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One Mind or Two? How Psychiatrists and Psychologists Manage Medical-Scientific and Religious Interpretations of Mind

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Building upon concepts from sociology of medicine, religion, knowledge, and professions, this study explores the social determinants of separation and integration of medical-scientific and religious approaches to mind and mental health. Using qualitative interviews, it shows how, to what extent, and why psychiatrists and psychologists of Judeo-Christian religious orientations or nonaffiliated believers in the State of Michigan are willing or reluctant to integrate religious paradigms in their mental health practices. The study turns to a content analysis of 3,680 articles from two leading professional journals to assess the participants’ claims regarding the treatment of religion prevalent in psychiatry and psychology.

Most of the study participants were found to believe that medical-scientific and religious paradigms are equally important and may coexist or even be integrated in psychotherapeutic practice. However, actual attempts to integrate them usually reflected the practitioners’ personal religious backgrounds and initiatives and/or were client driven. Yet these integration initiatives were found to face powerful institutional impediments ranging from politico-cultural norms of separation of religion from secular institutions, to traditions of marginalization of religious
issues in professional literatures. Thus, this study shows that the recently popular
appeals to bridge the traditional and alternative medical approaches and to overcome
the mind-body separation in mental health practices may be unrealistic unless the
institutional obstacles to such integrative approaches are fully taken into account and
dealt with by educational and professional organizations.
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I am grateful to the psychiatrists and psychologists who generously gave of their time, often beyond the agreed upon 1 hour, to share with me their views on and experience with religion, spirituality, and psychotherapy.

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Ellen Wagenfeld-Heintz
# TABLE OF CONTENTS

ACKNOWLEDGMENTS ........................................................................................................ ii  
LIST OF TABLES ............................................................................................................. iii  
LIST OF FIGURES ............................................................................................................ iv  

## CHAPTER

### I. INTRODUCTION ........................................................................................ 1

Statement of Research Problem ........................................................................ 1  
Overview of Findings ....................................................................................... 4  
Plan of Dissertation ......................................................................................... 5  
Practical Significance ....................................................................................... 7  
Academic Significance ...................................................................................... 9  
Sociology of Religion ....................................................................................... 9  
Sociology of Knowledge and Sociology of Professions .................................. 10  
Medical Sociology ............................................................................................ 10  

### II. CONCEPTUAL FRAMEWORK ................................................................ 12

Structure of Knowledge .................................................................................... 13  
Paradigms ........................................................................................................... 13  
Rationalities ....................................................................................................... 13  
Domain Assumptions ......................................................................................... 14  
Sociology of Knowledge .................................................................................... 15  
Commonsense Knowledge of Professions ........................................................ 16  
Structure of Knowledge in Context ................................................................... 17  
Power of the Institution of Medicine and Science ........................................ 17  

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CHAPTER

Institutional Specialization ......................................................... 19
Training ........................................................................................ 21
Professional Socialization........................................................... 21
Discourses .................................................................................... 23
Conclusion ............................................................................................ 23

III. LITERATURE REVIEW .............................................................................. 25

Introduction ..................................................................................... 25
Definitions of Religion and Spirituality ............................................. 26
Historical Relationship between Religion and Medicine ................... 28
Psychiatry and Psychology as Science-Based Disciplines............... 30

Traditional Negative View of Religion by Psychiatry and Psychology ..... 31

Reasons for Negative View ............................................................. 32
Changing View of Religion as Part of the Professions ....................... 34

Overlap between the Domains ....................................................... 34
Are Religion and Spirituality Included in Psychotherapy? ...... 36

Christian Psychiatrists and Psychologists.................................. 39
Socialization and Religiosity ............................................................... 41

How Religious and Spiritual are Psychiatrists and Psychologists? ....... 42

Prayer ........................................................................................... 45

Impact of Psychiatrists’ and Psychiatrists’ Religious Values on Psychotherapy ................................................................. 48
Table of Contents—continued

CHAPTER

Impact of Clients’ Values on Psychotherapy ........................................ 49
Professional Socialization ........................................................................ 50
Training Programs ............................................................................. 51
Colleagues ......................................................................................... 55
Ethics Codes ...................................................................................... 56
Journals and Books .......................................................................... 61
Diagnosis and Insurance Practices ................................................... 63
Relationship between Personal and Professional Lives ......................... 64
Conclusion .......................................................................................... 66

IV. DATA AND METHODS .............................................................................. 67

Data Gathering ..................................................................................... 67
Selection Criteria ................................................................................ 67
Implementation .................................................................................. 68
Description of Matrix ......................................................................... 70
Denominational Classification .............................................................. 71
Description of Data Collection Method .................................................. 75
Why Qualitative .................................................................................... 75
Procedure ............................................................................................ 77
Reaction of Interviewees and Difficulties ................................................. 79
Data Analysis ....................................................................................... 80
Getting to Know the Data ..................................................................... 80
Methods and Procedures of Analysis .................................................. 81

v

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Table of Contents—continued

CHAPTER

Explanatory Variables ................................................................. 82
Constructing Ideal Types............................................................ 83
Content Analysis........................................................................ 84

V. FINDINGS FROM INTERVIEWS.................................................. 86
Personal Background Factors....................................................... 87
Professional Life ........................................................................ 88
Religious Life ............................................................................ 93

Professional and Institutional Regulations ..................................... 96
Definition of Psychiatry and Psychology ................................. 97
Definition of Psyche .................................................................. 101
Training ..................................................................................... 103
Residency and Internships ......................................................... 106
Not Discussed with Peers .......................................................... 108
Professional Organizations ......................................................... 113

How Psychiatry and Psychology View Religion and Spirituality ... 116
Ethics ........................................................................................ 120
Professional Norms .................................................................... 121
Rethink or Go Along with Religious or Spiritual Interpretations .................................................. 132
Sin, Soul, and Salvation ............................................................. 135
Openly Religious Practitioners .................................................. 136
Etiology of Disease: Two Languages or One? ......................... 138
# Table of Contents—continued

## CHAPTER

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Specialization and Distinction</td>
<td>144</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>146</td>
</tr>
<tr>
<td>Client Driven Factors</td>
<td>150</td>
</tr>
<tr>
<td>Are You a Christian Counselor?</td>
<td>150</td>
</tr>
<tr>
<td>Practice of Psychotherapy</td>
<td>152</td>
</tr>
<tr>
<td>Prayer in the Work Space</td>
<td>152</td>
</tr>
<tr>
<td>Religion and Spirituality Integrated into Role As Therapist</td>
<td>155</td>
</tr>
<tr>
<td>Religion and Spirituality One Thing among Many in the Assessment Process</td>
<td>160</td>
</tr>
<tr>
<td>Existential Crisis</td>
<td>161</td>
</tr>
<tr>
<td>Contrary to Beliefs</td>
<td>162</td>
</tr>
<tr>
<td>Tension between Roles</td>
<td>162</td>
</tr>
<tr>
<td>Therapists’ Own Level of Discomfort with Religion Influencing Therapy</td>
<td>165</td>
</tr>
<tr>
<td>What Has Changes Since First Started to Practice</td>
<td>165</td>
</tr>
<tr>
<td>Participants’ Reactions to the Interview</td>
<td>167</td>
</tr>
<tr>
<td>Positive Responses</td>
<td>167</td>
</tr>
<tr>
<td>Sorry for Being Complex</td>
<td>169</td>
</tr>
<tr>
<td>Did I Answer Your Question?</td>
<td>170</td>
</tr>
<tr>
<td>This is a Hard Question</td>
<td>171</td>
</tr>
<tr>
<td>Caught Off Guard</td>
<td>171</td>
</tr>
<tr>
<td>Annoyance and Defensiveness</td>
<td>172</td>
</tr>
<tr>
<td>Conclusion</td>
<td>173</td>
</tr>
<tr>
<td>CHAPTER</td>
<td>Section</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td>Ideal Types</td>
</tr>
<tr>
<td></td>
<td>Description of Types</td>
</tr>
<tr>
<td></td>
<td>Interpretation</td>
</tr>
<tr>
<td>VI.</td>
<td>CONTENT ANALYSIS FINDINGS</td>
</tr>
<tr>
<td></td>
<td>Data</td>
</tr>
<tr>
<td></td>
<td>Types of Articles</td>
</tr>
<tr>
<td></td>
<td>Method</td>
</tr>
<tr>
<td></td>
<td>Findings</td>
</tr>
<tr>
<td></td>
<td>The American Journal of Psychiatry</td>
</tr>
<tr>
<td></td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Psychotherapy</td>
</tr>
<tr>
<td></td>
<td>Discussion</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
</tr>
<tr>
<td>VIII.</td>
<td>DISCUSSION</td>
</tr>
<tr>
<td></td>
<td>The Normative Discourses of Integration and Separation</td>
</tr>
<tr>
<td></td>
<td>Separation of Paradigms</td>
</tr>
<tr>
<td></td>
<td>Integration of Paradigms</td>
</tr>
<tr>
<td></td>
<td>Role of the Institution</td>
</tr>
<tr>
<td></td>
<td>Contribution to Existing Literature</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
</tr>
<tr>
<td>VIII.</td>
<td>CONCLUSION</td>
</tr>
<tr>
<td></td>
<td>Limitations and Directions for Future Research</td>
</tr>
</tbody>
</table>
Table of Contents—continued

Practical Implications ................................................................. 207

APPENDICES

A. Telephone Script ................................................................. 209
B. Interview Guide ................................................................. 211
C. Human Subjects Institutional Review Board Approval Letters .... 216
D. Informed Consent Form ....................................................... 222

REFERENCES ............................................................................... 225
LIST OF TABLES

1. Matrix of Psychiatrists and Psychologists ...................................................... 71
2. Theoretical Perspective of Psychiatrists and Psychologists ........................... 91
3. Age Range of Participants by Profession and Sex ......................................... 92
4. Ideal Type Categories ...................................................................................... 175
5. Regular Articles in *The American Journal of Psychiatry* Themes by Year . 185
6. Special Articles in *The American Journal of Psychiatry* Themes by Year . 188
7. Clinical and Research Reports and Brief Reports in *The American Journal of Psychiatry* Themes by Year .......................................................... 188
8. Articles in *Psychotherapy* Themes by Year ................................................... 191
LIST OF FIGURES

1. Conceptual Model ................................................................. 86
CHAPTER 1

INTRODUCTION

Statement of Research Problem

Recently, the mind-body divide in medical practices has been broadly discussed by specialists and the general public. Indeed, in 1993 the Public Broadcasting Service aired the series *Healing and The Mind* that explored this issue with the foremost researchers and thinkers in the field such as Candace Pert, Margaret Kemeny, David Felten, and Robert Ader, all of whom see the mind-body as one phenomenon and believe that both mind and body should be taken into account by health professionals (see also the companion book to the series, Moyers (1993)). Exciting as it sounds, this idea is problematic. When one says that "mind" has to be dealt with in medical treatment, what does one mean? Distinct cultures of interpretation of the mind exist in health care. One is rooted in the scientific and medical approach to mind and illness and the other in multiple religious traditions. Both are represented in this country, yet little is known about the extent to which these two cultures influence the day-to-day work of mental health practitioners, especially those trained to deal with the mind in scientific and medical terms and, at the same time, not alien to spiritual and religious traditions.

Traditionally, religion and scientific perspectives in the practice of psychotherapy have been viewed as a dichotomy, for historical, professional, and institutional reasons. The goal of the study is to explore the ways in which psychiatrists and fully licensed psychologists in the State of Michigan (hereafter, psychologists), who described themselves as either affiliated with a Judeo-Christian denomination (as a member or non-
member of a congregation) or having religious or spiritual beliefs outside of a
denominational association, interpret the problems of mind and mental health. This study
is limited to these Western religions because of different cultural perspectives that would
have to have been taken into account if non-Western religions were included.

Psychiatrists and psychologists versus other health care providers, such as family
practice physicians, were chosen because they deal most readily with the mind. These
mental health professionals could provide an interesting contrast because psychiatrists
could be more structurally influenced by medical thinking than psychologists. In order to
have some degree of representation, and a basis of comparison, women and men of
various Judeo-Christian religious traditions, as well as nonaffiliated believers, were asked
to be interviewed.

Particularly of interest are the ways in which their religious and spiritual and
medical-scientific interpretations are kept separate from each other or brought together.
How do psychiatrists and psychologists who describe themselves as religious and
spiritual reconcile their scientific training, which teaches that mind is a physiological
entity and describes it in behavioristic terms, with their religious training, which
interprets mind as soul? Do they see their patients’ conditions as predominantly a soul
problem or a biochemical/brain problem in etiology? What are the ways and are there
ways the individual can traverse this perceived breech? If religion and science are not
viewed as opposites, how does one handle the integration of these divergent views? What
are the “commonsense knowledges” (Garfinkel 1967) in psychiatry and psychology about
the “proper” role of or place of religion that guide these professions?
Finally, how and where did these individuals learn their integration or separation strategies and what factors led to it? Do the institutions of these respective professions, including schools attended, training sites, books used, professors, peers, professional organizations, and journals play a role in supporting their religious and spiritual beliefs as they apply to the patient they are treating? How do institutions shape their thinking about what is the “proper” relationship between science and faith? On the other hand, what role do religious institutions play? This study fundamentally questions how religious ideas, values, and expression survive in secularized settings and how religion as an institution and expression is kept apart from other institutions and human activities.

Taking the practitioners' interpretation as its point of departure, this study investigates what they see as obstacles and/or stimuli to the integration of the religious and spiritual and scientific-medical traditions. Specifically, I focus on real and perceived institutional impediments to such integration. This was achieved through semi-structured open-ended qualitative interviews (to gather the same data from each participant) with an unstructured segment to follow-up with interesting points raised during the structured segment. In order to understand institutional and professional influences on psychiatrists and psychologists, as well as to see how participants' perception of the treatment of religion and spirituality in their field matches up to an objective measure, I conducted a content analysis of 10 years (1990-2000) of the journals The American Journal of Psychiatry (120 issues) and Psychotherapy (40 issues). As shown in the literature review below, very little research has been conducted on this subject. It is not known how the alternative interpretations of mind shape the mental health practitioners' perceptions.
Overview of Findings

This study shows powerful institutional constraints that psychiatrists and psychologists had to overcome in order to incorporate religious and spiritual paradigms with a medical-scientific one. For example, in order to be a member of the profession, certain behaviors were required such as adherence to diagnostic schemes and delineation of professional role from that of clergy. Professional literature gives little attention to the issues of religion and spirituality in psychotherapy. Professional discourses emphasize the norms of not imposing one’s religious or spiritual values on clients, following clients’ lead and discussing what is of importance to the client. The majority of psychotherapists reported not having training in discussing religious and spiritual issues.

At the same time, a number of participants found ways to overcome institutional impediments to integration and found ways to incorporate their religious and spiritual beliefs and knowledge into psychotherapy. However, it is important to remember that this group represents a special portion of psychiatrists and psychologists, those who identify themselves as religious. Therefore, the relationship between the medical-scientific and religious and spiritual paradigms can best be characterized as existing side-by-side with some degree of reciprocity between the two, versus completely separate or a seamless blending of the two. In addition, integration attempts usually were reported to reflect clients’ preferences and/or practitioners’ theoretical orientations rather than, and usually in spite of, institutional norms.
Plan of Dissertation

I begin with a discussion of the theoretical underpinnings of the question of “one mind or two.” Specifically, in Chapter II the notions of paradigms (Kuhn 1996), rationalities (Winch 1977), domain assumptions (Gouldner 1970), sociology of knowledge (Berger and Luckmann [1966] 1967), medicalization (Conrad 1996), ethnomethodology (Garfinkel 1967), and ideologies of professions. These concepts are crucial to understand the notion of competing frames of knowledge, the role of the institution in shaping professionals’ thinking, and what is taken-for-granted in professional practice.

In Chapter III I review the relevant literature and note gaps in knowledge. I set the stage for the findings by discussing the conflicting ways in which religion and spirituality have been defined in the literature and the historical relationship between religion and medicine. Next, I show how psychiatry and psychology have defined themselves as science-based disciplines and their traditional negative view of religion. I explore the reasons for both this negative view and ways this view is changing. I then review what is known about therapists’ private religiosity and spirituality and ways in which their and clients’ values impact psychotherapy. I conclude this chapter with a discussion of the degree to which agents of professional socialization such as training programs, colleagues, ethics codes, journals and books, diagnosis and insurance include or exclude religion.

Chapter IV, “Data and Methods”, describes the data gathering strategies I used including selection criteria, implementation, description of the matrix, and denominational classification. I then delineate my data collection method including why I
have chosen to use qualitative methods for this study and the procedure for carrying out
the interviews. Next, I detail my data analysis method and describe the construction of
ideal types. I conclude the chapter with a brief description of how I completed the content
analysis of two professional journals. More is said on this in Chapter VII.

Findings from the interviews are reported in Chapter IV. I break these findings
into four areas: (1) personal religious and professional background factors of the
participants, (2) professional and institutional norms, (3) client driven factors, and (4) the
practice of therapy. I then discuss participants' reactions to the interview as an indication
of the extent to which medical-scientific and religious and spiritual paradigms are present
in professional practice but are not obvious and taken-for-granted. Finally, I conclude
with classifying participants into an ideal types matrix. I analyze the potential affect of
the following seven variables on the integration or separation of religious and medical-
scientific paradigms: (1) profession; (2) denomination; (3) sex; (4) race; (5) theoretical
perspective, (6) years in practice, and (7) age.

In Chapter VI, I report on findings from the content analysis of the The American
Journal of Psychiatry and Psychotherapy and suggest implications of what I found with
respect to what participants perceived about the amount of attention paid to religion,
spirituality, and psychotherapy in their profession.

In Chapter VII, I discuss the findings in light of the questions I raised in the
conceptual framework. I begin with describing the normative discourses of integration
and separation and the norms that these emphasize. I comment on ways in which
therapists both separated and integrated the medical-scientific and religious and spiritual
paradigms in their professional practice, and institutional obstacles that had to be

6

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overcome. I conclude with inventorying ways in which this study contributes to existing literature.

The final chapter of the dissertation discusses limitations and directions for future research as well as practical implications of the study.

Practical Significance

Health and mental health problems exact a great toll on American society. According to *The Global Burden of Disease* (Murray and Lopez 1996), unipolar major depression is second only to diabetes in terms of disease burden in established market economies (p. 273, 276). The role of religion and spirituality in medicine is receiving more attention in research and the popular press. The work of David Larson, Dana King, Deepak Chopra, Harold Koenig, and Larry Dossey (all physicians), to name a few, addresses this link. On a mass level, people such as the late Norman Vincent Peale (1955; 1956), a minister and founder of the Institutes of Religion and Health in New York and M. Scott Peck (1985; 1993), a psychiatrist, have attempted to affect a *rapprochement* between religion and mental health and popularized their joining. However, the relationship between religion and the practice of mental health is under-studied and the research literature is lagging behind.

In addition, according to the most recent Gallup Poll (2001) 61% of Americans say religion is a “very important” part of their lives, and 27% say it is “fairly important” (p. 93). Additionally, 66% believe that religion can answer all or most of today’s problems (p. 95). These findings show that religion is a vital component of daily life for many Americans. Although religion is still a notable institution in the United States and
part of the culture, secularization has led to the compartmentalization of religion and human activities, including healthcare. Fifty-eight percent of Americans polled believed that religion is losing its influence on American society (Gallup, Jr. 2001).

Clients who are religious and spiritual may want to integrate that part of their life into the cure of their problems. Therapists (psychiatrists or psychologists) have a perspective on the etiology of the problem as well, created and supported by the institutions of the respective profession (including school attended, training sites, books used, professors, peers, professional organizations, and journals) and religious denomination and/or spiritual beliefs. Traditionally psychiatrists and psychologists are trained to view the etiology of emotional/mental problems from a scientific framework. The scientific-practitioner movement in counseling psychology is an example of this.

Bernstein and Kerr (1993) described this as a model that was adopted by the American Psychological Association (APA) in 1947. The conception of the scientist-practitioner model is one in which practitioners consume and apply the results of research about assessment and treatment, evaluate their own intervention using (p. 136) empirical methodology, and report the results of their own research to the scientific community. Similarly, the work of the researcher is informed by practice: Hypotheses and designs are generated by the experience of practice (Barlow, Hayes, & Nelson, 1984). The Boulder Conference in 1949 established the scientist-practitioner model of training. (P. 136-137)

Yet some psychiatrists and psychologists also have strong personal religious and spiritual beliefs. A conflict then could arise between competing constructions of realities (Berger and Luckmann [1966] 1967:21) and rationalities (Winch 1977:175) or frames of knowledge (both of these terms will be explained in more detail in the next chapter).

This study has the potential to contribute to training mental health professionals in a more holistic spirit that involves multiple perspectives of mental health, including the
ones originating outside of the medical establishment. It will highlight obstacles to forming a more integrative approach to mental health and the training of these professionals. An implication of this study is the effect of this division on psychotherapists’ internal experience of their self as a whole person. This study addresses this issue from the perspective of the practitioner.

Finally, both clients and some clergy desire therapists who are comfortable and conversant in both the psychotherapeutic and religious and spiritual domains (Blasi 2002, personal communication). This study points to the extent to which therapists are filling this need.

Academic Significance

In an attempt to uncover ideologies of psychiatry and psychology and commonsense knowledge that guides these professions, this study draws upon and contributes to the fields of: sociology of religion, sociology of knowledge, sociology of professions, and medical sociology.

Sociology of Religion

Contributions to the sociology of religion consist of describing the ways in which religious interpretations are used and/or blocked in largely secularized fields of the application of knowledge, in this case, psychiatry and psychology. This shows how religious ideas, values, and expression survive in secularized settings and how religion as an institution and expression kept apart from other institutions and human activities.
Sociology of Knowledge and Sociology of Professions

This study’s contribution to the sociology of knowledge and sociology of professions consists of assessing the effects of specialization of knowledge on professional’s willingness and ability to have an integrated view of human existence and mind. This study shows if and to what extent specialization deprives professionals of the ability to come up with a holistic view of the human mind, existence, and psychological well-being. It addresses the role of professional socialization in shaping professional’s view of the boundaries of the profession (Joseph 1989:40) and as a result, what is taken-for-granted in the practice of psychotherapy. Finally, how psychiatrists and psychologists bring together different rationalities and different logical systems as well as the result of clashes between conflicting paradigms is discussed.

Medical Sociology

This study contributes to the medical sociology literature on religion and health. Josephson, Larson, Juthani (2000) (psychiatrists) noted a number of studies that have shown, “depression, alcohol abuse, drug abuse, anxiety disorder and suicide have been found at lower rates among persons who are more involved with religion.” (p. 526). Similarly, according to Koenig, Larson, and Larson (2001):

The vast majority of such studies [that examine the relationship between religious involvement and an indicator of mental health] do indeed find that religious involvement is associated with greater well-being and life satisfaction, greater purpose and meaning in life, greater hope and optimism, less anxiety and depression, more stable marriages, and lower rates of substance abuse. (P. 356)

In addition, much research has been done on the effect of religion and religious involvement on health and mental health, as well as recovery from surgery (see for

Daaleman and Frey (1999) researched the level of personal religious and spiritual beliefs of family practice physicians and found that 79 percent “reported a strong religious or spiritual orientation.” (p. 98). However, a study of family practice doctors by Ellis, Vinson, and Ewigman (1999) found that spiritual issues were infrequently discussed with their patients. Ehman, Ott, Short, Ciampa, and Hansen-Flaschen (1999) found that if gravely ill, pulmonary patients would like their physician to inquire about their spiritual beliefs (p. 1803). Maugans and Wadland (1991) studied religious beliefs of family practice physicians and patients and the appropriateness of the discussion of religion in the clinical encounter. McKee and Chappel (1992) supported addressing spiritual issues in family practice medicine and briefly suggested how to accomplish this, as well as the importance of including this topic in medical education.

