to be understood as being part of the client.

G6) If you don’t ask about religion, you may censor the topic, and the client won’t feel like he has the permission to discuss it.

G7) connects the client to others
- connects client to a community
- connects client to others within a community
- becomes a problem when it disconnects client from others
G8) discussing client’s religious beliefs can enhance therapy
- provide motivation
- provide opportunities for intervention
- aids in crisis intervention
- provides direction when at a loss
- helps to foster exploration
- can help to extend therapeutic concepts

G9) beliefs can interfere with treatment
- supports psychopathology
- supports resistance to therapy or defends pathology
- monopolizes the therapeutic discussion

G10) Addressing religion in therapy is dangerous when the therapist pushes beliefs
- pushes own belief system
- judges client based on beliefs
- quality of therapy suffers because of client beliefs

G11) religious beliefs can interfere with therapy when they are rigid and inflexible
- belief becomes certainty

G12) discussed if the client brings it up
- can be brought up directly
- can be brought up indirectly
- if client has mentioned religion is important previously

Principles

G13) know and be aware of your own beliefs and biases

G14) Don’t overstep your boundaries as a psychologist
- don’t speak outside of your professional role
- don’t inappropriately disclose
- remember that your role as psychologist continues outside the office, such as in your public
  Image

G15) know and be aware of your own limits

G16) be open with client
- beliefs
  - competence
  - biases

G17) seek continuing education
- continuing education
- be aware of literature

G18) respect client beliefs
   - don’t judge
   - respect beliefs and conflicts
   - clients have a right to their beliefs
   - accept client

G19) don’t generalize beliefs

G20) seek consultation

G21) Seek supervision

G22) refer if there is a conflict

G23) encourage environment of open and curious exploration

G24) understand the purpose of the beliefs for the client