While there is much research on specific fields in medicine, integration and separation of the medical-scientific and religious and spiritual approaches in psychotherapy was not explored in depth. Little is known about how religious beliefs influence the work of medical practitioners.

In the next chapter I will discuss in more detail the ways in which the theoretical perspectives of sociology of science, sociology of knowledge, ethnomethodology sociology of religion, and sociology of professions inform my topic.
CHAPTER II

CONCEPTUAL FRAMEWORK

The purpose of this study is to learn how clinicians mediate the separate discourses of medical-science and religion. While I begin with the present view that science and religion are distinct spheres, I do not essentialize their differences. That is, the divergence of science and religion is a relatively late product historically, coming to be by the Enlightenment. By acknowledging the historical relationship between science and religion, it opens up an understanding for how religion can be part of medical-scientific practice, as will be shown in the empirical findings.

However, analytically religious and medical-scientific views can be viewed as two distinct forms of knowledge. They define the nature of illness and the nature of cure differently because of what is seen as the source of truth and the essence of human nature. Watts (2000) noted that science and Judeo-Christian theology conflict in their respective views of human nature because they focus on different aspects of human existence, the former on biological aspects and the latter on sin and salvation (p. 47). Yet in this field very little is known about how scientific and medical components are linked to (or separated from) religious and spiritual ones. How do practitioners view the relationship between these two divergent views on what it means to be human? Do mental health professionals still feel they are acting as psychiatrists or psychologists when bringing in religion or spirituality (whether verbally to client, or nonverbally in the way they conceptualize what the client is describing), or do they feel their roles change to that of spiritual advisor?
Structure of Knowledge

Paradigms

Religion and medical science both provide paradigms that represent different ways to view problems to be solved and define how to solve them (Kuhn 1996). The study of paradigms is part of the socialization and training process of therapists so they may take their respective places in the “membership in the particular scientific community with which he [and she] will later practice” (Kuhn 1996:11).

Paradigms also provide a map and directions for map making (Kuhn 1996:109). That is, they give people acceptable ways to view a problem and solve it. Paradigms seem to explain more than their competitors (Kuhn 1996:17-18), in this case, religion or science. Therefore, the question can be asked if a religious explanation or scientific explanation seem better and explains more for a particular psychotherapist.

Rationalities

Paradigms are bounded by rationalities (Winch 1977). That is, the outlook supported by a paradigm is consistent with certain assumptions and beliefs that seem rational and logical to the holders of this view. Therefore, two paradigms (science and religion) offer competing rationalities. Both the religious rationality and medical-scientific rationality follow a logic (albeit different) and have different assumptions about mind, human nature, and illness. A conflict then could arise between competing constructions of realities (Berger and Luckmann [1966] 1967:21) and their rationalities (Winch 1977:175) or frames of knowledge. That is, a conflict between medical and
scientific views of mind (mental and emotional problems) learned in one’s academic training and professional socialization, and religious views of mind and human nature learned in personal life. From this point of view, the focus of my study is the perceived compatibility of alternative rationality forms.

Domain Assumptions

Gouldner (1970) in *The Coming Crisis in Western Sociology* called background assumptions that relate to a specific domain, “domain assumptions” (p. 31). Each profession has domain assumptions and ways of viewing the world that are seen as “right.” These are taken for granted and often not articulated. Domain assumptions are formed and re-formed through socialization and reinforced through institutional specialization. That is, each profession has a world view, a piece of the world that it carves out as its domain of expertise or specialized knowledge. Psychiatry and psychology treat the mind, brain, behavior, or soul, depending on definition (Hillman 1975; Watts 2000). It is this specialization that accounts for diversity of background assumptions. One of the key problems this study addresses is the existence of competing communities of knowledge (religious and medical-scientific) and the result of this competition on psychotherapists. A question of this study then is: what domain assumptions do psychiatrists and psychologists have about mind? What are considered “proper” ways of viewing this subject?
Paradigms, rationalities, and domain assumptions all point to the notion of paramount reality and finite provinces of meaning. This study explores how knowledge becomes specialized and structured by certain “frames” of knowledge that may complicate its integration with other forms of knowledge. Therefore, Berger and Luckmann’s ([1966] 1967) view of the finite provinces of meaning and paramount reality are highly relevant for this study.

Psychiatrists and psychologists, like all people, operate out of a natural attitude. Berger and Luckmann ([1966] 1967) described this phenomenon as the “wide-awake state of existing in and apprehending the reality of everyday life [that] is taken by me to be normal and self-evident. . . .” (p. 21). In this natural attitude one reality (medical-scientific or religious and spiritual) is paramount or “the reality par excellence. This is the reality of everyday life. Its privileged position entitles it to the designation of paramount reality.” (Berger and Luckmann [1966] 1967:21). This conceptualization leads to the following reformulation of my research question: What was paramount for the mental health practitioners? Was it the medical and scientific construction of the mind or religious and spiritual construction of the mind? How did practitioners deal with what was not paramount? Did they have difficulty integrating the two?

An aim of this study is to understand how the worlds of psychotherapy (psychiatry and psychology) are built, both the scientific and religious world views. How does religion and spirituality form part of the process of world building? That is, what seems right and commonsensical for psychiatrists and psychologists to include in treatment? How do psychiatrists and psychologists reflect on religious knowledge and
scientific knowledge? I will catalog what is known about this from prior research studies in my literature review.

Schutz (1977:230) pointed out that negative actions are actions. Not discussing religion and/or spirituality is an action as well as not thinking in terms of the religious and spiritual. This study will address what actions are negative and under what situations they occur. That is, when are religious and spiritual ideas excluded from psychotherapists’ formulation of clients’ difficulties and when were religion and spirituality not discussed by the therapist?

Commonsense Knowledge of Professions

In an effort to understand if, how and why psychiatrists and psychologists reconcile competing knowledges or rationalities, it is necessary to understand how they make meaning out of the world, what is taken-for-granted, what are commonsense assumptions about the profession, and what were the community of understandings. Further, an understanding of commonsense assumptions and what is taken-for-granted illuminates the milieu or setting in which psychiatrists and psychologists worked, that is, their respective institutions. Ethnomethodology, as formulated by Garfinkel (1967), offers help with these questions.

According to Watson (1995) ethnomethodological study is “concerned with the way ordinary members of society in their everyday lives make the world meaningful by achieving a sense of ‘taken-for-grantedness’” (Watson 1995:61). They do this through their commonsense knowledge, what members of a society “know and use” (Leiter 1980:3). It is “knowledge I share with others in the normal, self-evident routines of
everyday life” (Berger and Luckmann [1966] 1967: 23). Part of commonsense knowledge, the shared knowledge of a social group, are the community of understandings, or “knowledge of shared agreements” (Garfinkel 1967: 27). By definition, these knowledges are often unarticulated but shape how practitioners view their profession and professional behavior. A question of this study is what are shared agreements about the “proper” role of or place of medical-science, religion and spirituality, respectively in the process of psychotherapy. These shared agreements point to institutional constraints.

Structure of Knowledge in Context

Forms of knowledge co-exist in an institutional and social contexts. That is, institutions shape participants’ thinking. As Hargrove (1984) noted:

The sociology of knowledge, then, can never concern itself only with the internal structures of human views of the world, but rather must see that those structures rest upon and reflect the forms of the social institutions in which they are imbedded. We must see the reciprocal effects of structures of consciousness and of institutions, particularly structures of religious consciousness and of religious institutions. (P. 9)

I will next explore the ways in which this role of the institution can shape psychiatrists’ and psychologists’ knowledge both of their field of study and their role as professionals.

Power of the Institution of Medicine and Science

Conrad (1996), described medicalization as “a process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses
or disorders” (p. 137). The previously religious or moral becomes medical (Conrad and Schneider 1980:8).

One outcome of medicalization is that medical knowledge is seen as “best.” Zola (1997) commented on this when he wrote:

The theme of this essay is that medicine is becoming a major institution of social control, nudging aside, if not incorporating, the more traditional institutions of religion and law. It is becoming the new repository of truth, the place where absolute and often final judgments are made by supposedly morally neutral and objective experts. And these judgments are made, not in the name of virtue or legitimacy, but in the name of health. Moreover, this is not occurring through the political power physicians hold or can influence, but is largely an insidious and often undramatic phenomenon accomplished by ‘medicalizing’ much of daily living, by making medicine and the labels ‘healthy’ and ‘ill’ relevant to an every increasing part of human existence. (P. 404, emphasis in original)

The institution of medicine gives doctors power with the ability to diagnose and the methods of treatment. This institution and the way it frames symptoms supports a medical view. By nature of being a physician, psychiatrists have institutional support to engage in medical social control—“the authority to define certain behaviors, persons and things” (Conrad and Schneider 1980:8). Empowered by their training to do so, behaviors and feelings are seen as medical in nature. Psychiatrists (and to a lesser extent psychologists) also have social authority and cultural authority (the authority to interpret signs/symptoms) (Starr 1982:13,14,144) The decrease in religion and increase in faith in science and rationality encouraged medicalization. Conrad (1996:141) noted that:

Numerous writers have suggested that medicine has ‘nudged aside’ (Zola 1972) or ‘replaced’ (Turner 1984, 1987) religion as the dominant moral ideology and social control institution in modern societies. Many conditions have become transformed from sin to crime to sickness. In Weberian terms, this is of a piece with the rationalization of society (Turner 1984). The argument is that secularization leads to medicalization. (P. 141)
Therefore, science has taken over religion’s specialization function. As Zola (1997) pointed out, science took some behaviors out of the realm of religion and into the realm of disease. To what extent has an allegiance to science and medicalization of emotional and mental problems led to a marginalization of religion for psychiatrists and psychologists?

**Institutional Specialization**

Institutional analysis shows how as societies developed, spheres of life specialized. Specifically, in *The Division of Labor in Society* ([1893] 1964) Durkheim discussed that the division of labor leads to occupations specializing in their respective tasks. Morrison (1995) described that in the division of labor,

The new social components (economic, legal, political and religious) are separated by specific occupational functions which act to restrict the sphere of individual experience by confining social ties to occupations. Beliefs and values become narrowed in scope and are confined to the particular occupational sphere. Specialization creates different interests among individuals, since they are able to share common interests only with those whose occupational experiences are the same and with those whose values and beliefs are associated with shared occupations. As the division of labor advances, it narrows what individuals do in society down to tasks and roles determined by training and occupational interests. Common beliefs and values are now confined to occupational roles and this reduces the individuals’ grasp of society as a whole and of its overall collective unity. This individual’s link to society is thus diminished and the collective unity is weaker. (P. 145)

Turner (1997) wrote that religion, and to a degree medicine and science, have differentiated from the original institution of kinship or family to develop specialized knowledges and areas of concern. Frank (1978) and Matthews and Larson (1997) also noted that religion and medicine used to be more integral to one another. (A more extensive discussion of this follows in the next chapter). In addition, secularization in the...
United States has led to the compartmentalization of religion and human activity. As noted by Swatos and Christiano (2000) a main tenant in secularization theory is “a claim that, in the face of scientific rationality, religion’s influence on all aspects of life—from personal habits to social institutions—is in dramatic decline” (p. 6). As a result of the secularization, for the most part, religion is kept separate from the work world.

Professions are a clear example of specialization because by laying claim to specialized knowledge they acquire privilege. Watson (1995) defined this term as:

A process followed by an occupation to increase its members’ status, relative autonomy and rewards and influence through such activities as setting up a professional body to control entry and practice, establishing codes of conduct, making claims of altruism and a key role in serving the community. (P. 224)

Larson (1977) described professionalization as “A process by which producers of special services sought to constitute and control the market for their expertise” (p. xvi, emphasis in original). Watson (1995) suggested that those occupations following the professionalization strategy will therefore tend to stress a claim to esoteric competence, the quality of which:

it will argue must be maintained for the sake of client and society, and will accordingly seek for its licensed member the exclusive right to do work in its sphere of competence whilst controlling who enters the work, how they are trained, how they perform their work tasks and how this performance is checked and evaluated. (P. 224-225)

The result of institutional specialization and secularization is that the institutions of religion and medical-science have developed separate spheres of specialized knowledge and have responsibility for different parts of society (with overlaps between institutions as discussed by Turner (1997) on p. 278-279). They serve different functions for society and have a range of legitimate knowledge. A purpose of this study is to discover the effects of this institutional separation, as it has the potential to be a pressure
and constraint for psychotherapists to keep science and religion separate.

Training

It is through training (classes, internships, and conferences) that students of paradigms are trained to have what Kuhn (1996) described as a “time-tested and group-licensed way of seeing” (p. 189). This describes how a rationality is trained. To what extent is the importance of religion and spirituality for these fields reflected in training programs? How does the support or lack of support of religion and spirituality as legitimate domains of psychiatry and psychology impact on psychiatrists’ and psychologists’ separation or integration of this paradigm into their work? More will be said in the literature review about the degree to which religion and spirituality are included in the training of psychiatrists and psychologists.

Professional Socialization

An outcome of the competition of knowledge is seen in professional socialization and training. Psychiatry and psychology are occupational communities. Watson (1995) noted that in its sociological usage, “The essence of community is an integrated set of social relationships, a system which provides its members with a sense of common identity and shared values system” (p. 230). Part of any community is socialization. It is through the process of professional socialization that psychiatrists and psychologists learn “about the norms, values, customs and beliefs associated with an occupation which they have joined so that they are able to act as a full member of that occupation” (Watson 1995:215). These values and “correct” attitudes are acquired during training (Joseph
The purpose of professional socialization is that, "Through learning the ideology, values, norms—the culture of the profession—members become bound to their chosen field and to each other" (Joseph 1989:40). Socialization also serves the development of a professional identity (Pavalko 1971:82).

In the professional socialization process, the occupation becomes the reference group and exerts control over the individual’s behavior, specifically in this study over individual psychiatrists and psychologists (Pavalko 1971:100). Reference groups also perform normative functions ("reference groups may set and enforce standards or norms for behavior") and comparison functions ("as groups against which a person evaluates himself and others"), terms Pavalko (1971:89) credits to Kelley (1952). Shibutani (1955) described reference groups as, "that group whose outlook is used by the actor as the frame of reference in the organization of his perceptual field." (p. 565). This groups’ perspective structures how individuals view their world. An outcome of socialization is that the individual takes "as his own the perspectives of the occupation for a wide range of occupational, and also nonoccupational, behavior" (Pavalko 1971:89-90). To what degree does the reference group influence individual psychiatrist’s or psychologist’s views of competing knowledge systems?

Professions have formal (codes of ethics, licensing regulations) and informal (gossip, criticism by colleague, referrals by colleague) social control mechanisms (Pavalko 1971:101). Examples include occupational associations such as the American Psychiatric Association and the American Psychological Association. These associations exert control over members and form a collective identity. As Pavalko (1971) noted, "the annual conventions of professional associations and learned societies function to
reinforce their members' sense of identity with and membership in the occupational group." (p. 105). Collegial evaluation is another form of social control. It is judgments professionals make of each other that stay within the group (Pavalko 1971:102). The degree to which these are influences on viewing mind from a medical-scientific or religious and spiritual perspective is of interest to my study.

Discourses

Professions have discourses that support the boundaries of the profession. Watson (1995) defined discourses as “A set of concepts, statements, terms, and expressions which constitute a way of talking or writing about a particular aspect of life, thus framing the way people understand and act with respect to that area of existence” (p. 75). This study uncovers discourses used by psychiatrists and psychologists that shape their view of the profession and what is paramount reality for them, respectively. Additionally, what discourses are used to legitimate the annexing of the institution of religion into psychotherapy will be explored.

Conclusion

Drawing upon the above perspectives, my initial question is clarified and reformulated into the following pertinent questions. Which exerts greater influence and explains more to psychiatrists and psychologists, medical-scientific or religious and spiritual paradigms? To what extent has an allegiance to science and medicalization of emotional and mental problems led to a marginalization of religion for psychiatrists and psychologists? How do psychiatrists and psychologists reflect on religious and medical-
scientific knowledge? Are these seen as compatible paradigms? If so, how have practitioners integrated them in their practice? Additionally, which finite province of meaning, medical-scientific or religious and spirituality, has greater influence on the form of participants’ paramount reality of their everyday life as professionals?

Additionally, how does the perceived support or lack of support by their respective institutions (including training and reference group) of religion and spirituality as legitimate domains of psychiatry and psychology impact on psychotherapists’ separation or integration of this paradigm into their work? What are shared agreements about the “proper” role of or place of medical-science, religion and spirituality, respectively in the process of psychotherapy? Are group norms of psychiatry and psychology perceived to be too restrictive and in conflict with the psychotherapists’ personal beliefs, therefore leading them to be alienated from their profession?

What discourse patterns are used to legitimate the incorporation of religious and spiritual content into psychotherapy? What normative frameworks and value orientations do these discourses reflect with regards to medical-science and religion and spirituality?

Also of interest is an understanding of to what extent do participants’ perceptions of norms their professional community has with regards to religion and spirituality reflect the actual state of affairs in their community?

In a search for the answers to these questions, I carried out a literature review and two empirical studies.
CHAPTER III

LITERATURE REVIEW

Introduction

In this chapter I review the relevant literature related to the question, how do psychiatrists and psychologists reconcile their medical-scientific training with their religious and spiritual beliefs. This chapter will show that while there is ample literature that suggests religion and spirituality "should" be included in psychotherapy, very little has been done to assess how religious beliefs influence the work of mental health practitioners. I agree with Waldfogel's, Wolpe's, and Shmuely's (1998) assertion that "the bulk of research on religion and psychiatry has generally ignored the religious beliefs of psychiatrists and focused instead on the religious beliefs and behaviors of their patients" (p. 29).

Additionally, little is known about how the notion of mind in scientific terms comes to be taken for granted in treatment. Similarly, it is not certain the degree to which the institutional arrangements of psychiatry and psychology promote integration or separation. The manner in which practitioners view the relationship between these (medical-scientific and religious and spiritual) two divergent views on what it means to be human is a phenomenon that merits further investigation.

Because religion and spirituality are core concepts in this study, a review of the various ways these terms have been conceptualized is an important starting point for this review. Next, I discuss both the historical relationship between medical-science and religion, as well as the current state of affairs in both psychiatric and psychological...
practice. This study explores the impact of personal socialization factors as well as professional ones on psychotherapists' ability to reconcile or separate medical-scientific and religious and spiritual paradigms in their professional practice. Therefore, an understanding of the degree of religiosity and spirituality of these professionals as well as their use of prayer both personally and in the session is crucial. In this section I also describe the impact of both psychotherapists' and clients' values on the therapeutic process.

The degree to which religion and spirituality are apparent in four sources of professional socialization: (1) training programs, (2) colleagues, (3) ethics codes, and (4) and publications are reviewed. Because both psychiatrists and psychologists diagnose mental health, the extent to which religion and spirituality are included in this medical-scientific scheme is reviewed. I end this review with a summary of the small literature that looked at the degree to which psychotherapists personal and professional lives overlap with regard to religious and spiritual beliefs.

Definitions of Religion and Spirituality

The terms “religion” and “spirituality” have many definitions (McKee and Chappel 1992; Larson, Swyers, McCullough 1998 ; Fetzer Institute/National Institute on Aging Working Group 1999 ; Remen 1999; Josephson et al. 2000; Koenig, McCullough, and Larson 2001). For example, the Fetzer Institute/National Institute on Aging Working Group (1999) noted that in their work:

It became important to articulate the distinction between religiousness and spirituality. While some may regard the 2 as indistinguishable, others believe religiousness has specific behavioral, social, doctrinal, and denominational characteristics because it involves a system of worship and doctrine that is
shared within a group. Spirituality is concerned with the transcendent, addressing ultimate questions about life's meaning, with the assumption that there is more to life than what we see or fully understand. Spirituality can call us beyond self to concern and compassion for others. While religions aim to foster and nourish the spiritual life—and spirituality is often a salient aspect of religious participation—it is possible to adopt the outward forms of religious worship and doctrine without having a strong relationship to the transcendent. (P. 2)

Koenig, McCullough, and Larson (2001) in their landmark book, *Handbook of Religion and Health* defined religion as:

an organized system of beliefs, practices, rituals, and symbols designed (a) to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality) and (b) to foster an understanding of one’s relationship and responsibility to others in living together in a community. (P. 18)

Spirituality was defined as: “the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community” (p 18). Miller (1999a) also noted a distinction between the two terms, “Unlike religion, spirituality is part of every individual, an aspect to be understood in gaining a comprehensive picture of a person” (p. 255).

An indication of the complexity of what is meant by “religion” and “spirituality” is seen in the decision by the panel members for the definition of religion and spirituality at the Scientific Progress in Spirituality Conferences convened by the National Institute of Healthcare Research to not offer a single definition of religion and spirituality. This decision was made because either a too broad or narrow a definition “will not move the field forward” (Larson et al. 1998:15). Instead, their efforts “focused on describing the fundamental characteristics of each construct and identifying domains of spirituality and religiousness likely pertinent to health outcomes.” (Larson et al.1998:15). Indeed, in their review of the status of spirituality in psychiatry, Josephson et al. (2000) noted the
complex relationship between religion and spirituality and concluded, "Correspondingly, the terms spirituality and religion are used interchangeably in this article and are frequently combined in the single term ‘religious-spiritual’" (p. 533).

Whereas Lukoff, Lu, and Turner (1992) described the difference in behaving in religious versus spiritual ways, surveys by Zinnbauer, Pargament, Cole, Rye, Butter, Belavich, Hipp, Scott, and Kadar (1997), Roof (1999), and Marler and Hadaway (2002) found a similarity in the way that respondents defined religiosity and spirituality.

Given that “religion” and “spirituality” are not necessarily unitary concepts, how these terms are defined by psychiatrists and psychologists impacts on what is in its (religion’s) purview and whether they are seen as distinct from psychiatry and psychology. If by “religion” is simply meant values, then the need to adopt another language is not certain. Other definitions of “religion” and “spirituality” could make it easier or harder to bring together the two languages and see them as complementary versus contradictory. The postulate of adequacy, that the meaning of a situation has to be understandable to actor and fellow individuals (Schutz 1977:237), is useful in understanding the meaning participants give to religion and spirituality. Learning what this is, is a crucial piece of this research.

Historical Relationship between Religion and Medicine

Historically, religion and medicine were used in conjunction to heal the sick (Cartwright 1977; Frank 1978; Bhugra 1996; Matthews and Larson 1997). Matthews and Larson explained that:

The linkage of these twin traditions of healing practices is as ancient as history itself; religion and medicine have joined hands in the care of the sick for
thousands of years. In ancient societies (and less well-developed societies today),
the connection was close: medical practice was steeped with spiritual presence
and authority, the ‘medicine man’ was also the priest, and vice versa. The first
hospitals were founded by monks, and missionary movements across the centuries
and continents have recognized the need for spiritual change alongside physical
healing. (P. 3)

Matthews and Larson contended that the split in these “twin traditions” occurred
since the Scientific Revolution when achievements in science threatened the “worldview,
dogma, and reach of religious authorities” (p. 3). Bhugra (1996) noted that, “Until the
fifteenth century, medicine and the priesthood could work together but for several
reasons, chiefly secularisation led to the two professions going their separate ways” (p. 1-
2). Foskett (1996), writing on psychiatry in the United Kingdom reported that, “The
Church, once the dispenser of healing, gave way to medicine—physicians needed a
bishop’s license to practice until the beginning of the eighteenth century but by 1800 it
was doctors who authorized clergy to minister in their asylums” (p. 53).

Frank (1978) offered a similar view and added that the etiology of mental illness
changed from possession to a view that the mentally ill’s behavior was interesting to
study scientifically. He noted:

Psychiatry and religion do converge in one area, however, and that is the nature of
man, and it is in this realm that their teachings can be compared. This
convergence is firmly rooted in history. Medicine and religion were once
undifferentiated. Temples were hospitals and priests were physicians. The care of
the mentally ill remained under the aegis of religion long after bodily ills were
separated out as the province of the physician. Mental illness was viewed as
possession by evil spirits and therefore a problem for the priest, not the
physician. . . . [However], the territory of mental illness was rewon for medicine,
starting about the turn of the nineteenth century. (P. 250)

Bhugra (1996) agreed with this view and commented:

There is no doubt that psychiatry and its practitioners have often been the agents
of the society to curb ‘deviancy.’ Whereas religion has locked its practitioners in
institutions of a different variety, their spiritual welfare has been its main concern. This division between spiritual and psychological well-being led to the parting of ways between religion and psychiatry. (P. 230)

Whether present-day healers draw upon the religious traditions in their healing practices, or align themselves more with medical-science is unclear.

Psychiatry and Psychology as Science-Based Disciplines

Psychiatry and psychology are medical and scientific fields. Galanter, Larson, and Rubenstone (1991), in their study of psychiatrists in the Christian Medical and Dental Society noted, “In its recent history, psychiatry has emerged from a tradition of empirical science strongly influenced by a materialist, positivist perspective.” (p. 94-95).

Psychology as well has strong empirical, positivist roots. Koch (1985) reported that with the founding of psychology by Wilhelm Wundt in 1879 the meaning of psychology became associated with the adjectives “scientific” and “experimental” (p. 8). Although psychology has changed its exclusive focus on mind and behavior to include practice as well, the scientific aspect to this field remains (“Psychology Continues to Redefine Itself” APA Monitor Online 1999:1).

The scientific focus of the field of counseling psychology was made clear at the Third National Conference for Counseling Psychology in Georgia in 1987. The conference committee stated that:

Those at the Georgia conference agreed that because psychology is a science, both the generation and application of psychological knowledge are based upon scientific views of the world. Psychologists, whatever their work, are professionals and their attitude toward their work is scientific” (Meara, Schmidt, Carrington, Davis, Dixon, Fretz, Myers, Ridley, and Suinn 1988:368).
Many psychiatrists and psychologists have noted the traditionally presumed incompatibility between these fields and religion. According to this premise, philosophically, psychiatry, psychology, and religion are diametrically opposed concepts and religion is viewed in a negative light (Lovinger 1990; Larson and Greenwold Milano 1995; Koenig, Bearon, Hover, and Travis 1995; Shafranske and Malony 1996; Haug 1997; Koenig, Larson, and Larson 2001). Koenig et al. (2001) stated that, “For nearly a century, religion was portrayed by mental health experts as a neurotic influence on psychological functioning, many still hold this view today” (p. 353). Koenig et al (1995) agreed:

Religion is often the butt of jokes or an object of ridicule in professional circles, either at work or during social gatherings. It may be viewed as the province of the weak-minded, the uneducated, and the socially outcast. Seldom is there time to cultivate and nurture both one's spirituality and one's specific prowess in medicine. (P. 163)

Consequently, religion as an element that exists within the human framework is often not discussed in the therapy session, at academic presentations, or presented in textbooks or journals (Larson, Pattison, Blazer, Omran, and Kaplan 1986; Taggart 1994; Becvar 1997; Miller 1999c). Larson and Greenwold Milano (1995) suggested:

It still remains that, the longstanding bias against religion by a few within the health care community who regard religion as detrimental to health and proper emotional functioning could also continue to inhibit clinicians from trying to address their patients’ religious and spiritual concerns. (P. 154)

Several authors noted the negative view of religion in psychotherapy (Lovinger 1990; Taggart 1994; Shafranske and Malony 1996; Becvar 1997). Lovinger noted that when religion as a topic is brought up in therapy it is either seen as resistance or
digression, thereby derailing the professional work, or the client is told the therapist does
not discuss this topic (p. 19, 31). Becvar (1997) pointed out that her “views . . . are
outside the mainstream and . . . to express them is risky” (p. 59).

Koenig et al. (1995) noted the especially negative view of religion held by
academia, “The professional and social factors which act to diminish the value of religion
and the spiritual aspects of life for the physician may gather particular strength in the
academic environment.” (p. 163).

**Reasons for Negative View**

Larson et al. (1986) found a similar negative view in four psychiatric journals
*The American Journal of Psychiatry, British Journal of Psychiatry, Canadian Journal of
Psychiatry, Archives of General Psychiatry*) that they analyzed from 1978-1982. They
suggested that psychiatry is biased against religion because the great deal of psychiatric
literature on “psychopathological and neurotic uses of religion among psychiatric
patients—[is] a skewed sample without a comparison group” (p. 330). They concluded
that psychiatric researchers are not as informed about religious variables as other social
science researchers and while religion as a variable is seen as worthwhile to study in
other behavioral sciences, it is not seen as so in psychiatry:

religion has a minimal place in psychiatric theory of human behavior. As a gross
generalization, religion is viewed as a secondary derivative of structural psychic
process. Therefore, we might expect psychiatric research to ignore state of the art
research on religion if it is viewed as theoretically unimportant. (P. 333)

As a result of the lack of sophistication of and limited nature of research in psychiatry,
they contended that nonreligious psychiatrists are reinforced in their view that religion is
not important so they can “misinterpret religious dynamics” (p. 333).
Taggart (1994), a professor and therapist (M.S.W) suggested that “Biology and its stepchild, psychology, have been presented as vehicles for modifying human experience, and we have dismissed religion as belonging to the dream world of superstition and magic—irrelevant if not harmful, of a different order from scientific fact” (p. xii). She suggested that her experience of religion (either her client’s or hers) being discounted was, “the result, not of insensitivity or unkindness, but of a particular professional mindset created by what I am convinced is an obsolete attempt to have a ‘scientific’ understanding of human psychology” (p. xv). As will be seen below, she is very much in favor of the incorporation of clients’ religious beliefs into psychotherapy and disagrees with this negative view of religion. Lukoff, Lu and Turner (1992) added that, “the positivistic tendencies of psychiatry reject subjectivistic and mentalistic ideas, which results in a devaluation of religion” (p. 674). Haug (1997), in the Foreword to Becvar’s book Soul Healing: A Spiritual Orientation in Counseling and Therapy, said that therapists have traditionally focused on the negative qualities of spirituality and religion (dogma and fanaticism) (p. ix).

These assessments suggest that the separation of the religious and medical-scientific world views and aspects of mental health care can lead to serious psychological alienation in both the professionals and their clients, and that opposing such separation may pose existential risks to professionals and lead to second guessing the therapeutic process.
Changing View of Religion as Part of the Professions

Contrary to the established canon that religion is unacceptable for science and therefore there is hostility to religion among scientists, is another view. This suggests religious experiences are legitimate matters for psychotherapy and are part of their respective domains (see for example, Frank 1978; Conway 1989; Loving 1990; Shafranske and Malony 1990; Lukoff, Lu, and Turner 1992; Taggart 1994; Lukoff, Lu, and Turner 1995; Turner, Lukoff, Barnhouse, and Lu 1995; Shafranske 1996b; Becvar 1997; Richards and Bergin 1997; Miller and Thoresen 1999; Yarhouse and VanOrman 1999; Argyle 2000; Koenig, McCullough, and Larson 2001).

Overlap between the Domains

For example, some psychiatrists and psychologists see religion and psychotherapy as two sides of the same coin and not distinct from one another (Taggart 1994:xii). As Taggart noted in the preface to her book *Living as If*:

*The premise of this book is that every person has a set of ‘core beliefs’ about the nature of reality and lives as if certain absolutes were true. However, as professionals, we in mental health practice have somewhat unquestioningly accepted the reality of assumptions of science, and competing core beliefs such as those of religion have made us uncomfortable to the extent that we have usually excluded them from professional literature and traditional practice modalities. I contend that we have thereby excluded a vast and important arena of human experience and a potentially huge clientele in need of our services.* (P. xi, emphasis in original)

In this explanation, she thus makes explicit the idea of competing rationalities.

Jones (1994) suggested that, "Because there is no impassable chasm between science and religion, it is inevitable that religion and religious belief will and do relate to the scientific discipline of psychology..." (p. 185). Argyle (2000) stated that psychology
also studies scientifically those things explained by religion: consciousness, behavior, beliefs, and human personality development. (p. 7). Shafranske and Malony (1996) agreed that “meaning making becomes one nexus where psychology and religion intersect. . . ” (p. 574).

Psychiatrists, as well, noted similarities between religion and their discipline. For example, Josephson et al. (2000) stated, “Religion and science are two different conceptual endeavors, yet they both claim to be ways of knowing and understanding.” (p. 535). Foskett (1996) noted that:

In contemporary Western society there are similarities between Christianity and psychiatry, both are preoccupied with subjective phenomena and with internal and illusive realities. Each depends upon the testimony of individuals, as difficult to refute as they are to believe. (P. 52)

Frank (1978) concurred:

As soon as the psychiatrist turns to the study of man as he functions in his social environment, however, and he must do this in the practice of psychotherapy, he cannot avoid infringing on the territory of religion. He must be concerned with the nature of man, including the values man lives by. His beliefs, including his religion, are facts which the psychiatrist cannot avoid. (P. 251)

Frank even went as far as to say that:

Perhaps the main upshot of this review is that psychiatry, a very recent newcomer, really has little to add to the basic insights about human nature developed over the centuries by the great religions. At best, it has been able to reformulate some of them so that the are more accessible to scientific study. (P. 259)

Bhugra (1996) suggested a dialogue between religious personnel and psychiatrists:

Religion and psychiatry have a lot to say to each other and need to continue the dialogue to understand each other’s weaknesses and strengths and work together or separately (as long as each is aware of the contribution the other can make) for the betterment of the individual who is suffering. (P. 231)

As can be seen in the above discussion, religion and psychiatry and psychology, respectively, are seen by some as compatible.
Are Religion and Spirituality Included in Psychotherapy?

It Should Be Included, It Is Said

Several authors commented that religion and spirituality should be included in psychotherapy (Larson et al. 1986; Worthington 1989; Conway 1989; Shafranske and Malony 1990; Hawkins and Bullock 1995; Yarhouse and VanOrman 1999). For example, Conway (1989) wrote that, "The presence or absence of religious faith has important implications for adult identity and a person's approach to living. To disregard religion as outside a psychologist's domain is to limit our ability to understand the whole person" (p. 624). Miller and Thoresen (1999) agreed with this and added:

Spiritual and religious involvement is not only common but is often important in clients' lives and has been generally linked to positive health outcomes. A client's spiritual perspective may be relevant in understanding his or her problems and useful in the process of treatment. (P. 13-14)

Survey data also show that most therapists support the view that religion and spirituality are important components to include in psychotherapy. Almost half the clinical members of the American Association for Marriage and Family Therapy surveyed by Carlson, Kirkpatrick, Hecker, and Killmer (2002) (n=153) agreed that 'it is usually necessary to work with a client's spirituality if you expect to help them.' Another 62% of those surveyed believed that 'every person has a spiritual dimension that should be considered in clinical practice' (p. 162).

Therapists in Carlson et al.'s study thought it was appropriate to ask about clients' spirituality versus religious beliefs. The authors conjectured this was because of the specificity of religion (beliefs, values, right, and wrong) and the "powerful discourse in U.S. culture requiring the separation of church and state" (p. 167). This theme was found
as well in this current study and will be discussed in the next chapter. However, unlike this current study, 84 percent of marriage and family therapists “agreed or strongly agreed that it is appropriate to talk about spirituality in professional circles.” (Carlson et al. 2002:162). It is unclear from the article whether by “appropriate” therapists meant spirituality ought to be discussed or it is already being discussed with peers.

Both psychiatrists and psychologists stressed the necessity of attending to religious and spiritual issues in the assessment process (Conway 1989; Worthington 1989; Josephson et al. 2000) Worthington (1989) commented:

A main point of this article is that religion may be involved in normative and nonnormative life transitions of adults and children, especially for religious people who are highly committed to their religious faith and who frequently employ their religious faith adaptively or defensively. In such cases, assessment of the client’s religious functioning and developmental level is essential to understand the client accurately. (P. 588)

This assessment process also includes presenting problems such as: pregnancy, abortion, parenting, sexual abuse, depression, suicide, and facing death in which religious beliefs and values are often a major component for clients (Conway 1989; Worthington 1989). However, Koenig and Larson (2001), two of the main proponents of religion and health research, suggested caution when introducing religion and spirituality into the therapeutic relationship:

In most circumstances, the psychiatrist’s role is fulfilled by taking a religious or spiritual history, involving a chaplain or clergyperson when warranted, and supporting the healthy religious beliefs of the patient. If the psychiatrist has the same religious background as the patient and if the patient requests, then there may be some rare circumstances in which the psychiatrist may engage in a religious activity with the patient. Admittedly, such instances should be chosen with great care. (P. 74-75)

Another theme among those who argued for the inclusion of religion and spirituality in psychotherapy was the importance of paying attention to these areas as

It is our view that religious issues should be included within the clinical practice of psychology. We believe this inclusion is justified in light of four interrelated factors: the professional ideal of cultural inclusion; the substantial evidence of religion as a cultural fact; the developing body of theoretical, clinical, and empirical research literature concerning religion as a variable in mental health; and the appreciation of psychological treatment as a value-based form of intervention. (P. 561)

They added that often in the literature on difference (such as race and sexual orientation), religion is ignored as an important difference of which to be aware. Conway suggested an "ethical responsibility to understand differences among people, including religious differences, to remain aware of the effect of such differences on the counseling process, and to address them when relevant" (p 627).

Cox (1996), a British psychiatrist, noted:

It can be argued, however, that if mental health services in a multicultural society are to become more responsive to 'user' needs then eliciting this 'religious history' with any linked spiritual meanings should be a routine component of a psychiatric assessment, and of preparing a more culturally sensitive 'Care Plan.' (P. 158)

The extent to which religion is seen as a cultural diversity issue and how that impacts on the integration or separation of religious and medical-scientific domains is unclear. Neither is it clear from pervious research to what extent religion and spirituality are included.
But Are They Included?

While it is clear from the above discussion that many authors and therapists who have been surveyed think religion and spirituality should be included in psychotherapy, it is less clear how often this occurs. Part of this is because of vague wording of surveys. For example, as explained above with regards to the study by Carlson et al. (2002) what was meant and how therapists interpreted the question about appropriateness of inquiring about clients’ religious and spiritual beliefs is unclear. Similarly, their finding that seventy-two percent thought that spirituality was ‘relevant to my clinical practice’” (p. 163) is equally ambiguous in its meaning. However, Shafranske’s (2000) study of psychiatrists gave a clearer answer to this question. Almost half study, “reported that religious or spiritual issues were involved in psychiatric treatment often or a great deal of the time, 43% sometimes, and 8% rarely.” (p. 528). One of the aims of this study is to understand the extent to which religion and spirituality actually are included in professional practice.

Christian Psychiatrists and Psychologists

Christian psychiatrists and psychologists are good examples of those who are aware of the tensions between competing paradigms and attempt to reconcile them. These types of therapists differ from clinicians who also hold religious and spiritual beliefs because they explicitly integrate their Christian beliefs into their work and market themselves as such.

Three authors who teach at schools affiliated with the evangelical movement described models of integrating psychology with religion/theology. Carter and Narramore
(1979), professors at Rosemead Graduate School of Professional Psychology, endorsed a model they called the “Integrates” model which is:

rooted in the assumption that God is the author of all truth. Reason, revelation, and the scientific method all are seen as playing a valid role in the search for truth. Since the human being is created in the image of God and since God has revealed Himself in a special way through Scripture and in a general way through creation, we expect to find congruence between Scripture and the findings of psychology. (P. 103)

Tan (1996), professor at the Graduate School of Psychology, Fuller Theological Seminary, suggested that the two models of integrating religion and clinical practice are implicit and explicit (p. 368). The former use of religion entails therapists keeping their beliefs and practices private and in the background. For example, a therapist might pray silently either before or during a session for the session. Explicit religious and spiritual actions by clients such as prayer or Scripture would be uncomfortable for this type of therapist.

Explicit integration entails directly addressing clients’ religious and spiritual issues through prayer, Scripture, referral to religious groups and the spirituality of the client and therapist (p. 368). The therapist who engages in this type of integration can come from both a Christian and other faith perspective (Tan 1994). In articles published in 1994 and 1996, Tan listed guidelines for explicit integration so it does not violate ethics codes.

He noted the limits of an explicit integration of religion into psychotherapy. He stated that while this type of integration:

is therefore an integrated psychospiritual approach that attempts to provide both effective psychotherapeutic help as well as spiritual guidance to clients so that they can grow as whole persons. The therapist who practices explicit integration, however, does not try to assume all of the roles or functions of pastor or
ecclesiastical leader, in addressing spiritual and religious issues openly in therapy. (P. 378)

The degree to which religious psychiatrists and psychologists use such models in their work and how this impacts on the view of their work as medical-scientific is unclear.

Socialization and Religiosity

Previous sections have dealt largely with professional factors. What is the impact of personal, as opposed to professional, socialization (religious and spiritual upbringing) on the ease or difficulty of integrating the competing frames of knowledge and accompanying languages? Pavalko (1971) noted the importance of individual personal factors on the socialization process:

These two factors, what members of the occupation would like to produce as the end result of the training process and what would-be members of the occupation bring with them to their training, combine to create relatively unique socialization problems and conflicts. (P. 93)

McWhirter (1989) and Shafranske and Malony (1990) commented on the role of prior religiosity on professionals' view of the compatibility for religion and psychology. For example, McWhirter (1989) suggested that "Might our lack of professional interest in religion stem from our rejection of childhood faith and subsequent rejection of religion in total?" (p. 614). Shafranske's and Malony's (1990) study of clinical psychologists found that

Attitudes and behaviors regarding interventions of a religious nature were primarily influenced by the clinician's personal view of religion and spirituality rather than by his or her theoretical orientation in psychology. The subject's personal experience of religion significantly correlated with their attitudes and behaviors regarding interventions of a religious nature. The data reflected a positive correlation between affiliation and participation in organized religion and
the performance of the aforementioned interventions \((r=27)\). The more negatively the subject viewed the religious experience in their past [background factors] the less likely they were of utilizing interventions of a religious nature \((r=.16)\). (P. 76)

Personal socialization, therapists' own religious upbringing and faith are an important part of the reconciliation/separation equation. As will be seen below, many authors noted that therapists' own beliefs cannot be eliminated from therapy.

**How Religious and Spiritual Are Psychiatrists and Psychologists?**

Bergin and Jensen (1990), expounding on Jensen's earlier work in 1985, found that psychiatrists and clinical psychologists were the least religious of mental health professionals (clinical psychologists, psychiatrists, clinical social workers and marriage and family therapists) surveyed (p. 6). Specifically, 32 percent of psychiatrists \((n=71)\) and 33 percent of clinical psychologists \((n=119)\) described themselves as regularly attending church compared to 50 percent of marriage and family therapists \((n=118)\) and 44 percent of clinical social workers \((n=106)\). These findings were similar to Shafrankse (2000) who reported that 26 percent of psychiatrists reported attending a place of worship in the last seven days. However, it is important to note that in the Bergin and Jensen study no measure of statistical significance was presented so there may not be a significant difference between groups. Also it is possible that clinical psychologists are differently religious than the way these authors assessed it.

Similarly, a 1995 study of doctors, nurses, patients, and families at Duke University Medical Center found that, "'belief in a higher power, church attendance, and religious coping were all lowest among psychiatrists, who also referred the fewest patients for pastoral services of any physician specialty'" (Koenig et al. 1995:162). It
should be noted that the sample size for each specialty was small. For example, twenty psychiatrists, four neurologists and eleven pediatricians were included in this study.

Several studies showed that compared to the public at large, psychiatrists and clinical psychologists find religion less salient (Ragan, Malony, and Beit-Hallahmi 1980; Cross and Khan 1983; Larson et al. 1986; Worthington 1989; Shafranske and Malony 1990; Koenig et al. 1995; Shafranske 2000). For example, Cross and Khan (1983) found that 37 percent of Australian psychiatrists (n=56) and 36 percent of psychologists (n=173) believed in God, compared with 79 percent of the Australian public (p. 17). Shafranske’s (2000) study of members of the American Psychiatric Association (n=111) found similar results, with 58 percent reporting religion to be salient (p. 527).

At the same time, 73 percent in this study by Shafranske reported believing in God or a Universal Spirit, a number less than the general public (91 percent) (Gallup, Jr. 2000:281). A study of 121 psychiatric residents showed similar findings (Waldfogel et al. 1998). These authors noted that, “the psychiatric residents who responded in our study appeared to have stronger religious convictions and identification than prior studies of practicing psychiatrists” (p. 33). For example, 76 percent of respondents reported a belief in God, 67.8 percent said “religion is important in their lives.” In addition, 73.9 percent believed that “religion can help solve personal problems” (p. 31). In addition, Lannert’s (1992) study of psychology internship training directors (n=79) found that 72 percent either participated with or identified with a religious denomination (p. 79). Finally, while 84 percent of the public say they try to live according to their religious beliefs, 74 percent of psychiatrists and 65 percent of clinical psychologists agreed or strongly agreed with
this statement in the study by Bergin and Jensen (1990: 5). They explained these findings as “discrepant from previous findings” (p. 5) and concluded that:

Although the professionals’ rates of conventional religious preference and involvement are lower in some aspects than for the public at large, they show an unexpected, sizable personal investment in religion by mental health professionals. This involvement is much greater than would be anticipated on the basis of published literature and convention presentations in the field. There thus appears to be a significant degree of unrecognized religiousness among therapists. Some of this religious interest is expressed in conventional ways, such as in affiliation and attendance, but a sizeable portion appears to be less conventional and personal in form. (P. 6)

In addition to a stronger affiliation with religion than previously described, Bergin and Jensen found more respondents (68 percent) endorsed the item, “seek a spiritual understanding of the universe and one’s place in it” versus 44 percent who endorsed having a “religious affiliation in which one actively participates” (p. 6). Similarly, Shafranske’s (1996) review of surveys found that “although they may value religiousness in general, psychologists personally participate in religion to a lesser extent than the general public” (p. 155)

This finding of spirituality (not rooted in a denomination) versus religiosity (affiliation and involvement with a denomination) being stronger among psychiatrists and psychologists was reported by others as well (Shafranske and Malony 1990; Lannert 1992; Shafranske 2000; Carlson et al., 2002). Sixty-two percent of marriage and family therapists in a study by Carlson et al. (2002) considered themselves to be religious and ninety-five percent considered themselves to be spiritual. Shafranske (2000) reported similar findings with more than 80 percent of psychiatrists who, “rated spirituality as fairly important or very important” (p. 528). After reviewing survey data on the degree of religiosity and spirituality among psychologists, Shafranske (2000) concluded that, “They
may be somewhat more similar to the general population than previously assumed, particularly in terms of noninstitutional expressions of spirituality” (p. 154).

While there is data on the degree of religiosity and spirituality of psychotherapists, what is unclear is if it is easier to integrate spiritual language into the belief system of psychiatry and/or psychology than religious language? How does this differ by denomination and profession? These are questions this study will answer. While we know some psychiatrists and psychologists are religious and spiritual, it is not known what this means for their everyday life and work.

**Prayer**

Poloma and Gallup (1991) reported that based on 1988 data, 88 percent of the general public reported praying. Survey data indicate that the prevalence of prayer is lower among psychotherapists than the public. Cross and Khan (1983) in their study of Australian psychiatrists, psychologists, and social workers found that 28 percent of psychiatrists and 30 percent of psychologists prayed daily or once a week (p. 16). Carlson et al. (2002) study of American marriage and family therapists found that 71 respondents pray regularly. The discrepancy between reported rates of prayer among Australian and American therapists can be at least partly attributed to a lower level of religiosity among the former group. For example, 27 percent of Australians reported monthly church attendance in 1983 (Thompson 1994: 114) versus 41 percent of Americans who reported attending church in the last seven days (Gallup 1984:14). In addition, 7.8 percent of Australian’s described themselves as being “very religious” whereas 19.5 percent of
Americans described themselves this same way (International Social Survey Program 1998:116).

In their review of studies on prevalence of prayer and mental health, Koenig et al. (2001) noted numerous studies that pointed to a sizable amount of clients/patients desiring physicians pray with them, whereas physicians often do not think patients want this (p. 93-94). For example, King and Bushwick’s (1994) study of family practice adult inpatients (n=203) reported that 48 percent would like their physician to pray with them, however, 68 percent said their physician never inquired about their religious beliefs (p. 350). Koenig, Bearon, and Dayringer (1989) found that almost 63 percent of family practitioners and general practitioners (n=160) did not think older patients wanted them to pray with them “during severe illness or emotional distress.” (p. 443).

In terms of appropriateness of physicians praying with patients, 66.4 percent of physicians agreed it was appropriate for physicians to pray with patients if they are religiously oriented (Koenig et al. 1989: 443). A 1991 survey of psychiatrists in the Christian Medical and Dental Society (n=193) found that respondents said “they would use prayer for about one-half the patients who were ‘committed to Christian beliefs’ but for less than one-fifth of patients from a nonbelieving Christian background” (Galanter, Larson, and Rubenstone: 92). In this study, prayer and the Bible was considered more effective than medication and insight psychotherapy for “suicidal intent, grief reaction, sociopathy, and alcoholism, although not for depressive neurosis.” (p. 92). Half of the respondents in Carlson et al’s study (2002) agreed or strongly agreed that it is appropriate to pray for a client, while 17 percent agreed or strongly agreed that it is appropriate to pray with a client (51 percent disagreed or strongly disagreed). More respondents (32
percent) were comfortable meditating with clients (p. 163). As with the Carlson et al. study, Shafranske’s (2000) study of 111 psychiatrists found that the majority (74 percent) “disapproved of praying with a patient” (p. 529).

In his small study of religiously devout physicians (n=28), Olive (1995) found that they prayed for more of their patients (65 percent) in cases of life-threatening illness versus routine situations (37 percent) (p. 1253). Praying for patients without their knowledge was reported by 78 percent of respondents. Sixty-seven percent of physicians surveyed reported that they have prayed in patients’ or family members presence at least once. This explicit prayer was “initiated by the physician 53% of the time” (p. 1253).

McCullough and Larson (1999) suggested that therapists pray with clients only when the client requests this, a thorough religious and spiritual assessment has been completed, the therapist is convinced such behavior would not compromise therapeutic boundaries, and “competent psychological care is being delivered” (p. 101). These authors suggest that:

Although praying with clients is probably wise only in limited cases, it is not unethical, inappropriate, or therapeutically counterproductive for practitioners to pray for their clients in session (briefly) or out of session. This is true even if (and perhaps especially if) practitioners do not let their clients know that they are praying for them. (P. 102)

Post, Puchalski, and Larson (2000) endorsed prayer in the medical encounter only if it is in adjunct to traditional medical therapy. They also cautioned against physician led prayer because of concerns of blurring of professional roles. However, if requested by the patient it was viewed as more acceptable (p. 582).

Tan (1996) suggested both ways in which prayer can be used appropriately in psychotherapy session as well as potential misuses. He also described beneficial and
appropriate uses of Scripture in this setting. He noted, “Despite the dangers of misusing
or abusing the Scriptures or sacred texts in therapy such texts can be used in constructive
and helpful ways with religiously committed clients who hold them to be authoritative
and divinely inspired” (p. 375).

These findings show that it is not unusual for healthcare providers to pray for or
with patients. How this explicit religious behavior impacts on viewing the client out of a
medical-scientific framework bears investigation.

Impact of Psychiatrists’ and Psychologists’ Religious Values on Psychotherapy

A concern in psychotherapy is that an intrusion of therapists’ values on clients
would impair the therapeutic relationship and make therapy ineffective (Worthington
1989). Richards, Rector, and Tjeltveit (1999) cited numerous studies discrediting the
notion that psychotherapists’ values can and ought to be kept out of therapy (p. 135).
Shafranske and Malony (1996) agreed that a value-free position is a myth, “Clinicians
bring their own personal values to the clinical setting; the idea that one could park one’s
faith commitments and ways of organizing experience at the office door seems to us to be
a naïve notion” (p. 572). An aim of this study is to illuminate the degree to which this
“parking one’s faith commitments” occurs.

Carter and Narramore (1979) presented a balanced view in their conclusion to
their book, The Integration of Psychology and Theology: An Introduction:

It is impossible for our personal commitment to have no influence on the direction
of our work. The decision to ‘be objective’ and to exclude such concepts as God,
faith, and repentance from the study of scientific psychology leads to a distorted
perception of the human race. Under the guise of objective scientific method-
ology, we end up ignoring an essential side of human nature. At the same time we
must not err on the opposite side—that of ignoring the data of psychology because of our Scriptural focus. (P. 121-122)

Tan (1994), Hawkins and Bullock (1995), and Yarhouse and VanOrman (1999) went as far as encouraging self-disclosure by therapists of their religious and spiritual beliefs to clients if asked about it by clients as part of informed consent. Hawkins and Bullock (1995) noted that:

Initially, in our efforts to be more ethically responsive to the public we serve, we should strive, when appropriate, to make religious values explicit. This would be a responsible and ethical course when clients are struggling with spiritual or religious issues that surface in their presenting problem in psychotherapy. We can no longer afford to hide behind our discomfort or neutrality stance surrounding this important dimension, seeking to avoid this issue by simply claiming that it does not fit within our theoretical framework, or worse yet, by promoting the idea that therapy is value-free. Research does not support these contentions. (P. 299)

Shafranske (1996b) described the relationship between therapists personal and professional lives:

The clinician's personal values, beliefs, and faith commitment (couched in part in the form of therapeutic orientation) may enter into the clinical discourse, shape technical interventions, and yield behavioral prescriptions. It seems reasonable to assume that preprofessional experiences and the ongoing personal life of the clinician are often a source of influence. Culture, history, family, values, and beliefs, continue to shape the backdrop on which therapeutic values are expressed in both subtle and overt ways in the conduct of psychotherapy. (P. 150)

While it is clear that therapists cannot maintain a value-neutral stance, the extent to which psychiatrists' and psychologists' medical-scientific and religious beliefs are in conflict or harmony with regards to the cause and healing of clients’ problems is not known.

Impact of Clients’ Values on Psychotherapy

Clients' religious and spiritual values as well impact therapy in terms of their selection of therapist (Hendlin 1989; Worthington 1989). Hendlin (1989) suggested that:
Those who are strongly fundamentalist or charismatic, or others with a strong ‘born again’ orientation, simply do not feel safe reaching out to a secular therapist who is outside their own belief system. Those who are less dogmatic in orientation (and, therefore, less threatened) seem to have much less trouble developing a solid therapeutic relationship with a secular therapist of the same or differing religious persuasion. (P. 619)

Tan (1994) agreed with Hendlin’s assessment of the concerns of religiously conservative clients and concluded that, “Religious or Christian psychotherapy may be a more ethical type of therapy to provide for such religiously committed Christian clients than purely secular therapy” (p. 391).

Rose’s, Westefeld’s, and Ansley’s (2001) study of 74 counseling clients found that “Clients appeared to believe that discussing religious concerns in counseling was appropriate and to have a preference for discussing both religious and spiritual issues.” (p. 68). Those clients with the most past spiritual experience had the “greatest desire to discuss religious and spiritual issues” (p. 68)

The impact of clients’ request for religion and spirituality to be a part of the therapy session on psychotherapists’ use of a religious or spiritual paradigm over a medical-scientific one is worth investigation.

Professional Socialization

As mentioned in Chapter II, professional socialization plays a role in shaping how professionals view the problem the profession treats, what are its boundaries, and how a person acts as a member of the profession. Socialization of psychiatrists and psychologists occurs in graduate training programs and is reinforced by colleagues, professional institutions such as the American Psychiatric Association and the American Psychological Association, their ethics codes, and publications. Pavalko (1971)
commented that occupational organizations perform tasks such as “setting goals for the occupations, and serving as a mechanism for the exchange and dissemination of new information and discoveries” (p. 105).

**Training Programs**

Not only does research show that religion (but not spirituality) is less salient to psychotherapists than the general population, but that religion has not been universally recognized as a viable component in academic training. Numerous authors noted both the lack of discussion of religion or spirituality in training programs, the need for this, and proposed what this training ought to include (Conway 1989; Sansone, et al. 1990; Shafranske and Malony 1990; Lannert 1991; Lannert 1992; Lukoff et al. 1992; Taggart 1994; Larson and Greenwold Milano 1995; Shafranske and Malony 1996; Haug 1997; Waldfogel et al. 1998; Miller 1999a; Koenig and Larson 2001). These findings are noteworthy because training programs are another source of socialization and potential institutional constraint.

**Psychiatry**

Koenig and Larson (2001) lamented that the:

large body of research [on religious involvement and positive mental health], however, is not well known to many mental health professionals who were introduced to the harmfulness of religion during their psychiatric training and remain skeptical about the mental health benefits of religious practice. (P. 75)

Larson and Greenwold Milano (1995) agreed and noted:

In addressing this [the neglect of religion and spirituality in healthcare] problem, what is first needed is better, more informative, research-based educational programs for clinicians during their medical school and residency years. If
supplied with such training, the authors believe that clinicians would not only feel more capable and confident in their ability to treat the whole patient, but would feel freer to support and respond to their religious patients as well as refer their patients, when indicated, to chaplains and clergy. (P. 155)

Sansone et al.'s (1990) study of American Association of Directors of Psychiatric Residency Training reported that religion and psychiatry were rarely discussed in didactic training while it was more likely to be discussed in supervision about clients, although it was far from a sure thing (p. 37). They concluded that, “psychiatric educators do not emphasize religion on an academic level (e.g., as a psychodynamic process or a cultural phenomenon)” (p. 37). It is important to note that in this study, 33 of the 276 programs described themselves as having a religious affiliation (p. 36). Olive (1995) reported that in his study of religiously devout physicians, the majority (24 out of 28) were not encouraged to discuss religious issues with clients (p. 1251).

Similar findings were discovered in a survey of psychiatric residents in five programs, “not noted for their affiliation with religious institutions” in the 1992-1993 academic year. This study found that almost 39% of post-graduate year three to post-graduate year five residents discussed religious issues during supervision and 29% of these residents discussed these issues during didactic training as a resident (Waldfoget et al. 1998: 30, 32). They found that, “Those residents who received didactic and/or supervision exposure to religious issues, however, tend to believe that religion is important in the clinical setting, and they feel more competent to address these issues with their patients.” (p. 33). Commenting on the findings of his study of members of the American Psychiatric Association, Shafranske (2000) reached a similar conclusion, “Most of the psychiatrists rated the training they received regarding religious and spiritual issues as inadequate” (p. 530).
However, Puchalski, Larson, and Lu (2001) reported gains in the inclusion of spirituality in medical schools in general and psychiatric residency programs specifically. According to these authors, the Association of American Medical Colleges has “supported the development of courses in spirituality and medicine. There are currently 72 medical schools with courses in spirituality and medicine, many of which are required and integrated into the curriculum” (p. 132). In collaboration with the John Templeton Foundation, the National Institute for Healthcare Research published The Model Curriculum for Psychiatric Residency Training Programs: Religion and Spirituality in Clinical Practice: A Course Outline presented at the American Psychiatric Association meeting in May 1996 and subsequently published by the National Institute for Healthcare Research (Larson, Lu, Swyers 1997; Puchalski, Larson, and Lu 2000; Puchalski et al. 2001:134). In addition, the Accreditation Council for Graduate Medical Education (2000) requires that psychiatry residency programs include in their didactic curriculums, “presentation of the biological, psychological, sociocultural, economic, ethnic, gender, religious/spiritual, sexual orientation, and family factors that significantly influence physical and psychological development throughout the life cycle” (p. 11, emphasis added).

**Psychology**

A similar state of affairs exists in clinical psychology programs (Shafranske and Malony 1990; Bergin and Jensen 1990; Haug 1997, and Miller 1999a). As Bergin and Jensen concluded, “the psychotherapy that does take place is hindered by an unspoken
'religiosity gap' (p. 7) because therapists', "clinical frameworks have room only for secular and naturalistic constructs" (p. 6-7).

Bergin and Jensen (1990) suggested, "The clinical fields, in general, have significantly addressed gender, ethnic and racial issues and, perhaps, the same consideration and emphasis need to be given [in training, education, and practice] to religious factors" (p. 6). In a similar fashion Miller (1999a) suggested that:

There is ample justification for devoting training time to preparing students to work competently with spiritual and religious diversity. In the course of their careers, nearly all therapists are likely to be called on to help clients who vary in age, ethnicity, cultural background, gender, sexual preference, and socioeconomic status. It is virtually certain in a pluralistic society that their clients will also vary widely on spiritual and religious dimensions (P. 255)

Miller (1999a) also recommended student therapists address their own potential religious and spiritual prejudices, along with those currently addressed, such as racial and sexual. Shafranske and Malony (1996) concluded that:

the beliefs, practices values, and affiliations expressed within the structure of a formal religious body or held privately, hold the potential to be significant variables in mental health. In our society whose members almost universally identify themselves as religious and as a culture of diverse peoples and faiths, clinicians need to be mindful of the role that religion may serve in promoting or impeding mental health. We conclude that religion in all of its varied expressions and nuances be included in the clinical practice of psychology. This requires a commitment within the profession to mount a sustained effort to better understand the influence of religious involvement on psychological functioning, mental health, and psychological treatment. (P. 582)

These notions of respecting cultural diversity fits with the ethics code for psychology as will be seen below.

Conway (1989) agreed with the lack of religious issues addressed in training programs and the need for clinicians' own religious beliefs to be addressed. Hawkins and
Bullock (1995) viewed it as “a professional and ethical responsibility to address our training needs” in the areas of “religious values and beliefs in psychology” (p. 296).

Shafranske’s and Malony’s (1990) survey of clinical psychologists found that 85% said they had no or rare discussion of psychology and religion in their training (p. 78). The study of training directors for psychology internships mentioned earlier found that 100% of training directors did not receive training or education in religious or spiritual issues (Lannert 1992:136). Although 76 percent of respondents to Carson et al’s (2002) study of marriage and family therapists noted that, “spirituality was not emphasized in their training”, and 54 percent wanted “to learn more about integrating spirituality with assessment and interventions,” 71 percent indicated that they thought it was ethical to address spiritual issues in psychotherapy (p. 162, 163). Finally, fifty-three percent agreed that “a course on spirituality should be offered as part of MFT [marriage and family therapy] training” (p. 162).

In general, psychiatrists and psychologists surveyed reported an inadequate coverage of religious and spiritual issues in their training. This illustrates an institutional separation of religion, spirituality, and medical-science. However, recently there have been moves to include these topics more in psychiatry.

Colleagues

Do psychotherapists who view clients’ problems through a religious and/or spiritual lens and use religious language to describe their problems encounter difficulties with supervisors and peers? Does talking to someone else about this conflict help or does it confuse the situation because the practitioner feels it necessary to hide her/his religious
side for fear of criticism? As Pavalko (1971) noted, “To the extent that individuals are strongly identified with their occupational group, the seeking of colleague approval gives colleagues a high degree of control over the individual’s behavior and legitimates effort to further socialize him” (p. 103).

While it is unclear how supervision by a colleague affects the problem or resolution of two views of minds, Miller (1999a) suggested that “the supervision of new therapists’ clinical work affords many opportunities to explore training issues related to spirituality” and the impact of these on the therapeutic relationship (p. 260).

Very little literature was found on the degree of consultation with colleagues about religious and spiritual issues in therapy. Therefore the impact of colleagues on these practitioners who view client’s problems through a religious and spiritual lens is not known.

Ethics Codes

Pavalko (1971) described the role ethics codes play in a profession. He suggested that:

Their [code of ethics] controlling force consists of the fact that they exist as an explicit statement of the standards to which members of the occupation are expected to adhere. . . In a sense codes of ethics represent a collective statement of the group’s goals and expectations and serve as a reference point to which the individual practitioner may compare himself and modify his own behavior. In this way individuals may exert control over their own behavior irrespective of that exerted by colleagues or clients. (P. 102)

Thus, ethics codes are a pivotal component of a profession. What are the codes of conduct for psychiatry and psychology and how do they relate to religion? To what
standards do these professions hold its members? Are religion and spirituality acknowledged?

The ethics code for psychiatry is called, *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* (American Psychiatric Association: 2001) and is based on the American Medical Association ethics code. There are seven principles (p. 1). The American Psychiatric Association code is described as “not laws but standards of conduct, which define the essentials of honorable behavior for the physician.” (p. 15).

On August 21, 2002, the American Psychological Association Council of Representatives adopted a new ethics code, *Ethical Principles of Psychologists and Code of Conduct*, to become effective June 1, 2003. The code “provides a common set of principles and standards upon which psychologists build their professional and scientific work” (2002:3). The code contains General Principles and Ethical Standards. The former are defined as “aspirational in nature” (2002:3). Whereas Ethical Standards are “enforceable rules for conduct as psychologists” (2002:3).

Respect for Religious Differences

Psychiatry. Although historically and traditionally religion is seen as antithetical to psychiatry and psychology, respect for religious differences is stressed in these codes of conduct, although to a greater degree in the American Psychological Association codes. For example, although religion is not explicitly discussed in the American Psychiatric Association ethics code, in the April 1990 issue of *The American Journal of Psychiatry*, the American Psychiatric Association Committee on Religion and Psychiatry
published a half-page “Guidelines Regarding Possible Conflict Between Psychiatrists’ Religions Commitments and Psychiatric Practice.” It was noted that, “The committee concurred that many psychiatrists take these issues and their solutions to be self-evident and easily subsumed under existing ethical formulations (p. 542, emphasis added).

They were approved by the Assembly in November 1989 and the Board of Trustees in December 1989. There are two main guidelines, with sub-points, as well as an Appendix that gives examples of ethics violations of the two main guidelines. The Committee came up with examples for the Appendix because:

Many other practitioners, however, were of the opinion that this category of anti-therapeutic ethical violation occurs frequently enough and with sufficiently important negative consequences to the individual patient and to the profession to merit a specification of ethical guidelines. (P. 542, emphasis added)

It is interesting to note that the violation is not only to the client but to the profession as well. It hurts the profession when psychiatrists force their religious beliefs on the client.

These guidelines explicitly stated that “Psychiatrists should maintain respect for their patients’ beliefs” and that “Interpretations that concern a patient’s beliefs should be made in a context of empathic respect for their value and meaning to the patient” (p. 542). These statements signaled an officially sanctioned change from the pathological view of religion psychiatry has held. The guidelines went further and stated:

II. Psychiatrists should not impose their own religious, antireligious, or ideologic systems of beliefs on their patients, nor should they substitute such beliefs or ritual for accepted diagnostic concepts or therapeutic practice.

A. No practitioner should force a specific religious, antireligious, or ideologic agenda on a patient or work to see that the patient adopts such an agenda.

B. Religious concepts or ritual should not be offered as a substitute for accepted diagnostic concepts or therapeutic practice. (P. 542)
Little is known about the impact of this committee’s recommendations on how psychiatrists practice in general and if this has lead to a greater distancing or integration of religious or spiritual language in their practices.

Psychology. Religion was explicitly discussed in one General Principle and in three Ethical Standards put forth by the American Psychological Association. Principle E: Respect for People’s Rights and Dignity stated in part 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 the activities of others based upon such prejudices. (P. 4, emphasis added)

In addition, religion is mentioned under the Ethical Standard, Human Relations, subsections Unfair Discrimination and Other Harassment. These respectively stated:

In their work-related activities, psychologists do not engage in unfair discrimination based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, socioeconomic status, or any basis proscribed by law. (P. 5, emphasis added)

Psychologists do not knowingly engage in behavior that is harassing or demeaning to persons with whom they interact in their work based on factors such as those persons’ age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status. (P. 6, emphasis added)

Thus, as seen in the literature on the inclusion of religion and spirituality in psychotherapy, respect for religious differences is a cultural diversity issue.
Competence

As noted above, a number of authors (Conway 1989; Sansone et al. 1990; Shafranske and Malony 1990; Lannert 1991; Lukoff et al. 1992; Taggart 1994; Larson and Greenwold Milano 1995; Shafranske and Malony 1996; Haug 1997; Waldfogel et al. 1998; Miller 1999a; Koenig and Larson 2001) expressed concern over the lack of training in psychiatric and psychological programs on issues related to religion and spirituality. Lukoff et al. (1992) warned that therapists who engage in discussing these issues are acting unethically and “outside the boundaries of their professional training” (p. 675). This comment was made by Lannert (1992) as well.

Their concerns are not unfounded. The American Psychiatric Association code comments on providing services outside one’s area of training in the following statement: “A psychiatrist who regularly practices outside his/her area of professional competence should be considered unethical. Determination of professional competence should be made by peer review boards or other appropriate bodies” (p. 4). “Competence” could easily include addressing religious and spiritual issues with clients.

The American Psychological Association (2002) code noted:

Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience. (P. 4)

The extent to which the above statements in the ethics code act as a deterrent to seeing clients difficulties in a religious or spiritual framework is unknown. That is, do psychiatrists and psychologists who belong to these organizations and who have not had specific training in religious therapies think of their behavior as an ethics violation?
drawing upon one's own religious and spiritual beliefs in delivering psychotherapy an 
ethical issue for psychiatrists and psychologists? To what extent do these guidelines 
shape how the practitioner views the profession and the role of religion in the profession? 
Finally, the degree to which the above is an issue for psychiatrists and psychologists who 
are not affiliated with the respective organizations and are therefore not under their 
jurisdiction is unclear.

Journals and Books

Professional publications are another source of professional socialization. What is 
published, especially by professional organizations, represents current views of the 
profession. Both the American Psychiatric and American Psychological Associations 
have published books on religion, spirituality and psychiatry and psychology. For 
example, a search of the American Psychiatric Association web site showed that the 
following books are published by this organization: Cults and New Religious Movements 
(Galanter 1989), Leaders and Followers: A Psychiatric Perspective on Religious Cults 
(Group for the Advancement of Psychiatry, Committee on Psychiatry and Religion 
1992), Clinical Methods in Transcultural Psychiatry (Okpaku1998), The Sword of 
Laban: Joseph Smith, Jr. and the Dissociated Mind (Morain1998), and Psychiatry and 
Religion: The Convergence of Mind and Spirit (Boehnlein 2000). The American 
Psychological Association also has published a series of books on this topic: 
Psychotherapy and Religion (Bradford and Spero 1990) Religion and the Clinical 
Practice of Psychology (Shafranske 1996a) Integrating Spirituality Into Treatment: 
Resources for Practitioners (Miller 1999b); A Spiritual Strategy for Counseling and
Psychotherapy (Richards and Bergin 1997; Handbook of Psychotherapy and Religious Diversity (Richards 2000). The publication of such books points to an objective indication of an acknowledgement of the tension between psychology and religion and spirituality and also the potential for integration between them. This change was noted by Miller (1999c). He described:

a quest to integrate rather than alienate the spiritual side of human nature [in psychology]. This quest is seen in a plethora of new books, in professional organizations, and in a more general resurgence of interest in religion and things spiritual, reflected even in the popular press. (P. xviii)

A number of psychology journals have devoted special issues to religion and spirituality. For example, Professional Psychology: Research and Practice (December 1999) had a special section devoted to “Collaboration Between Psychologists and Clergy” and Psychotherapy focused on “Psychotherapy and Religion” in its Spring 1990 issue. These journals are published by the American Psychological Association. Finally, The Counseling Psychologist (October 1989) dealt exclusively with “Religious Faith Across the Life Span.”

Larson et al.’s (1986) study of psychiatric journals mentioned above looked at:

the extent to which scientific knowledge of research on religion had diffused into the psychiatric domain. . . at least one reference would indicate greater awareness of the scientific base of religious research; no reference would indicate no awareness of the available religious literature. (P. 331)

They concluded that:

the overall results of our systematic analysis indicate that quantitative psychiatric research including religiosity has an absolute and relative low frequency rate when compared to other behavioral science research, uses methodologically inadequate measures of religion, and lacks appropriate use of current conceptual approaches to religious research. (P. 332-333)
One component of this study is an analysis of the extent to which institutional constraints pointed to by participants objectively exists (see Chapter VI). Very little if anything is known about the role of journals professional conferences in shaping practitioners' views.

Diagnosis and Insurance Practices

Inherent in the practice of psychiatry and psychology are diagnostic systems. The ability to diagnose forms a cornerstone of these professions. Diagnosis is needed not only to determine the course of treatment, but for insurance reimbursement.

The Diagnostic and Statistical Manual of Mental Disorders IV (1994) (hereafter, DSM-IV) is the current standard for diagnosis in psychiatry and psychology. It is produced and published by the American Psychiatric Association. In the current version the diagnostic category V62.80 Religious or Spiritual Problem has been added. It is defined as:

This category can be used when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution. (P. 685)

The inclusion of this code marked an improvement in how religion was viewed in mental health. Lukoff et al (1992), who proposed this category to the Task Force on DSM-IV, noted that, “All 12 references of religion in the Glossary of Technical Terms are used to illustrate psychopathology” (p. 673). Commenting on the addition of this V code to the DSM-IV (1994), Lukoff et al. (1995) noted:

For the first time in the DSM, there is an acknowledgment that religious and spiritual problems can be the focus of psychiatric consultation and treatment, and
that many of these problems are not attributable to a mental disorder. It is hoped that this development will increase the accuracy of diagnostic assessments, reduce iatrogenic harm from misdiagnosis, and increase mental health professionals' respect for individual beliefs and values. (P. 469)

Turner et al. (1995) added that, "this new category contributes to the greater cultural sensitivity incorporated into the DSM-IV." (p. 443). The extent to which this diagnosis is used by psychiatrists and psychologists and its usefulness as a way to mediate or balance scientific and medical with religious and spiritual view of clients' problems is unknown.

Discussing the role of medicalization in aging, Conrad (1996) wrote, "Given the changing American demographic patterns into the twenty-first century, and the continuing insurance coverage only for 'medical' problems, it seems likely that the medicalization of aging will persist and expand." (p. 145, emphasis added.) This same analysis can be applied to mental illness. Irrespective of the use of the V code mentioned above, to what extent do diagnostic categories per se and the need for a diagnosis to be reimbursed by insurance companies impact on psychiatrists' and psychologists' views of mind as medical-scientific and mind as religious and spiritual? Do psychiatrists and psychologists feel a pressure to think exclusively in medical diagnostic terms so they are reimbursed? The role of these factors in defining a problem as medical versus religious is not clear.

Relationship between Personal and Professional Lives

Ragan et al. (1980) found that a majority of psychologists surveyed from the American Psychological Association (n=555) "saw their beliefs and their work as related, suggesting that few psychologists compartmentalize the two ways of thinking" (p. 214). Similarly, very few (8%) of the 121 psychiatry residents in the study by Waldfogel et al.
(1998) study reported feeling a "tension between their religious beliefs and their role as physician. Shafranske’s (2000) study of members of the American Psychiatric Association found that, “The personal religious orientation of the clinician was not found to contribute to the perception of the frequency of religious or spiritual issues in treatment” (p. 528). Blazer, a self-described “fundamentalist, evangelical Christian” and “academic psychiatrist” (p. 13) stated in his 1998 book *Freud vs. God: How Psychiatry Lost Its Soul and Christianity Lost Its Mind* that:

> As a Christian, I have not been relegated to the periphery of psychiatry. Rather, I have worked at the very center of academic psychiatry. I have remained an active churchman, my beliefs have changed little, and frankly, I have carved out a comfortable life within my profession and within my faith community. (P. 21)

At the same time, he did acknowledge that:

> I cannot deny that my concerns [questions that his work with clients of similar faith has raised for him] derive in part from my inability to integrate my spiritual and professional lives—that is, at times there appears to be little relationship between the two. Integration is a developmental task to which I have devoted many hours of thought and prayer, a task that will never be completed. (P. 22)

Walters (2000), a Predoctoral Fellow in Psychology and self-described Christian psychologist, also described his experience of balancing the contradictory knowledge systems of religion and psychology. He noted that, “Science is one stick (but not the only one) I use to infer true things about the world” (p. 271).

> While these examples point to the possibility for co-existence between religious and spiritual beliefs and professional practice, they do not explore the role of professional institutional norms and socialization in this process, which is a goal of this study.
Conclusion

As has been shown in this review, although much has been written prescriptively on ways in which religion and spirituality can be integrated into the work of mental health professionals, and some research has documented the religious beliefs, practices, and training of psychotherapists, virtually no research has been done to show how psychotherapists think about the relationship of these forms of knowledge in day-to-day professional life. This study will fill this gap in knowledge. Additionally problematic are the slippery definitions of religion and spirituality. What these words mean in the lives of mental health professionals has not been well documented.

The impact of personal socialization factors such as personal beliefs and values, in addition to professional socialization factors such as training, ethics codes, journals and books on professional work and a need to compartmentalize one’s self from core beliefs is unclear. What is the role of colleagues in this process? The majority of studies on religion and health have focused on patients’ beliefs. This study explores instead the ways in which mental health professionals of Judeo-Christian faiths make sense out of their medical-scientific training and their religious and spiritual beliefs and the role of personal religious beliefs and professional and institutional factors in this process.
CHAPTER IV

DATA AND METHODS

Data Gathering

Selection Criteria

In order to be included in the study, participants had to meet the following three criteria: (1) be either a psychiatrist or fully licensed psychologist in the State of Michigan; (2) affiliated with a Judeo-Christian denomination (either as a current member or nonmember of a particular congregation), or not affiliated with a denomination but describe themselves as having spiritual beliefs; and (3) have had experience with outpatient psychotherapy with adults. This criterion did not disqualify some psychotherapists who had lately switched to other areas of psychiatry or psychology or had specialized in certain areas of practice with adults, such as geriatrics. Religiously affiliated practitioners were of interest because they combine a religious orientation with medical practice. Michigan represents a typical midwest state with cities of typical sizes and a large number of residents trained in large state colleges.

Psychologists included those trained in counseling psychology and clinical psychology programs. These types of programs were comparable in terms of course content and orientation toward a scientific view of human nature. This was verified by reviewing the requirements for both counseling psychology (Western Michigan University, Michigan State University, Indiana University) and clinical psychology (Western Michigan University, University of Michigan, and Indiana University...
programs). All programs were approved by the American Psychological Association that sets a standard for the inclusion of core courses covering the neuropsychological, cognitive and social bases of behavior, and provided a basis of comparison and uniformity between the programs.

Psychiatrists and psychologists were included in this study because while both professions focus on mental and emotional problems, psychiatrists are clearly trained in a medical model, whereas it is possible that psychologists are less steeped in this tradition. They may therefore have less difficulty with integrating religion, spirituality, and psychotherapy. Additionally, men and women were both represented because research consistently shows that they express their religiosity differently and that women tended to be more religious than men (Argyle and Beit-Hallahmi 1975; de Vaus and McAllister; Cornwall 1989; Taylor, Mattis, and Chatters 1999.) Indeed, a male Fundamentalist Protestant psychiatrist in my study commented on this and inquired if I was going to include women in my study for this reason. Although 33 participants were interviewed, three were eliminated from analysis because of not fitting the inclusion criteria (two) and the tape recorder not working properly (one) during the interview. Therefore, fourteen women and sixteen men were included in the analysis.

Implementation

My multiple snowball sample was generated through a networking strategy involving contacting colleagues from many different sources to find potential participants or those who might know of potential participants. These included professionals in (a) health and mental health care; (b) chairs and professors of departments of psychiatry,
psychology, counseling psychology, religion, and holistic health; (c) rabbis; (d) a Jewish Community Center; and (e) phone directories. These informants represented a wide variety of religious orientations. Additionally, I asked participants at the end of the interview for others they might suggest I interview, stressing that I was looking for a wide range of religious denominations. A list was then generated for each profession with potential participant’s contact information, who suggested her/him, date each person was called, and the result of the call.

Reading from a phone script I wrote (see Appendix A), I called the potential participants, mentioned who suggested I contact them, described myself and the study. If I got an answering machine, I left a message describing the study according to the phone script. I asked these professionals to call me back if they wanted more information and/or would like to participate in my study. Due to their busy schedules, if potential participants did not call me back within 10 days, I called them one more time. Once participants called me back, I explained the study in more detail, answered questions, verified that the person fit my inclusion criteria, and also were a member of a denomination I was looking to represent. This became harder as the matrix became full. I regrettably had to decline to interview people who were members of denominations I already had represented in the study.

Participants were drawn from Southern Lower Michigan. These cities ranged in size from 36,316 to 197,800 (U.S. Census Bureau 2001a). One city was known for its Dutch Reformed influence. Indeed, a participant from that city noted:

It tends to be a very religious community—religious community in the sense that there um, there’s a lot of people who are, who take seriously religious practice. I mean there’s 100, over a 100 Christian Reformed Churches in this town. There’s probably 50 Reform Church of America Churches in this town. There’s a big
Catholic community, active Catholic community. So there are — there are a lot of churches here. There’s a lot of people practicing religion if you have the sense — if you would use that term.

Another participant who practiced in a suburb of that city described above compared its religiosity to Salt Lake City. One psychiatrist described the city in which he practiced as having a “Bible belt sort of feel, to the area here.” Finally, a psychiatrist described his city on the Southeast side of the state as, “predominantly Caucasian and predominantly [religiously and politically] conservative.”

Description of Matrix

Data exists on the percentage of psychiatrists and psychologists of different denominations. Frank, Dell, and Chopp (1999), in their survey of female physicians, found that of the 522 psychiatrists queried, 22 percent were Protestant, 19 percent Catholic, 19 percent Jewish, and 15 percent Atheist. No such similar study was found describing the religious affiliation of male psychiatrists. Bergin and Jensen (1990) found that of 119 clinical psychologists and 71 psychiatrists surveyed, 32 percent of clinical psychologists and 30 percent of psychiatrists were Protestant; 9 percent of clinical psychologists and 21 percent of psychiatrists were Catholic; and 24 percent of psychologists and 14 percent of psychiatrists were Jewish (p. 5).

However, because my goal was not statistical representativeness but finding a representative of each category in order to secure maximum diversity and to represent a variety of backgrounds, perspectives and potentially differentiating factors, my study does not match these percentages. Therefore, an attempt was made to fill-out a matrix consisting of equal numbers of men, women, psychiatrists, and psychologists, as well as
at least one representative from each of the following religious orientations: (a) Fundamentalist, Moderate Protestant, and Liberal Protestant; (b) Roman Catholic; (c) Conservative and Reformed Jewish; and (d) nonaffiliated believers (see Table 1).

Table 1. Matrix of Psychiatrists and Psychologists

<table>
<thead>
<tr>
<th>Psychiatrists</th>
<th>Female</th>
<th>Male</th>
</tr>
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<tbody>
<tr>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fundamentalist Protestant</td>
<td>Fundamentalist Protestant (two)</td>
<td>Fundamentalist Protestant (two)</td>
</tr>
<tr>
<td>Moderate Protestant</td>
<td>Moderate Protestant</td>
<td>Moderate Protestant</td>
</tr>
<tr>
<td>Liberal Protestant</td>
<td>Liberal Protestant</td>
<td>Liberal Protestant</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>Roman Catholic</td>
<td>Roman Catholic</td>
</tr>
<tr>
<td>Conservative Jewish</td>
<td>Conservative Jewish</td>
<td>Conservative Jewish</td>
</tr>
<tr>
<td>Reformed Jewish</td>
<td>Reformed Jewish</td>
<td>Reformed Jewish</td>
</tr>
<tr>
<td>Nonaffiliated Believer*</td>
<td>Nonaffiliated Believer</td>
<td>Nonaffiliated Believer</td>
</tr>
</tbody>
</table>

* African-American. Female Moderate Psychologists includes one African-American

Denominational Classification

Protestant participants were originally asked to classify themselves as liberal, moderate, or fundamentalist. This proved to be impractical due to lack of consistency with what was meant by these terms. Additionally, there was often discrepancy between denominational affiliation and self-identification. For example, one psychologist belonged to a Presbyterian Church USA congregation, attended an evangelical graduate
school, but considered herself liberal. Another participant was a member of the Evangelical Covenant denomination and also attended an evangelical graduate school. He said that some would describe his denomination as fundamentalist while others would call it liberal. He described it as moderate. Perhaps his hesitation in describing himself and denomination as fundamentalist or evangelical was a perceived negative connotation of fundamentalism among professionals. One participant who attended a Christian Reformed Church expressed the difficulty in defining terms like conservative and fundamentalist:

Well, I've been a lifelong Christian, um, the Protestant brand [short laugh] What would by many people's standard probably be seen as a somewhat conservative but not necessarily fundamentalist type of church. Again, those terms are not always very easy to define. Um, very Bible centered, but also a church that tries to emphasize uh, people having a person relationship with God, not just a set of beliefs and doctrine, but a relationship.

Other participants (two Fundamentalist Protestants and one Liberal Protestant) also noted the variation of views from liberal to fundamentalist within a church.

These examples raise the difficulties of unequivocally placing people into camps and saying that simply based on affiliation that was what the participant “was.” People join congregations based on factors other than denominational affiliation such as geographic location, preferences of spouse, and social reasons. Due to these problems of classifying participants according to self-identification, for consistency I have classified Protestant participants according to their denominational affiliation. I used the scheme devised by Smith (1987) for the General Social Survey that divides denominations into Fundamentalist (including Evangelical), Moderate, and Liberal categories. The question “Is a belief in the inerrancy of the Bible supported by your congregation?” was used as an additional fundamentalism test in cases of doubt.
The literature supports the idea that Liberal, Moderate, Fundamentalist, and Evangelical Protestants differ considerably theologically, in measures of religiosity, as well as in social and political attitudes and tolerance (Smith 1987; Smith 1998; Smith 2000; Karpov 2002). Compared to Liberal Protestant denominations, Fundamentalist and Moderate Protestants score higher on orthodoxy and traditional beliefs scales. Additionally, they tend to believe in Biblical inerrancy and report having been born again (Smith 1987). Therefore, I especially wanted to represent these perspectives because they are potentially the most dramatic cases of separation or integration of the two paradigms. For that reason, I had two participants in each of the following categories: male Fundamentalist Protestant psychiatrist, male Fundamentalist Protestant psychologist, and female Moderate Protestant psychologist.

While the desired matrix would have contained representatives from the aforementioned denominations, after an exhaustive search, I was unable to find a representative to fill-in the female Moderate Protestant psychiatrist square. This could have been due to the limited geographical area of the study or the fewer number of women in psychiatry versus men. Indeed, a recent study issued by the Center for Mental Health Services (1999) found that out of 28,970 psychiatrists in the United States, 21,651 are men and 7,319 are women. A Jewish female psychiatrist and historian at one of the medical schools in Michigan who I interviewed, commented that only within the last four or five years have the medical school classes of Harvard and John Hopkins gone 50-50 male-female. The university at which she works just went 50-50 in 2001. Additionally, she commented that she believes women are in the minority in psychiatry, especially as she calculated the few women in positions of power in the American
Psychiatric Association and full professors in her medical school. She said in terms of numbers, and not just positions of power, there are fewer women on the faculty than men. The data from the Center for Mental Health Services support her conclusion.

One limitation of this group was that participants were not always the “perfect” example of a denominational representative. For example, the female Roman Catholic psychologist indeed was reared as a Roman Catholic but attended mass irregularly. Although she found some ritual aspects of Catholicism satisfying, Native American and Eastern practices were more spiritually gratifying. The female Conservative Jewish psychologist made a similar comment that although she was religiously Jewish and attends the synagogue, spiritually she felt more connected to Native Americans. One participant went as far as to say that although she belonged to the Reformed Jewish synagogue and went once or twice a month, she was not sure that she believed in God. At the same time, she believed her religion is important for life cycle events, would not consider converting, and the identification with Judaism was important to her. Another example was the male Liberal Protestant psychiatrist who although he considered himself Unitarian Universalist, he has not belonged to a congregation in 20 years and has only attended sporadically. He was considering returning to a church. The male Roman Catholic psychiatrist, while raised Catholic in Ireland, called himself now a “haphazard Christian.”
Description of Data Collection Method

(A copy of the interview is found in Appendix B).

Why Qualitative

The goal of research in qualitative studies is to produce new concepts versus test concepts already in existence (Neuman 1997:328). This was the goal of this exploratory study. I sought to describe a phenomenon in-depth, its etiology, practical consequences, and solutions, versus achieve representativeness or generalizability. I was interested in the social construction of the fields of psychiatry and psychology. What people think, why they think that, and how does it affect their practice and life. Qualitative interviews allowed me to do that. The set categories of a questionnaire may not fit what respondents think so they are forced to fit themselves into categories (Neuman 1997). What is lost in this standardization is what is important to respondents and their emotions. (Neuman 1997; Fontana and Frey 1998). Respondents’ words ought to be the data of the questionnaire, so questions and format that are geared toward eliciting this seemed most appropriate.

The purpose of in-depth interviewing is to “understand the experience of other people and the meaning they make out of that experience” (Seidman 1998:3). Kvale (1996) commented that, “interviews are particularly suited for studying people’s understanding of the meanings in their lived world, describing their experiences and self-understanding and clarifying and elaborating their own perspective on their lived world” (p. 105). Guiding in-depth interviews was the assumption that “the meaning people make out of their experience affects the way they carry out that experience” (Seidman 1998:4).
This related to domain assumptions and was the heart of what the study was aimed at finding out.

My data gathering method was semi-structured open-ended interview. A strength of this method was its ability to allow "persons being interviewed to take whatever direction and use whatever words they want in order to represent what they have to say." (Patton 1990 297) Although I had standardized questions for each participant, I also pursued questions that seemed interesting, relevant, or for clarification. Patton (1990) described this as a combination of an "interview guide approach with a standardized open-ended approach." (p. 287). Additionally, I was unable to ask every participant all questions due to the degree of specificity with which each question was answered, and how much time over the allotted 1-hour participants were able to spare. I was, however, able to get a sense of each participant's views of the topic of investigation.

A limitation of this method deals with the pivotal role the relationship between participant and interviewer plays in data gathering. What information respondents share with interviewer depends on how they perceive this person (Benney and Hughes 1984; Bailey 1994; Neuman 1997). The issue is if participants are straightforward with the interviewer, especially given the sensitive nature of this study. In addition, participants only had only the name of the person who recommended them to me, my institutional affiliation, my appearance to judge my integrity and trustworthiness (Bailey 1994).

I accept that the participants will not share their worlds with me as plainly as with someone else with whom she/he has a primary relationship. Through carefully constructed questions and awareness of interviewer effect and rapport, I hope I have minimized this.
Issues of interviewer affect brings-up the dilemma (in both a negative and positive sense) in qualitative studies that who I am affects the responses I get. I am bound by who I am, both in terms of how I interpret my participants’ behavior and how they interpret my behavior. This realization need not be a negative one. As Neuman (1997) noted, “A qualitative researcher takes advantage of personal insight, feelings, and perspective as a human being to understand the social life under study, but is aware of his or her values or assumptions...” (p. 334). During my interviews I was aware of the interpersonal dynamics and responses of participants to questions and their overall attitude toward the study. These behaviors and attitudes were not taken personally but thought of as data.

Procedure

Human Subjects Institutional Review Board approval for the study was obtained on November 12, 2001 with revisions approved on November 28, 2001 and December 10, 2001 (see Appendix C). As noted in my HSIRB proposal, the risks to subjects did not exceed minimal risks involved in any research. Participants could have experienced discomfort as a result of reflecting on their experience of integration or separation of religious and professional lives. Patton (1990) noted that, “The process of being taken through a directed, reflective process affects the persons being interviewed and leaves them knowing things about themselves that they didn’t know—or at least were not aware of—before the interview” (p. 354). Hopefully this experience of learning more about themselves was helpful. The issue of participant’s reaction to the interview will be addressed in more detail in the next chapter.
The sequencing of my questions started with non-invasive fact finding information such as where the participant attended school and did residency or internship, and information about practice location and population served. I then moved to more personal information and the research question. The interviews focused on the psychotherapists' perception of the role of the institution, (including place of work, training, journals, professional organizations), professional socialization and norms, religious upbringing, and description of their professional practices in shaping their thinking about the role of religion in their day-to-day work.

Elements of phenomenological and ethnomethodological approaches were used in the interviews in order to reveal assumptions and patterns of thoughts that people took for granted as well as actions that came out of those thoughts. Kvale defined the phenomenological perspective as one that, "includes a focus on the life world, an openness to the experiences of the subjects, a primacy of precise descriptions, attempts to bracket foreknowledge, and a search for invariant essential meanings in the description" (p. 38-39). That is, in the interview questions I looked to see if the participants were aware of using one set of concepts, languages, and ways of thinking when they treat clients (because of their institutional socialization) and another when off-duty. Were there different finite provinces of meaning? In addition, I wanted to understand the underlying background assumptions participants had about their discipline and boundaries of that discipline. If, and in what ways, were they or were they not allowed or encouraged to cross boundaries? I attempted to get at social norms about which are known but not consciously thought. Out of these questions may come a typology of assumptions. This study was also ethnomethodological to the extent that I limited the amount of shared
knowledge I had by asking questions such as “What do you mean by _____?” or “Important in what sense?” With such devices, I forced people to clarify shared knowledge and depart from what they take for granted, or as Garfinkel (1967) stated “treat[ing] the rational properties of practical activities as ‘anthropologically strange’” (p. 9).

All but three interviews were conducted in participants’ offices, at their request. The remaining three participants asked to meet in their respective homes. Interviews lasted between an hour and an hour and forty-five minutes. All participants read and signed an informed consent form (see Appendix D) detailing protection of participants, confidentiality of the data, potential risks and benefits of participation prior to being interviewed. At the conclusion of the interview participants were promised a brief summary of the results of the study when completed. A thank you letter was sent for participating.

Reactions of Interviewees and Difficulties

Although participants only agreed to 1 hour interviews, one-third of them went longer than that, an indication of interest on both parties. Other favorable responses were that the questions were “good” or “interesting.” Some of the questions caught the participants off guard or they were said to be “hard” or “something not thought about.” While other questions were met with defensiveness and annoyance. (These responses will be explored in more depth in the next chapter).

Additionally, participants varied in the degree of specificity with which they answered questions. As can be the nature of open-ended qualitative interviews, at times
some participants rambled off the subject. An extreme example was the participant who took control of the conversation immediately before I could ask any questions and delivered a 45 minute lecture on the history of psychiatry and religion from ancient times. As a result, these interviews were difficult to analyze and get a sense of the participant’s position on the subject. The majority of participants were focused in their answers and stayed on the subject.

For the most part, participants did not comment on the interviewer. Some showed excitement or interest in my topic, as I describe more fully in the next chapter. Two exceptions were three people (a male Fundamentalist Protestant psychiatrist, a male Fundamentalist Protestant psychologist, and male Conservative Jewish psychologist) who asked me if I had a denominational affiliation and if I was actively practicing my religion. In all cases I answered the question and refocused the interview back to them. Although this question was jarring, it could be seen as “fair play” or as indication of general interest in religion. It could also be the case, especially in the case of the fundamentalists, of a desire to make sure I was not “out to get them.”

Data Analysis

Getting to Know the Data

Because this study explored a new field and it was crucial for me to be very deeply knowledgeable about the data, I chose to transcribe fully every interview and checked my work by listening to the interview in full one more time. Another reason for transcribing the tapes was to stay true to Schutz’s (1977) postulate of adequacy (p. 237) as described in the previous chapter. Therefore, in my analysis I did not use a pre-given
meaning of religion and spirituality but use the meaning participants had for these terms and understandings in their everyday exchanges.

A final consideration in transcribing the data personally was the issue of confidentiality. One participant specifically asked if I was transcribing the tapes because she was concerned that inadvertently her client might also be my transcriptionist.

Craftsmanship was a term used by Kvale (1996) as an alternative to “validity”. It entails checking facts, questioning one’s assumptions, having a theory about what’s been learned and relationship among phenomena. (Kvale 1996:241). Kvale (1996) suggested that, “In a broader concept, validity pertains to the degree that a method investigates what it is intended to investigate...” (p. 238). Open-ended interviews can meet the criteria of craftsmanship, given that attention is paid to interviewer affect, interviewer bias and assumptions, and protocols are put in place to eliminate these sources of error. I maintained craftsmanship to the extent that ideas were continually checked against the transcripts for accuracy and adequacy.

The medical-scientific and religious and spiritual paradigms were viewed for analytical research purposes as competing views with competing claims as ways to represent mind. My stance was neutral with regards to both claims. That is, I did not view one claim as more legitimate and correct.

Methods and Procedures of Analysis

In the process of transcribing the tapes, I annotated the transcript to note impressions I had of the participant’s ideas as well as my reactions to their answers. After transcribing the tapes and listening to them again to check work, each transcript was read...
at least two more times. Using inductive analysis, I looked for themes and patterns in the data. A card was then created for each theme, with a code identifying the participant’s number and explanatory variables. Additionally, a summary of each card with a brief interpretation and contradictions were noted as well at the top of each card. Some parts of the transcript counted in more than one theme and were given a separate card. I therefore noted that the quote was already used. Between four to ten hours was spent on each transcript for this step. Each card was then sorted into piles of like themes. Each pile was then further sorted to determine patterns in answers among the participants and how the theme connected with the larger question of the study.

**Explanatory Variables**

Sex, profession, and religion functioned both as selection criteria as well as explanatory variables. Other explanatory variables were as follows: race, where the participant was trained (including school and residency or internship site), years in practice, age, theoretical perspective, and indicators of professional activity and engagement with the profession (membership in a professional organization, most notably American Psychiatric or Psychological Association, attendance at national conferences, and (if) journals read). However, because my approach was not inferential but instead illustrating differences that may or may not have consequences for the larger question of reconciliation of medical-scientific and religious interpretations of mind, in order to truly document the effects of race and sex a much larger and more representative group of participants would be needed.
Race was included because of the literature that suggested African Americans have a higher level of subjective and objective religiosity than whites (Beeghley, Velsor, and Bock 1981; Jacobson, Heaton, Dennis 1990; Taylor et al. 1999). There were three African Americans in the sample (female nonaffiliated psychiatrist, female Moderate Protestant psychologist, and male Moderate Protestant psychologist). This proportion (10 percent) is slightly less than their numbers in the general population (12.8 percent) (U.S. Census Bureau 2001b:13).

Years in practice and age were noted to check for cohort effects in terms of opinions about the place of religious and scientific-medical paradigms in the work of psychiatrists and psychologists and to see if their degree of integration or separation changed the longer one practiced. Finally, cognitive-behavioral therapy and psychoanalysis have historically been anti-religious in their approach (Propst 1996:393; Rizzuto 1996:409, 420). However, both of these authors described these therapeutic perspectives becoming more open and accepting of the role of religion in patients’ lives. To determine if that was the case and a factor in the separation or integration of paradigms, the theoretical perspective of participants was noted.

Constructing Ideal Types

Because I had spent so much time with the transcripts, I had a sense of where participants fell on an integration-separation continuum. In order to verify this and see what patterns existed in terms of explanatory variables, I drew a table on a large sheet of paper. On the left column participants were listed in the following order: Fundamentalist, Moderate, Liberal Protestant; Conservative, Reformed Jewish; and Nonaffiliated
believers. Rows consisted of questions considered to be indicative of integration or separation of religion, spirituality and psychiatry or psychology. These included: (1) awareness and/or attendance at sessions on religion or spirituality at professional conferences, (2) awareness of articles on religion and spirituality in professional journals, (3) prayer in work life, (4) how clients' religious interpretation of a situation was handled, and (5) if there was judged to be overlap between religious and scientific language to describe illness. Other questions used were: (1) whether the therapist used language such as sin, soul, and salvation with clients; (2) diagnosis and assessment; (3) religion seen as a large or small part of clients' lives; (4) religion or spirituality discussed for existential crises; (5) religion and spirituality asked about only if necessary; (6) believing religion and psychotherapy should be integrated; (7) belief in something is important; and (8) bringing theological knowledge into the session.

A check mark was placed in the appropriate coordinate (column and row) for each participant and question. For example, if a participant indicated that she/he would use religious language such as sin, soul, and salvation with clients, a mark was placed in that psychotherapist's square. Once a visual pattern became clear, a list for High, Medium, and Low integration was generated. On each list the sex, denomination, profession, race, age range, years in practice, and theoretical perspective of each participant was noted. The results for each of these explanatory variables were then tallied.

Content Analysis

In order to understand institutional and professional influences on psychiatrists
and psychologists, as well as to see how participants' perception of the treatment of religion and spirituality in their field matched up to an objective measure, I conducted a content analysis of the *The American Journal of Psychiatry* from 1990 to 2000 (120 issues) and *Psychotherapy* from 1990 to 2000 (40 issues). *The American Journal of Psychiatry* contains a mixture of articles on psychotherapy, psychopharmacology and neuroscience and is published by the American Psychiatric Association. *Psychotherapy* is published by Division 29, Psychotherapy, of the American Psychological Association and is representative of the application of the science of psychology to treating mental health problems. Articles were reviewed for the terms "religion" and "spirituality." They were then divided into categories based upon the prominence of these terms. A more in-depth explanation of data gathering and analysis, as well as results, will be presented in Chapter VI.
CHAPTER V

FINDINGS FROM INTERVIEWS

For the purpose of analyzing the interviews, I developed a conceptual model that mapped sites of integration, separation, and the interplay between medical-scientific and religious and spiritual paradigms (see Figure 1). This model focused on four areas: (1) personal religious and professional background factors of the participants, (2) professional and institutional norms, (3) client driven factors, and (4) the practice of therapy.

Figure 1. Conceptual Model
Personal religious and professional background factors of the practitioner included the description of the practitioner both religiously (degree of religiosity, description and frequency of prayer, and definition of religion and spirituality) and professionally (practice information, theoretical perspective, and degree of involvement with the profession).

Second, professional institutional norms included definitions of psychiatry, psychology, and psyche to determine if tensions between the medical-scientific and religious and spiritual transpired in how the field was defined. Additionally, ways in which religion and spirituality were or were not included in training, how they were viewed by the respective professions, and degree of discussion of this topic with peers were also part of this category.

Third, data was grouped into client driven factors, or situations where the therapist was reacting to what clients ask for with regards to religion and spirituality. The final category, practice of therapy, revealed the strategies psychiatrists and psychologists used to integrate or separate the two paradigms.

In the description that follows, I use the following abbreviations to denote participants’ denomination: Fundamentalist Protestant (FP), Moderate Protestant (MP), Liberal Protestant (LP), Roman Catholic (RC), Conservative Jewish (CJ), Reformed Jewish (RJ), and Nonaffiliated (NA).

Personal Background Factors

This section describes participants professionally in terms of keeping up-to-date with their profession, theoretical perspective, where trained, length of time in practice
and age range. Next, findings that characterize these psychiatrists and psychologists religiously are reported. These include degree of religiosity, their definition of religion, spirituality, and prayer, as well as the form and frequency of prayer.

Professional Life

Professional Activities

The majority of the participants kept up with their profession. This was accomplished through reading journals, both those published by the American Psychiatric Association (APA) or American Psychological Association (APA) or other organizations, books, and or attending professional meetings. Only one participant (female RC psychiatrist) noted not having time to read journals or attend meetings due to working part-time while rearing her young children. One psychologist (female CJ) noted minimally reading in her field and attending meetings, also due to parenting responsibilities.

Psychiatrists. All of the female psychiatrists were members of the American Psychiatric Association (APA) and two attended the meetings. One of these women attended yearly and chairs a committee. The other attended every other year, although she went to the Association of Academic Psychiatry meeting yearly. Two of those who did not attend the APA kept up with their field by attending other professional meetings and workshops.

Five out of eight of the male psychiatrists were members of the APA and three attend the meetings. Four of the male psychiatrists who did not go to this meeting were
members of other professional organizations such as the American Academy of Child and Adolescent Psychiatry, U.S. Psychiatric Congress, Michigan State Medical Society, or Alpha Omega Alpha, an honorary medical society. One psychiatrist (male NA) held an office in a state level association.

Psychologists. Likewise, the psychologists also kept up with the profession through their affiliation with professional organizations. All of the female psychologists were members of the American Psychological Association (APA) or the state level organization, Michigan Psychological Association (MPA). Four belonged to divisions of APA, a further sign of involvement. Two regularly attended the APA meeting, and one occasionally went to the MPA meeting. One of the regular attendees to the APA meeting was secretary of a division and was also a member of numerous other professional organizations. This psychologist also attended two other professional meetings yearly in addition to APA. The other recently finished as secretary of a different professional organization.

The most common reasons for not attending the APA meeting was the time of year, having parenting responsibilities, cost, or attending a different meeting instead, such as the American Psychoanalytic Association or International Study for Stress and Trauma and Dissociation. One participant who went to one of these professional meetings was very involved in outreach efforts to decrease the stigma of mental health and was on the editorial board of a journal.

The male psychologists were slightly less involved in the professional organizations than their female counterparts. Six out of eight of the male psychologists belonged to the APA, MPA, or WMPA (West Michigan Psychological Association). One
regularly attended the APA meeting and was secretary of a division. Another participant went to the WMPA meetings, while another participant regularly attended the Association for Applied Psychophysiology and Biofeedback. Two of the participants belonged to APA divisions. Finally, one participant was a member of both secular organizations (MPA and WMPA), in addition to the American Association of Christian Counselors. He was the only participant in the study to mention membership in a religious organization.

Theoretical Perspectives

Most participants identified their theoretical perspective as “eclectic,” but upon further questioning were able to identify up to three main theoretical perspectives. One participant (male FP psychiatrist) could not identify just one perspective. Additionally, the male RC psychiatrist did not answer this question. The summary of perspectives is shown in Table 2. Shafranske’s and Malony’s (1990) study of psychologists from the 1987 membership of Division 12 (clinical psychology) of the American Psychological Association found that the majority of respondents described themselves as psychoanalytic (33 percent) or cognitive (30 percent) (p. 73). The majority of participants in this current study as well described themselves as one of these two orientations.

Three of the participants (male FP psychiatrist, and male and female FP psychologists) worked in a large Christian counseling agency in the state with sixteen satellite clinics throughout Michigan. Two others (male and female FP psychologists) described themselves as Christian counselors.


Table 2. Theoretical Perspective of Psychiatrists and Psychologists

<table>
<thead>
<tr>
<th>Theoretical Perspective</th>
<th>Profession and Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychodynamic</td>
<td>13 (9 psychiatrists, 4 psychologists)</td>
</tr>
<tr>
<td>Short-term Dynamic</td>
<td>1 (psychiatrist)</td>
</tr>
<tr>
<td>Object Relations</td>
<td>2 (psychologists)</td>
</tr>
<tr>
<td>Cognitive-behavioral</td>
<td>14 (4 psychiatrists, 10 psychologists)</td>
</tr>
<tr>
<td>Humanistic</td>
<td>1 (psychologist)</td>
</tr>
<tr>
<td>Developmental</td>
<td>3 (2 psychiatrists, 1 psychologist)</td>
</tr>
<tr>
<td>Biological-medical</td>
<td>3 (psychiatrists)</td>
</tr>
<tr>
<td>Psychopharmacological</td>
<td>1 (psychiatrist)</td>
</tr>
<tr>
<td>Supportive</td>
<td>2 (1 psychiatrist, 1 psychologist)</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>1 (psychologist)</td>
</tr>
<tr>
<td>Client-centered</td>
<td>1 (psychologist)</td>
</tr>
<tr>
<td>Family Systems</td>
<td>1 (psychologist)</td>
</tr>
<tr>
<td>Family of Origin</td>
<td>1 (psychologist)</td>
</tr>
<tr>
<td>Self-actualization Enhancement</td>
<td>1 (psychologist)</td>
</tr>
<tr>
<td>Psychosynthesis</td>
<td>1 (psychiatrist)</td>
</tr>
<tr>
<td>Christian Counselor</td>
<td>2 (psychologists)</td>
</tr>
</tbody>
</table>

**Training**

Two psychologists (female and male FP) attended an evangelical university for their doctoral degree, while two psychiatrists (female FP and LP) and three psychologists...
female RC, male FP and LP) completed their residency or internship at a Christian mental health agency or Christian counseling private practice. The rest of the participants attended secular universities and completed their residency or internship at a secular site.

**Length of Time in Practice**

The average length of time in practice was 18.1 years. The average for psychiatrists was 21.57 and 15.06 years for psychologists.

**Age Range**

Table 3 shows the number of participants in each age range by sex and profession. The majority of participants were between 36 and 65 years of age.

<table>
<thead>
<tr>
<th>Table 3. Age Range of Participants by Profession and Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists Female</td>
</tr>
<tr>
<td>26-35: 1</td>
</tr>
<tr>
<td>36-45: 3</td>
</tr>
<tr>
<td>56-65: 4</td>
</tr>
<tr>
<td>66+: 1</td>
</tr>
</tbody>
</table>

1 Time in practice was determined by counting from when the participant graduated from medical school or doctoral program. Some psychologists have actually practiced longer than this because they practiced at the Masters level first.
Religious Life

Participants’ Religiosity

Psychiatrists. Psychiatrists were split almost evenly between those who had broader beliefs than their professed religion and were not observant, and those who were more strictly identified with a denomination, active in the church, and their place of worship was important to the person. Almost everyone in this group attended church at least two times a month and some went weekly. One participant in each of these groups noted that the set practices of their faith was not spiritually satisfying.

Psychologists. The degree of religiosity among psychologists varied. The majority of the psychologists identified with a specific denomination and often were active in their church. Additionally, most in this group attended church weekly.

A minority of the psychologists had broader beliefs (such as Eastern or Native American) than their professed denomination and often were ambivalent about the beliefs of their faith and not observant. For four of these people, the practices of their religion were not spiritually fulfilling. As might be expected, this included the NA psychologists.

Definition of Religion and Spirituality

As noted in the literature review, “religion” and “spirituality” have been defined many ways. However, because a goal of this study was to understand how psychiatrists and psychologists thought about religion and spiritual paradigms, it was important to learn what participants meant when they used these terms versus impose pre-existing definitions from the literature.
The majority of participants described religion as involving formalized rules, organization of beliefs, and an organization. Spirituality had to do with experience. There were two slightly different definitions of this experience:

1. Spirituality is a person’s experience of religion, God, the universe, higher power, or connection to something greater. It is often hard to explain this connection and not always tied to a religion.

2. Spirituality is personal experiences or expressions that might or might not have to do with a religion. It is how one lives out one’s beliefs.

For five of the participants religion and spirituality overlapped.

Two participants offered an alternative definition: religion is an outward organization and a place to learn about God and connect to others of your faith. Spirituality is who we are and our essence. Religion was also defined as groups “associated by certain belief systems,” whereas spiritually is a broader term that includes religion, cults, and the supernatural.” The female NA psychologist defined it as a ritual pattern, as in one belief system, but spirituality is a less defined term, more having to do with a state-of-being.” The male NA psychologist quoted Scott Peck’s definition of religion, how we choose to see the world, as another definition of religion:

Um, you know, I have my, part of my religion is my psychology. [laugh] I can’t get that out of my brain. So I have my psycholoese and it’s terrible [laugh].

Psycholoese?

[still laughing] Yeah, yeah, that language of psychologists, you know, ‘You’re projecting.’ [laugh] You know, like I hate to hear myself use these terms sometimes. Um, so I don’t know if I can get it clear or clean out of there. I try not to lay it in there too much.
Therefore, his psychology is part of that world view, an indication of an interaction of those paradigms.

The female RJ psychologist could not define the terms, "I—I—if I’m going to be really candid with you, which I will be, I’m very skeptical about religion and I’m not sure what spirituality means."

**Expressions of Spirituality**

For a number of participants, the way they expressed their spirituality or how they defined it for themselves differed from the definitions they gave. Examples included actions such as: breathing, gazing at nature, connection with friends, seeing movies, and performing music. Additionally, beliefs about how others should be treated, with affirmation and respect, and deciding what it means to act morally, was another way of expressing their spirituality. Finally, it was defined as an introspective, developmental process by a few.

Additionally, a few participants were able to make a connection between their spirituality and practice of psychotherapy. This is an example of incorporation of the two paradigms with each other. For instance, the female NA psychiatrist noted:

In terms of the spirituality, I guess the overlap for me has to do with um, [pause] how people assign internal meanings and internal values about things. Um, usually their sense of right and wrong um, their sense of feeling for other people, feelings of love, feeling of hate and all those areas that would overlap in terms of something spiritual, that I think actually has a very intrinsic part to psychiatry. We use different terms and probably they sound pretty antiseptic [??]. Um, but I think a lot of the things that people would think about or would have heard of in what would be included under the rubric of the spiritual, would also come under the rubric of—of the unconscious and feeling. And in the sense, it's hard for me to separate it. It's just a matter of semantics.

Separate what?
Separate the idea of spirituality and psychiatry.

**Prayer**

The majority of participants described praying daily, although the form of it varied. For seventeen participants, prayer took the traditional form of praying to a deity before meals, bedtime, and at their place of worship. For a few participants prayer extended into a greater part of their life as noted by this female FP psychologist:

*How often do you pray or engage in another kind of spiritual practice?*

Every day. I do pray with some clients. I pray for friends. I pray for different situations and guidance and help for myself, um, sometimes before I meet with people. Um just knowing that somehow I need God's intervention sometimes. And quite often with things—some of the things that may be going on.

Two participants (male and female CJ psychologists) noted only praying to a deity if having a tough time.

However, like the concept of spirituality, it was also defined nontraditionally and broadly to include meditative practices, reflection on one's place in the universe and how to lead an ethical life, centering one's self and remembering one's beliefs, or introspection and reflection on one's life often during exercise. One participant did not label introspective behavior as prayer, while the other was unsure if it was the same as prayer.

**Professional and Institutional Regulations**

The majority of themes in this study center around integration and separation of the medical-scientific and religious and spiritual paradigms as they related to professional and institutional norms and regulations. I begin this section with a
description of how participants defined their professional field and a closely related concept, “psyche.” Ways in which these concepts were difficult to define, indicating a lack of reflection on everyday professional activities is noted as well. Next, I turn to themes that relate to institutional aspects including training, residency and internship sites, professional organizations, peers, and ethics. A major finding of this study was the number of professional norms that influenced the practice of therapy. These norms and their impact on the integration or separation of medical-scientific and religious and spiritual are addressed. Finally, each profession has a specialized language that makes it distinct. The final themes focus on integration and separation of the medical-scientific and religious and spiritual paradigms in terms of the languages used by psychotherapists and clients.

**Definition of Psychiatry and Psychology**

All participants were asked how they would define their profession. Answers were examined to see if any tension between science and religion and spirituality transpired in how they define their field. As expected, most people defined both fields in scientific and behavioristic terms. However, as will be reported later, for some participants a greater joining between their fields and religion and spirituality existed than is apparent in their definition. The belief that religion and spirituality ought to be a part of the therapy was presented as an individual view versus a definition of the field.
Psychiatry

There was a broader range of answers to the question "what is psychiatry?" than with the same question about psychology. As one psychiatrist (male NA) noted:

[laugh] That’s a wonderful question. What is psychiatry? Um, [pause] well, I think you’ve hit on one of the uh, great questions of the field right now. I think there’s no consensus on what psychiatry is, even within the field. I certainly was trained by people who felt that psychiatry was a brain science, a neuroscience, first, foremost, and maybe lastly as well. I think it’s—psychiatry right now is a very um, dynamic combination of a lot of streams um, that would include modern neuroscience and things that go-run very deep and ancient as well. Um, archetypal psychology, and things having to do with the soul, so it’s—and everything in between. I think is to me, obviously it’s a difficult to define uh, field.

As might be expected, the definitions of psychiatry were more explicitly medical and scientific than the definitions of psychology. For example, the three main definitions included: (1) it is an off shoot of neurology, (2) the medical specialty of diseases of mood and thought, and (3) having to do with assessing or diagnosing how people think and behave with the goal of treatment of emotional and mental problems and decreasing emotional pain. This definition had the most participants. Three in this group added it is the branch of medicine that deals with these issues. All but two in this group advocated the inclusion of clients’ religion and spirituality in the session. The most inclusive, broadest and least scientific definitions described psychiatry as multifaceted, looking at a person holistically and dealing with not only the physical body but emotion, psyche, soul, and larger social environment and understanding how that is impacting clients’ current condition. Finally, the most non-scientific definition was given by a male FP, “The capacity to work, and to love, and to be creative.”

While some of the definitions included meaning making by the client and a more psychotherapeutic and interpersonal stance, none described religion or spirituality as part
of psychiatry. Although some individual psychiatrists believed it ought to be a part of the therapy, that was presented as an individual view versus a definition of the field. For example, the female RJ psychiatrist noted:

Well I think psychiatry in it’s core, is a practice of trying to help people uh, [pause] experience a certain absence of uncomfortable symptoms—depression, anxiety, psychosis. For some practitioners of psychiatry, it is helping a person grow. Um, ah, and I think in order to help somebody grow, one needs to work also within their religious, spiritual framework. Help them incorporate that in terms of meaning, place, peace, whatever that is. If you are just working toward the absence of symptoms, maybe that’s not as relevant, although I still would suggest that it is relevant. People are going to derive a better sense of well being, uh, that is, less depression, if they feel like they are an accepted part of the community.

The male MP psychiatrist commented:

I think that that [how religion and spirituality are viewed by psychiatry] is a bit in transition now. I think that um, psychiatry, particularly newer psychiatrists are coming out more neutral in relationship to religion now. And I think that’s good and bad. I think in part that’s because uh, uh, newer psychiatrists come out with much more of a biologic um, foundation for their practice and much less of a—a psychological foundation. I think—I think modern, newer psychiatrists think much more about brain and much less about mind. Um, and so religion actually tends to be sort of a null issue for them They’re into sort of bumping neurotransmitters one way or the other. Uh, they’ll—they’ll think about religion as maybe a little bit of a social support. But not, I think, think deeply about the sort of the meaning of religion in a person’s life. And often not even much about how religion relates to guilt, which relates to depression, much. They’re much more, ‘Okay that’s interesting. How do we adjust your medicine?’ And that’s overstating and oversimplifying but that’s I think the trend.

Caught Off guard. Two psychiatrists thought the definition question was “good” because it pointed out the complexity within the field. Five participants were caught off guard by the question, indicating a lack of thought about this question.
Psychology

The goal of psychology as defined by participants fell into three main categories: (1) understanding or studying human behavior, (2) the science of human behavior with the goal of treating emotional and mental problems, and (3) helping people understand their world and self and giving them tools and an environment to do so. Only one participant (male RC) mentioned spirituality in his definition:

Hmm. [pause, short laugh] Well it's the study of—of—I think primarily it's the study of human beings and their living experience. And, and that includes to me what’s going on with them both from a—not both, but from a relational standpoint, from a behavioral standpoint, from an emotional standpoint, um, and from a social standpoint. The physical—I end up involving myself in, because that’s part of, you know, how I was sort of brought up in psychology, being around the medical environment.

When you say the physical what do you mean?

Uh—well I’m, talking about physiological functioning. I would add also spiritual. Um, because I consider that part of the human experience as well.

Caught off Guard. As with psychiatrists, almost half the psychologists were caught off guard by this question, demonstrating the extent to which practitioners take for granted what they do, as seen in the following responses, the first from the female LP:

[pause] [laugh] That’s a hard question. I got my Ph.D. in it and I’m completely stumped. Um, well, psychology has to do with understanding, um, not only behavior, but I think also the kind of mind body connection kind of thing. [pause] I don’t know, understanding what makes people tick in terms of you know, their—their thinking, their body chemistry and their [?] and I think it’s all very related. It’s a really hard question. I really don’t know how to answer that.

A female RJ participant became slightly nervous when I asked the question and replied:

[short laugh] That’s—that’s broad. Oh goodness, that’s broad. [pause] I don’t know why I feel stymied when you ask me that question because it’s such a broad question... I don’t know what psychology is. It’s what I do everyday, it’s who I am, it’s my life, and I like sharing it with other people.
Definition of Psyche

Psychology and psychiatry come from the root “psyche.” According to Webster’s New International Dictionary of the English Language (Nelson 1959:2001), this is the Greek word for the human soul. Therefore, it is surprising that a notion that one might think is central to psychiatry and psychology raised the most definitional problems and the greatest lack of clarity.

Three psychiatrists (male FP, female LP, and female RC) and seven psychologists (two male and female FP, female LP, male and female RC, and male RJ) included spirit, spiritual concerns, or soul in their definition of psyche, along with mental, emotional, and rational processes. Some of these definitions equated the psyche with mind but not the brain, while others said the psyche was greater than the mind.

Other definitions of psyche mostly differed in terms of how psyche was related to mind and brain:

1. It is mind and brain and includes motivation, history, values, beliefs and thought processes.
2. It is mind, but not brain, and includes emotions, motivation and meaning.
3. It is bigger than the mind but related to it and including thoughts, feelings, and how one perceives one’s self.

It was also described as a “vague term” and more complicated than the mind as well as nontangible. The female NA psychologist noted:

[sigh] Well, the psyche is probably a term that somebody made up, so it’s a classification of what a general group of people have thought psychological processes are or that part of ourselves that is a little more abstract. We have brain activity and we have behavior and psychology is probably trying to connect why we behave and think what we do, and what we feel.
None of those who included spirit or soul in their definition of psyche mentioned it in the definition of psychiatry or psychology.

**Caught Off Guard**

The questions, “What is the psyche to you?” and “How do you distinguish it from the mind and brain?” caught more than one-third of participants off guard and was deemed a “hard” question to answer. Participants in this group included four psychiatrists (female FP, male MP, female RC and CJ) and seven psychologists (male FP and MP, female LP, male and female CJ, male RF, and female NA). This again pointed to the lack of reflection upon basic foundations of their work, as well as another indication of the separation between religion and spirituality and the profession. The female LP psychologist said:

> [pause] Well, I suppose to say that—that that the idea of the psyche implies um, [pause] the mind or some kind of—see I don’t really, I don’t know. I mean. I guess there are some things that I’m just not so sure about.

The female CJ psychologist echoed this sentiment when she stated, “I haven’t really [laughing] thought about these things [mind, brain, and psyche], probably since **graduate** school.” [still laughing]

At the same time, just because participants did not know what psyche was or defined it in terms of the soul, does not mean they separate religion and spirituality from the rest of their professional practice. It could also indicate that the psyche was not stressed in school or in their theoretical perspective.
Training

Not surprisingly, religion, spirituality and its integration and tensions with psychology were explicitly taught at the APA accredited evangelical university attended by two participants. These participants graduated with a Ph.D. in psychology and a MA in Theology. The following description illustrates:

And to what extent was religion and spirituality discussed in your program?

Quite a lot. Um, you earn a —I went through and I have a Ph.D. in clinical psychology and you also earn a masters in theology at the same time. Um, so there’s—you know you’re constantly sort of moving between both of those worlds. And then there are five, what are called integration courses where specific topics, and that are looking at spirituality and psychology and how the two may interact, are taught as well. Um, call it— what are some examples of those courses? [pause] I don’t know if you need to know that but, it’s—they’re different topics that look at how the two might come together.

Okay.

And what are tensions and what are the— the uh, blending points between the two of them.

However, only two participants (male NA psychiatrist and female RC psychologist) out of those who attended secular universities reported religion or spirituality was addressed specifically in their training. It was included as part of the assessment.

The majority of participants, both psychiatrists and psychologists, noted that religion and spirituality were absent from their training, as summed up by this quotation from the female RJ psychiatrist:

Um, when you think about your training, and you think about — um — your internship and residencies and post docs, to what extent was religion and spirituality discussed in your program, either implicitly, explicitly?

[short pause] Perhaps mostly not at all.
This psychiatrist felt the reason religion was not discussed in her medical training was because “we live in a Western society which tends to be more individualistic, and yeah, it’s okay if you go to church or synagogue to worship, but really you got to do it on your own.”

The need for separation of church and state implicitly expressed by the above participant was explicitly named by the male NA psychologist:

Ah, see inside the Counseling Psych. program is a—is a kind of—there’s a kind of—there’s a [pause] separation of church and state, I guess. You know there’s that the kind of thing where, you know, everyone in my background, in my training is very, very careful to never even insinuate that they had any spirituality or religion process going on at all [laughing].

You mean your fellow classmates?

Um. Especially the professors.

Oh really.

Yeah. A-a—a great deal, at least when I went through there—you know a great deal—I went for my doctorate, I went through my basic coursework in the early 80s.

The male MP psychiatrist noted that when religion was presented in his training it was done so negatively:

Um, it was discussed very, very little. And to the extent that it was discussed in my residency and child fellowship training, it was discussed predominantly derogatorily. Again, because of the psychoanalytic framework of where I trained, uh, religious beliefs were essentially seen as sort of expressions of—of anxiety and neurosis. Uh, uh, some of my supervisors would, somewhat ridicule the religious beliefs of the people we were talking about. But would predominantly feel that if these people were helped enough and if they became healthy enough, their religious beliefs would become much less held by them and much less important to them . . . But again, I’d go back in summary and say religion was discussed very little and predominately derogatorily within a psychoanalytic framework.
Substitutes for Religion and Spirituality

Psychiatrists and psychologists noted that discussion of ethics, multiculturalism (cultural aspects of religion), and having reverence for the work were as close as their training came to discussing religion and spirituality. The female RC psychiatrist summed up this experience:

And then um, in psychiatry they really don’t talk much about religion. I think there’s a little bit—interestingly enough sort of in the ethics section sort of when you are taught a little bit about that, but religion is just sort of left for each person to handle the way they want to and not really discussed at all.

Another participant (male FP psychiatrist) noted upon reflection that while discussion of religion was not okay, spirituality might have been.

Four psychologists (male FP, LP, and RC, and female NA) stated that although religion and spirituality mostly was not in their training, it was evident in their coursework only in minimal ways. For instance, they were taught to be aware of their beliefs (religious and non-religious) and not impose them on clients. Additionally, there was an acknowledgment that religion and spirituality are often important to clients and to be sensitive to those issue. However, how to do that was not taught. Other examples given included one participant’s professor who used himself as an example of how he wrestled with the issues of his own religious beliefs as a psychologist and exploring one’s own religious history in a self-exploration paper.

Several psychologists, (male FP, female and male CJ, and female RJ,) but not psychiatrists, also noted informal ways religion and spirituality were discussed outside of classes. These included discussion among peers, having supervisors with whom to discuss these issues or whose attitudes about it impacted them. A final informal way two
psychiatrists mentioned is affiliation with the Christian Medical Association, which one participant described as a group made up of students and professors who "prayed and did readings.

**Learn About it on Your Own**

A number of participants noted that if they wanted to learn about integrating religion, spirituality and psychology or psychiatry, it had to be done on their own, as expressed by the male LP psychologist:

You mentioned that your doctoral program didn’t talk about it very much. So how would you say that you got um, training, or some kind of understanding of the relationship between religion, spirituality and psychology?

Um, personal experience, um, I do a lot of reading. Um, I’m very interested in different religious perspectives and I think it’s a matter of kind of integrating that with the training that I’ve experienced.

**Residency and Internships**

Two psychiatrists completed their residency through a state medical school, although the inpatient portion of their residency was at a Christian mental health center. There, the training included seminars on religion and psychiatry, prayer before team meetings, discussion with clients about their problems from a spiritual perspective, in addition to work with the ministerial staff with regards to patients. Two psychologists also completed their internship at the same Christian counseling agency. Finally, a male psychologist started a Christian counseling agency and was able to complete his internship there as well, although he no longer practices at that agency.
Two psychiatrists (male and female NA) who completed their residencies at secular sites mentioned religion and spirituality was part of this training. For one, this was in taking a religious history and then referring clients to the appropriate clergy. The other reported it was obliquely there in case formulation. That is, understanding who the client is and what will be helpful for the client. A final participant (female RJ psychiatrist) noted that it was only in her fellowship training in addictions, in the sense of the Alcoholics Anonymous model where finding meaning, which can include religion, was stressed.

Two psychologists who had internships at secular agencies noted some inclusion of religion and spirituality. One described a few seminars on religious issues and informal discussions with fellow interns. The other noted that he put spirituality in the internship himself by including it on his intake form and approach with people.

Need for Better Models

Additionally, four participants (three psychiatrists and one psychologist) noted the need for better models of integrating religion, spirituality and psychotherapy, as well as tools to discuss client's religion and spirituality, as described by this female FP psychiatrist and female LP psychologist, respectively:

I don't think there are very many good models of how to do that well um, without a *National Enquirer* horror story [short laugh] associated with it.

So people [clients] I think are concerned about those issues and how therapy may effect or bias or impact their beliefs. But there’s not a lot of attention given to that in our training. And it probably would be helpful if it was. Um, I think, you know my impression in general of um, training in clinical psychology, tries to separate, I think for the most part, a religious and spiritual orientation from a more scientific-psychological kind of approach. And I think it'd be more holistic, more complete to at least pay more attention, and at least discuss those issues of
religion and spirituality and how, you know, to bring them into the treatment or how to deal with those issues when they arise. So it’s kind of an area, I really have to say is lacking in training as far as I’m concerned.

The male NA psychologist who reflected on the separation of church and state in his training noted that, “I see something evolving now and I think that may be part of your work, but I see something evolving where like one of the latest cultural diversity issues is, when do we include religion and spirituality in psychology.” [short laugh.]

According to one psychiatrist, The Residency Review Committee has made it a requirement to teach about how to understand clients’ religion and spirituality. It was intended to improve diagnoses in terms of a greater understanding of how religious differences in a cultural sense, impact how patients act and if and how to use the patients’ belief in therapy. When the female RC psychiatrist learned of this change (she asked for some preliminary findings of this study at the end of our interview) she was pleased about this addition to the residency training.

Not Discussed with Peers

There appeared to be a professional and institutional norm against discussing religion with peers and a general negative attitude toward this topic. For example, several participants (male FP psychiatrist, female and male CJ psychologists, and male RJ psychologist) noted that they do not discuss religion or spirituality (either how it applies to therapy or their own beliefs) with colleagues. Although the MP psychologist had a few people with whom he could discuss religion and spirituality, he summed up the situation in general:

I—I because—and it’s [this study] needed because I would say that uh—because I have worked in a variety of—of settings, but in terms of racial, culturally, and I
would say uh, large city, New York City, a small community of _____ outside of uh, Lansing, uh, in _____, I would say an industrial community and uh, I would say that seldom is—is this discussed.

Is what discussed, specifically?

Uh, the religious beliefs uh, of uh, mental health providers or practitioners.

It’s not discussed amongst providers?

Right, right.

Interesting.

And we talk about some of everything. But I cannot recall, I’m just looking at my current practice, I cannot recall you know, someone—we would talk politics before we would discuss religion. And as a result of this, I’m—I’m going to start asking my colleagues about religion, and uh, and you know.

A FP psychiatrist noted that while he had colleagues at his former position with whom to discuss these issues, he presently does not. He noted however that he had worked with chaplains and considered them colleagues.

The male NA psychologist who worked in a university counseling center intimated that it was taboo and “not done” to talk about religion and spirituality at work:

You know here we are, we sit around in our —in fact just recently we were doing internship interviews for the next year’s interns, we’re talking about ‘Well, you know, I believe in the separation of church and state’ and a number of people even said that in our committee meeting. And there was a real anxiety brought up about a person who openly mentioned his deep investment in his religion and spirituality, who was reading the Bible, the Christian Bible while he was waiting to be interviewed. And one of the people brought it up that he was reading the Bible. [whispering] [laughing] Which I mock, because and I don’t mean that as a put down that person, but it’s like that kind of fear [making a deep inhalation noise while saying “oh”]. And of course we’re similar age this person who was concerned about that. We grew up with this ‘Oh my goodness we can’t say that here.” [whispering]

You can’t say what here?

You know, religion, spirituality
Even though there was this restriction around talking religion and spirituality, he later added that he routinely meditated with some colleagues over the lunch hour:

And I will just a little bit talk about it [spirituality] with those folks. Um, there’s a couple of interns and that kind of thing. Um, not a lot. Like I said, there’s a—there’s a kind of a—kind of an uncomfortableness. I’m not sure what it’s all about, like I say I don’t want to make it a negative thing—[lots of words at once] the generation we grew up in or something. That there’s this kind of, ‘you don’t talk religion or politics’ [whispering these words] you know. Like I don’t know what any of those people vote, you know.

When asked if he would bring up religion and spirituality prior to a client in a session he was cautious in his answer:

Yeah, you know, I mean even get into, I hope this is confidential—

Oh definitely, you’re a number now. I changed you to a number.

[short laugh] I really hope, because I guess I still have a little bit of fear of this I definitely would, at times—

So even this very open person who was critical of his profession’s fear of this issue was reluctant to be known as including religion and spirituality into his therapy sessions.

One participant (female MP psychologist) who did not discuss religion or politics with most colleagues by choice, said that she did talk about these topics “for purposes of teaching” her psychological interns about what are their beliefs and how this will impact how they do therapy. This same psychologist noted that, “I used to always have in my office, and I took it out when I moved over here [academic medical setting], the Serenity Prayer, because that’s my prayer.” Although she did not elaborate on why she did not put it up in her current office it is interesting and may point to the way academia is not welcoming towards religion and encourages its separation.

Two psychologists (both female FPs) noted negative feedback when they shared that they were going to explicitly combine religion, spirituality and psychology. One
received what was she termed “razing” from her undergraduate advisor when she told him she was going to attend an evangelical school for her graduate degree. The other psychologist described the hostile attitude of a colleague when she told him of taking a position as clinical director of a Christian mental health agency.

**I Am Not Hiding It, I Am Being Discerning**

Four participants (male and female FP psychiatrists; male FP and female RC psychologists) noted a caution about choosing with whom to share these ideas. However, they were quick to add that they were not hiding their beliefs but discriminating about with whom to share. The female FP psychiatrist who worked in an academic setting noted:

Um, so I’m very selective about who I speak with this. I mean I think most of the people at _____ are agnostic, they look at me and go ‘huh?’ [made a facial expression]. That’s nice and just blow me off. Um, so you learn that’s not a place to discuss this.

A male FP psychologist who worked in a Christian mental health practice echoed this sentiment:

I would bring it [his model of integration of psychology and religion] up? I would raise it? No. No because most—I think if it was somebody knew—if I was meeting someone for the first time and I led off with this, they’d think, ‘This is a religious wacko here.’ I think you have to—have to earn the right to be seen as a competent therapist and then you can you say, ‘Here’s my theoretical perspective, here’s how I approach clients. Now there’s a layer underneath it, that’s driving this and it’s my own personal beliefs and value system and there’s a theology to it, and here’s what it is.’ And so, I wouldn’t lead with it, but I wouldn’t feel uncomfortable once I was in a relationship with someone to disclose that.

As with the above psychologist, the female RJ psychiatrist was aware her view that “in order to help someone grow, one needs to work also within their religious, spiritual framework” was not shared by all. She was less hesitant, however, to readily
voice it publicly.

I Am Not Sure What Religion They Are

Another indication of religion and spirituality not discussed among peers and separation of religion and spirituality from the profession was the number of people who did not know the religion of colleagues or were incorrect about the religion of colleagues. This most often came up when I asked contact people and participants for others who might be interested in my study. Perhaps the reason for this reluctance was best summed up by the male CJ psychologist:

Sometimes, maybe I’m a little bit reserved, [short pause] you know, [short pause] I’m a little bit reluctant sometimes to bring it up because [pause] it’s feels—it’s such a very personal thing for so many people.

Bringing up religion?

Yeah.

With the clients?

No, with other colleagues.

A dramatic example of the extent to which religion and spirituality was not in the forefront was when I asked a psychiatrist if he knew of a psychologist of a certain denomination, to which he replied, “No.” A few minutes later when I inquired about the colleague in his office and asked if he was this faith and he said, “Yes.”

I Have a Few People with Whom I Can Talk

A large number of psychiatrists and psychologists of all denominations noted that there were colleagues with whom they discussed religion, spirituality, and psychotherapy
professionally versus personally. However, for the majority of these, it was not talked about in much detail and there were only a couple of people with whom they discussed it. One participant (female RC psychiatrist) noted that she did not discuss religion but the “spirituality of things.” indicating that spirituality was safer to discuss with peers than religion. Another psychiatrist (male LP) noted that although potentially he had people with whom to discuss these issues it had not come up, an indication of separation of religion and spirituality in his practice. Only two participants (female FP and CJ psychologists) noted discussing their own spiritual or religious issues with colleagues.

As can be seen from the above findings, participants differed in their comfort and ability to talk with their peer group about religion and spirituality. The theoretical implications of this will be discussed in Chapter 7.

Professional Organizations

Professional Organizations and Meetings

Participants were somewhat aware of sessions at professional meetings that discussed religion and spirituality1. However, only two participants (male FP psychiatrists) indicated attending sessions on religion and spirituality at the American Psychiatric Association meeting. Additionally, one of these psychiatrists also mentioned attending a breakfast hosted by the Christian Medical Association at the American Psychiatric Association meeting. Three psychiatrists (female LP and male and female

1 Hardy (2002) reported a growing interest in religion and spirituality at the most recent American Psychological Association meeting. In addition, Oskar Pfister award, honoring those who have made contributions to psychiatry and religion is given out at the annual meeting of the American Psychiatric Association Meeting (Swanson 2002).
NA) and two psychologists (female FP and male CJ) reported awareness of such sessions but not attending at either American Psychiatric Association, American Psychological Association, or other professional organization meetings. Interestingly, one of these (male CJ psychologist) upon reflection described hearing Rabbi Kushner speak and then realized that was an example of religion and psychology. This showed the extent to which religion and spirituality was not foremost in his mind professionally.

No participants, even those who described comfort with discussing religion and spirituality with clients, reported being a member of the committee or division in either the American Psychiatric Association (Committee on Religion and Psychiatry) or the American Psychological Association (Division 36, Psychology of Religion). A female FP explained her reasoning for this:

So there is a section of APA that is Religion and Psychology.

Yeah.

Are you a member of that?

No. I don’t really have that interest. I mean, it’s another one of those things that it costs to do that so. Um, when I think about religion I think about that that’s who I am, but it’s not a thing that I’ve got a driving force in terms of, um, passion and interest in furthering at this point. So, and that’s where I spend my money. [laugh]

This was most remarkable given that many of these participants described their faith as an important part of their lives and were comfortable discussing clients’ religious and spiritual concerns, as well as praying with clients at their request. This contradiction perhaps indicated a separation of personal religiosity from professional interests.
Another example of professional interest in religion and spirituality and integration of two selves was whether participants were aware of and also read articles on this topic. Quite a few psychiatrists (male and female FP, male LP, male RC, male and female NA) and psychologists (male FP, male and female LP, female RC, male CJ and RJ) were aware of articles on religion and spirituality in their field and reported reading them. Given these participants’ views of religion, spirituality and psychotherapy it was not surprising and consistent with described beliefs that they read such articles. However, a few others psychiatrists and psychologists either said they did not recall seeing such articles or were not sure if they had seen articles on this topic. What was surprising was those devout participants in this group who did not see articles on religion and spirituality, possibly indicating that it is not on their radar, as noted by this female CJ psychiatrist:

I don’t recall seeing anything about it in journals. I mean that’s not the thing—now I wouldn’t necessarily seek it out, but it’s not something that I normally see.

Meaning religion and spirituality and psychiatry?

Yeah. Right, right. Uh, I mean it’s possible that it’s there and I’m just overlooking it. But my impression is psychiatrists in general don’t address these issues and don’t talk about them.

Another example was a male FP psychiatrist who worked at a Christian mental health center and described developing a model of integrating spirituality into his psychiatry. He noted that he had not seen articles on religion and psychotherapy in The American Journal of Psychiatry, The Archives of General Psychiatry, or the Journal or Alternative Medicine. It is surprising that he did not see this type of article, especially in
the first and last journals. As will be shown in the next chapter, articles on religion and spirituality are published in *The American Journal of Psychiatry*.

Related to the notion of if the participant noticed and read articles on religion and spirituality is their estimation of whether their profession supports it in terms of how it was presented in the journals and at conferences. Two male psychiatrists (Fundamentalist Protestant and Nonaffiliated) commented that they were not in a useful form. One complained that the articles were not “how to” focused enough and relevant to his daily practice while the other commented:

> going to those courses, reading those articles, I’m left with [pause]—just a feeling—a sort of—what shall I say—it’s a less then juicy. There just doesn’t seem to be a lot of life in it. It seems to be yet another of almost bureaucracy, another layer of more data—just more data to collect. It seems kind of dry. So as it’s being included it’s also being kind of medicinalized and uh, reduced to, ‘well if’ you know, ‘if Navajo then medicine man consult’ without any intervening interest or attention placed on meaning. That’s being a little harsh to what’s been done. But maybe when you have a course on cultural and religious sensitivity it’s got to get boiled down into sort of a dry curriculum. And so I think that’s kind of sad. But maybe it’s also good that it’s being more discussed.

**How Psychiatry and Psychology View Religion and Spirituality**

The interview question, “From your training, journal articles and conferences you’ve attended, what’s your understanding of how religion and spirituality is viewed by your profession?” drew a range of answers. There was general view among those who commented on this question that although the American Psychiatric and Psychological Associations were religion neutral, they were not opposed to either the inclusion of religion in therapy or to seeing religion as a part of individuals. Although one male FP psychiatrist saw the American Psychiatric Association as “not a friendly organization to Christians” and did not attend meetings regularly because of their agenda to “normalize
homosexual behavior."

Psychiatrists

A few believed their profession was negative toward the integration of religion and spirituality and a wall existed that separated the two domains (female CJ and RJ). More psychologists thought their profession was neutral to religion and spirituality and it was less peripheral to the field, although still a small part of it (male MP, female LP, female and male RC, and male NA), as illustrated by this male MP:

Um, there are sort of little boutique things that are happening in the profession now that really looks at, sort of, psychiatry and spirituality, psychiatry and religion. But that's still sort of a more of a small area in the general field.

A slightly smaller group (male FP, LP and CJ and female RJ) believed it was more accepted both as an important part of client’s lives and as part of what the therapist brings to the session.

Psychologists

The psychologists had a more favorable sense of their profession’s view of religion and spirituality. The majority felt that religion was more welcome in psychology than before, as commented on by this male LP:

Historically, I think my profession has had a pretty negative view of religion. I think uh, has viewed religion as a cop-out in terms of dealing with reality. I think there’s a growing acceptance in the field of psychology around incorporating spirituality into the process and seeing one’s spirituality as an important part of one’s life and then pulling that into the counseling process. So I think we have a ways to go. But certainly, especially among the, say the Humanist movement in psychology, this has been a big area. And I think more in mainstream psychology there’s getting to be more acceptance of the necessity of taking these issues seriously.
Only one psychologist (male RJ) had a less favorable, although still positive assessment. Although unlike the psychiatrists, no one reported a wall between the two domains, a male FP described a separation of sorts:

Um, I guess, um, [pause] there’s a lot of—kind of the chic thing is the distinction between—in my mind is the distinction between spirituality and religion. ‘Well, we’re interested in spirituality but we’re not interested in religion stuff.’

This notion was voiced by the male NA as well:

It’s an interesting thing too now. It’s a safe thing to say I’m into my spirituality. Safe thing to talk spirituality. It’s still not safe to talk a specific religion.

When you say “safe” you mean among professionals?

Among professionals. I mean that there are—there’s still such a separation... Uh, you see, across the board when I say, there’s everything from—from where you have to be a certain kind of religion [to get a job—Christian counseling agency], to you can’t even speak about religion, you know, to, uh, you know, you can talk about spirituality as long as you make it very amorphous term, but don’t ever let it get it down to the term like Christian or Catholic, or something like that. Then you’re in deep trouble. So—so I see that as kind of my sense of where things are right now. Is kind of this very uncomfortable place we are in our profession with it. I don’t know if people would say it that way, um, I don’t think the majority would say it that way, but I see it as just a very uncomfortable kind of thing. And a very interesting thing because like I say, I think it is so gigantic in people’s lives, I mean it’s large, and we kind of dance around that one.

A male Fundamentalist Protestant psychologist noted that it was accepted in the addictions area in terms of what he termed a “general spirituality” and in the Christian counseling professional organizations.

Spirituality therefore was more global. The focus on spirituality versus a specific religion pointed to the discourse of diversity and inclusion. One participant, the director of a psychiatric residency program, commented on the difficulty of getting her residents, who come from many different countries and faiths, to agree on a definition of religion and spirituality. Not only was spirituality safer with colleagues, but clients as well, as will
be discussed later.

**Impact on Work**

There was not a direct connection between what therapists think their professions' view of religion and spirituality was and their own attitude toward this subject. For example, a participant (female RJ psychiatrist) who thought psychiatry was anxious about those who talk about religion and spirituality in their practice, as well as five other participants (male MP, female LP, female RC, and male NA psychiatrists; male RJ psychologist) who thought it is less peripheral but not wholly accepted by their profession, were some of the most comfortable discussing the religion and spirituality of clients. Two even were comfortable praying with clients if asked. In addition, several of those who thought the profession was more accepting of religion and spirituality were either not comfortable or not one hundred percent comfortable with religion in their practice.

Finally, two of those who were not comfortable addressing religion and spirituality (female CJ psychiatrist and male RC psychiatrist) also viewed the profession as negative or ambivalent toward religion and spirituality. However, I think this view of the profession more reflected who they are versus an impact from the profession. Neither described wanting to bring religion or spirituality in but feeling constrained by professional norms to not do so. I do not think the profession influenced their view as much as their view reflects other personal beliefs.
Ethics

A major function of professional institutions is to provide ethics codes. The American Psychiatric Association and American Psychological Association have statements in their codes regarding religion and spirituality, as described in an earlier chapter. For the psychiatrists and psychologists in this study, the impact of the codes on their integration or separation of the religious and spiritual and medical-scientific paradigms seemed minimal given the small number of practitioners who were even aware of what their professional code said about religion and spirituality. Those that did know about them were male Fundamentalist Protestants (one psychiatrist and one psychologist). Perhaps those at the extremes religiously were most concerned and aware of the line they had to not cross, as seen in statements from these practitioners:

In what kinds of situations do you think would lead you to uh—offer to pray with the client?

One that is not considered particularly therapeutic. In the sense that uh, I -The APA very strongly says that’s—that it is—it is—I could probably quote you the statement—it is malpractice for me to pray with patients according to the APA. . . But I—I—though as a psychiatrists that would be inappropriate, as another human being who is a part of someone’s life, that is appropriate. So, that’s the line that you have to draw.

The psychologist noted that:

 Uh sometimes, again, knowing that they’re Christian gives me the freedom to sometimes challenge the behavior along strictly moral, ethical, Biblical kinds of lines. So, again, I try to do that within good professional ethics and sensitivity to where the client’s at and what ways they are open to that spiritual thought and influence.

He later he added, “And I’m—I’m very, very careful about professional ethics in terms of I don’t try to push towards commitment to faith if they’re—they’re not committed to faith.”
Professional Norms

There are professional norms for both psychiatry and psychology that supported the separation of the religious and spiritual from the medical-scientific. It is to a degree, hard-wired into the system and part of the fabric of the profession. Citing professional norms, although not always identified as such, was a way the majority of participants justified their integration or separation of religion and spirituality in their work. Discourses and commonsense notions about basic tenets of doing psychotherapy such as not imposing beliefs on the client, keeping the focus on clients, professional and clinical boundaries, and not wanting personal characteristics to be a stumbling block for the client were used.

Do Not Impose

A very prominent norm was the concept of not imposing one's beliefs. Many psychiatrists and psychologists were clear to point out after describing how they explored or discussed clients' religious beliefs or the function religion plays in the client's life, that they do not impose their view on the client. They do not want to be seen as pushing or proselytizing their own religion, certain behaviors or beliefs about what is correct behavior and what is sinful. Talking about religion and spirituality was okay but it was considered unethical to impose your beliefs on clients. This was a strong and pervasive norm. Perhaps participants were especially quick to note that they did not impose their religious and spiritual beliefs because it is a hot button issue in our society and because of the issue of separation of church and state.
The concern about the power inequity in the therapeutic relationship was a reason there was concern with therapists bringing their religious and spiritual beliefs into the session. The female NA psychiatrist pointed out the potential difficulty:

Um, I think there’s an awful lot of potential in psychiatry to [pause] endorse certain aspects of religion that could be misused very easily. There’s so much that people come to us for in the way of guidance and direction, or some people actually want you to do explicit problem solving, which, sometimes we do, but most times we try to give people the tools by which they can make decisions on their own. [pause] Um, I think there may be some wisdom to psychiatry not actively utilizing, um, religion as a means to [pause] more psychological health. Because my notion of what would be appropriate practice religiously and what would be comfortable for somebody else might be very different but they might not tell me that. And because they come to you, in some sense, as an authority figure, as a source of information they don’t have, you run the risk of uh, having them perhaps, trying to accept some things, or some attitudes maybe, religious attitudes that you have, um, that are really unacceptable for them. And that poses a huge conflict for them.

Not imposing religious or spiritual views applied even or especially, to those psychiatrists and psychologists who explicitly discussed religion with clients using religious language such as Scripture and religious principles. A male FP psychologist described this:

Okay. Um, and you just sort of touched on this. Um, do you think there’s an ethical professional issue in separating religion and spiritual from psychotherapy? What do you think the bounds of that are?

Well I think yes, it is an ethical issue. I think we uh—my professional ethics uh, need to very much respect where the client is coming from and what they’re coming for. Um, I have no right to push religion on people if that’s not what they want to talk about, their spiritual issue if that’s not what they want to talk about. Um, I have [short pause] no right to uh, try to convert them. Uh, some people are definitely searching, and I will talk to them [about it]. But most people are here for other kinds of things and I respect what they’re here for. [And so] I think if there’s a [?] you need to deal with spirituality in the context of each particular client, what they’re coming in with.

However, a female FP psychologist who at first said:
Um, let’s say it’s a person with very low self-esteem, um, and there doesn’t seem to be anyway for them to feel they are worthwhile as a person, I may interject—even if they have not indicated, that—let’s say that they don’t necessarily believe in God even, I might interject at that point, that you know, you are not alone. That God really does love you even though you may not think or believe that there is a God. But the reality is you are not alone. And that you are very special to God and you were created by God in His image and so therefore you are very special to Him.

went on to say that she helps clients’ figure out what their values are around divorce and birth control and what their religion says about these issues.

Strategies used to respect this norm of not imposing beliefs and still leave the door open to discuss religion and spirituality included: challenging a religious belief of the client and to clearly label the beliefs cited as the therapist’s. Another method was to ask open-ended, broad questions that left an opening for the client to talk about religious beliefs. The female RC psychiatrist described how she would bring this up to clients, “You know, do you think there could be another meaning to this or do you think there could be another reason for this, in a more global sense?” This therapist added that if she knew the client was devout she would be more inclined to talk explicitly about religion. Another participant (female CJ psychologist) also described this. This strategy may be used because it is seen as “safer” because there is little chance of being seen as pushing religion on clients. A similar approach was used a the male LP psychologist who asked clients about how they maintain balance in their life, thereby leaving the door open for other issues such as religion or spirituality.

Clients Need To Find Their Own Answers

Interwoven with the norm of not imposing one’s views was the complementary norm that therapy was about client’s finding their own answers. The religion, spirituality,
and accompanying beliefs of the therapist was a non-issue. Their beliefs do not matter. This view was implicit in all the participants who were clear about the importance of not imposing and articulated by a psychiatrist (female CJ) and psychologist (female MP). As the male MP psychiatrist noted in his concern about those working from an openly religious perspective:

but they [other psychiatrists] would feel uncomfortable working with and referring patients to uh, pushy people. Pushy people who try to impose solutions rather than help find solutions.

I Am Keeping Boundaries. Not Hiding My Religion

Participants almost uniformly stated that they did not feel they have a separate self at work in terms of their religion and spirituality. Not sharing beliefs or minimally sharing information such as what denomination one was with clients, or that one believed in God, was more about maintaining professional boundaries and adhering to norms that state therapy needs to be focused on the client, as described earlier, than hiding or because religion is in conflict with psychiatry or psychology. For example, the female MP psychologist stated:

I didn’t talk about who I vote for-- I still don’t talk about who I vote for and I don’t just have a discussion with you about my religion. But I don’t hide who I am. There’s a difference. I’m not a um, evangelist, I’m not coming out to recruit, but I am a person who believes in God. And I will say I do and if they say why I will just go ‘That’s not a point of discussion’ even with a client ‘Well why do you believe in God?’ And I just go, ‘That’s not why we’re here. You asked me if I believe, I believe.’

The female NA psychiatrist noted:

And uh, psychiatrists are trained to not answer direct questions, generally. And for sometimes good reasons and that is, when people are asking questions like that what they want to know is whether or not you’re okay and whether or not you’re
safe. And if you simple answer the question about whether you are a member of a church or not you don’t get the opportunity to talk about those other things.

On the other hand, two psychologists noted being comfortable being open with clients about their beliefs:

Um [short pause] some authors I have suggested that one’s own faith, meaning the therapist’s faith, should not be concealed but brought to work. Do you do this?

I will if a client asks me.

And how much would you tell a client about your own beliefs?

I tell them what I tell you. I would say, ‘I don’t have a particular religious belief but I am very tolerant about a lot of beliefs.’ And if they find that what they are looking for isn’t here then they should find another therapist, or I can help them find another therapist that will match that. And if they want, you know if they want something else I will help them find that, and if they have any questions they can always ask me, and I’ll generally answer to the best of my ability, because they’re the consumer and they should get what they want.

I Do Not Want My Religion To Be a Stumbling Block

Several of the Jewish psychotherapists did not want their religion and potential prejudices of the clients to be a stumbling block for the client, as clearly articulated by the female CJ psychologist:

Well another way to ask this question is if you feel you hide—have to hide your beliefs at work?

Well that’s an interesting question. I—my daughter is adopted from ______. And um, so the frame we got in ______ this summer and the picture [referring to the picture on her desk, very visible from the chairs] is from the party after her bat-mitzvah. And I toyed with having a picture of her with her tallit. And then I thought, no, I don’t want to introduce that into the office, just in case there’s some Christian person who might be put off by that. I guess that’s really the issue, I wouldn’t [laugh] be concerned about a Jewish person seeing it. And so I decided to put a neutral picture of her rather than, there’s a picture of her in her tallit in the house, but there isn’t one in the office. So, I guess in that way I would like to keep that out of the picture.
Because you don’t know the reaction of some people?

Right. Right. And I don’t want that to become a—a stumbling block for people who think I can’t understand them because I’m Jewish or they have some—I guess it’s part of growing up at a time where one was still more careful about acknowledging that you were Jewish and there was more rampant anti-Semitism in the fifties, than there is now—it’s out there, but it’s just more covert . . . But still, you know, it was part of that time to just be a little more circumspect about being Jewish and so I carried that over, I suspect.

She added that she would rather keep her Jewishness out of the picture. This sensitivity on the part of Jews came from knowing they were the minority in a Christian country and were seen by some as outsiders. This view was expressed by the male CJs. This psychologist stated, “I think a lot of people are threatened by the fact that someone’s Jewish because it’s so against everything they’ve been taught and indoctrinated about it. ‘You don’t believe in Jesus Christ?’”

The psychiatrist added:

So um, uh, so I think that [people can tell he’s Jewish] enters into it, it’s not so much the content of my own beliefs, but the recognition that I’m an outsider in a sense, you know, especially in a largely Christian community, that I think I tread carefully. So I want to be careful. And if I’m going to say something uh, that um, contradicts or somehow counsels someone away from a—what I think is a negative sort of influence of their religious practice or belief, or whatever, that I’m going to build a little case for it that isn’t one strictly of my having a different religious point of view, but that’s one that stems from, you know, here’s the effect of this, you know, frightening snake handling—it’s not quite like that—but, you know, sort of thing you’re doing. ‘Well no wonder, that would scare some people’ kind of thing that’s more straightforwardly simply human.

A male FP psychologist also noted that he viewed the potential distracting effect of clients knowing about his religion as similar to them knowing any personal information about him, such as the number of children he has. He thus did not make religion a special or unique case. He was clear to point out he was not hiding but respecting professional boundaries:
Do feel like that you have a separate self at work versus outside of work, in terms of your beliefs?

Um, [long pause]. “Separate”—“separate self” and “hide” um, are too strong for me. Let me give you another example. I don’t have my pictures of my kids up in my clinical office. I don’t see clients here. I don’t have them up because I don’t want—if they see— you know, if I’m dealing with somebody who um, is maybe struggling with infertility or is going through a divorce, or is very um—very sensitive to am I really there for her or him in the session. If they see five kids sitting on the table—they have a— it raises a threat for them that um, perhaps I’m distracted by this other group—I’m not there for them. It becomes --it contaminates or it becomes a-- much of a distraction rather than what’s happening here and now. And so I guess I would use the same thing about my religious beliefs. They’re a part of my life, but I wouldn’t want that to distract people like, ‘Oh, well he goes to ______ Church. You know what, my boss goes there. You know. Gee I wonder if he knows my boss.’ Now we’re off on a trail that has nothing to do with what brought them in. And so—that’s—is that hiding? Do I hide my family? Well, yeah in one sense I don’t tell them about it, I don’t tell them about my family, I don’t show them pictures, I don’t bring up my family. But I’m not really—I don’t really feel like I’m quite hiding them, I’m just trying to keep the boundaries around. Keep the focus on what brought them in and what they need. And if it involves spirituality and religion, religious beliefs, so be it. But I’m not going to have that distract us.

**Spirituality safer with clients.** As noted above, therapists had concerns about how their religion can get in the way for clients. It is understandable therefore that two psychiatrists (female RC and NA) and three psychologists (male MP and LP and female CJ) would rather talk about spirituality versus a specific religion with clients. The issue was the religious diversity of clients set against the single religion of the therapist. A client may be Muslim or Hindu and thus a religion-neutral stance is more appropriate.

The female CJ psychologist stated:

> Somehow I think it’s easier to acknowledge or deal with being spiritual than being Jewish or [laugh]. I see that as much more universal and cutting across all kinds of religions, formal and informal.

Another reason for discussing spirituality versus religion was because of how religious people are often viewed, as described by the male MP psychologist:
Uh, they’re [religion and spirituality] the same, and it is uh, safer to use spirituality because uh, what I find is uh, especially in the USA when you say a person is religious, you usually, uh, what comes up [sic] some fanatical individual uh [short laugh]. But to say ‘are you a spiritual person?’ you know, it uh, doesn’t have that same connotation and also at the same time it can include uh, individuals who have—who state that they are atheists or agnostics. You know, you can be a spiritual person, I believe, in terms of uh, your human values and be motivated by another force, but don’t call that force God, or view that force as God.

Fear of bias and prejudice. Both Jews and Fundamentalist Protestants concerns were real and not just an avoidance strategy but a serious issue because of theological differences in a religiously diverse society. Three of the Jewish participants quoted above, plus another, described experiences of or concerns about possible experiences of anti-Semitism from clients.

Fundamentalists, perceived by some to be an outsider group, also noted concern about negative views of others. They wanted to be seen as competent and know they were suspected of incompetence. In describing why he thought spirituality was okay in psychology but not religion, the male FP psychologist quoted above noted:

The fear is that —well I think there’s a bias. Religious people are stupid. Or the more religious the more uneducated. It’s a bias that’s seen in the press a lot. I think. Um, that—that churches are places for—there’s a lot of sort of mentally unstable people in churches. I think there’s probably a bias toward that, particularly more conservative or fundamentalist churches. And so that may be based on truth, too. But again, the problems you see, out of that Fundamentalist, Baptist church, helped the family pull through a crisis. You don’t hear about that. You hear about the fondling by a youth minister. So-- I think that’s probably where a lot of it comes from.

The desire to be seen as a competent professional was voiced by a number of Fundamentalist Protestants. For example, the other FP psychologist (not quoted above) who described himself as a Christian counselor said,
There may be counselors out there who are uncomfortable referring to someone with this—with this strong commitment to Christian counseling as I have and that’s their issue [short laugh]. Uh, but I think people who know me, they consider me to be a good therapist. Um, I think in general that’s—that’s probably a tough answer too. I think that some people view Christian counselors as narrow and maybe as quacks [short laugh]. Although I think the whole field is—is in the last decade really has gotten a lot more recognition. There’s a lot of public facilities that will specifically hire a Christian counselor because they get so many requests saying, ‘Do you have a Christian counselor?’

Note that he made a justification that secular agencies are hiring Christian counselors as a way of saying he was not an anomaly.

Implicit in the above statements and explicitly stated by a male FP psychiatrist was the difficulty of not being caught in a stereotype and hoping that he came across as tolerant:

Um, so to answer your question as to am I embarrassed to be a Christian psychiatrist. No. I—I bring those issues up. Um, and I look forward to opportunities to talk. The problem is finding the time to be able to adequately uh, express those views. Because it’s very easy uh, to be caught in stereotypes. You know, people say he’s going to be this way or that way. And hopefully my personal walk in terms of the, as I said, the skills of what I provide and presumably the tolerance that I show is an example that, you know, although I may say this and believe what ever this is, in terms of that there is an absolute truth out there, the ability for me to work with you in a world that’s a very messy, if you will, a very fallen world and still work effectively with you, hopefully is a witness of—of our ability to enter into the world. But I will not be a part of the world in that sense.

It is important to point out both the defensiveness in his answer and the contradiction in what he said. He appeared to say that as a Christian he was as competent as his colleagues. However, he then set himself apart by saying he and his colleagues had different world views.

This concern of Fundamentalist Protestants about how they were seen by colleagues was not unfounded. Participants of other faiths (Jewish and Liberal Protestant) also described a bias or initial bias against them, seeing these religions beliefs as unduly
hard on patients, rigid, and embracing the science-religion split as described by this male RJ psychiatrist:

Uh, I've heard some pretty scary stories about that sort of thing. Yeah. I mean, you know, people being told by their various religions that it was because they were bad in one way or another that this was being visited on them. [clears throat]. Again, I think you have to look at the specific religion. I mean some religions are—are very primitive in that perspective, some are a lot more sophisticated I think.

Um, would you say a more fundamentalist religion would be more—is that what you’re thinking is more primitive?

Yeah. You got people who don’t even believe in evolution. [clears throat]. You know.

Other negative views came from having a negative experience with Fundamentalist clients and feeling they are prejudiced and intrusive into the therapist’s religious beliefs.

On the other hand, a female FP psychiatrist hoped that her colleagues would first try to understand where the openly religious psychiatrist (deemed to be Fundamentalist Protestant) was coming from and why he/she conducted her/himself that way before judging it as wrong. The male CJ psychologist had a greater appreciation for a Fundamentalist Protestant colleague once he understood the “why” of her behavior and the positive role religion played in her life.

If Religion and Spirituality Are Important We Discuss It

It is a professional norm to be aware of client driven factors. That is, a norm stated by many therapists was succinctly articulated by the male CJ psychologist that in therapy the work is focused on “what’s primary to them [client].” This translated into a belief that if religion and spirituality or any issue was important to a client, it was discussed. On the other hand, if a therapist deemed religion and spirituality as not
important to the client it was not discussed. The rule was to follow the client’s lead. This was a belief held by therapists who both thought religion and spirituality were major and minor issues for clients and who had different levels of comfort with discussing them. It was through this norm that religion and spirituality was in the session. This norm was therefore a factor in giving permission to include religion and spirituality in the session.

While it was unethical to impose one’s beliefs on clients, if a client brought up religion and spirituality it was considered “unethical” by some (male NA psychiatrist, male and female LP, and female RJ psychologists) to not address it, which could mean discussing it themselves or referring to clergy. The norm of talking about what was important to clients and staying with their language was summed up by this male NA psychiatrist:

Okay. Do you think there’s a professional—or like a professional ethical issue in separating religion and spirituality and psychotherapy? Do feel like that’s—that’s part of the ethical code of being a psychiatrist?

I think our job is to join in—is to join the patient where they’re at. And it’s unethical not to do that. So if that means—if I’m with somebody whose using uh, their imagery from Islam, or Native American imagery, or Christian imagery, um, I think my job is to join with that and get it—get empathetically—be with that person. And—so part and parcel of that is going to be using some of the same words. I think that’s just basic, um, psychotherapy 101. Now if you get into pushing a dogma, a doctrine, of course that’s a completely different area. I think yeah, then you’re getting into ethical questions.

Part of following the client’s lead was also being cautious about bringing up religion and spirituality and waiting for an invitation from the client to do so or cueing off the client. A male FP psychologist described this:

To what extent is religion or spirituality involved in your therapy sessions?

Um, [short pause] my —my perspective is to let the client bring that up, if that’s important to them. And usually they do it two ways. One is, um, they hint around to see if it’s safe. . . but I’m very tentative, I’m looking for those cues. I’m
looking for obvious—obviously where they’re at religiously. Or they might say, ‘Gee, I don’t know where God is in all this. And this depression thing, and you know, it’s really shaken my faith.’ And I’ll just go with that.

Different frames. One way therapists met clients where they were and stayed with their framework was to be comfortable if a client framed an issue in religious or spiritual terms or psychological terms. Two participants (female LP psychiatrist and male NA psychologist) described comfort with lots of frames from problems. This showed an ability to switch between two notions of mind, as illustrated by the male psychologist:

If they’re [client] saying the devil can infiltrate the minds of people and make us see things in a very skewed way, what’s so different from that, than to say that the way a person is raised or conditioned—behavioral terms—makes them see the world in a skewed way. So, you know, on the one hand it might seem like this is real problematic. I mean not a problem at all. It’s just another way saying it.

Rethink or Go Along with Religious or Spiritual Interpretations

Stay with Clients’ Language

The question, “If a client comes in and views her or his problems in religious or spiritual terms, as a psychiatrist (psychologist) would you rather help the client to rethink the problem in psychiatric or psychological terms or go along with the religious/spiritual interpretation?” was asked to determine the degree to which therapists separated the religious and spiritual from the professional. The majority of respondents described some degree of integration. A major part of this issue was, again, the norm of starting where clients are and staying with their framework, meanings, and value system, as aptly described by the female NA psychiatrist:

I tend to like to talk about things in the currency that people bring to the therapy session. And I often think that there’s an awful lot lost in the translation if you try
to make a reframe. Because there’s some reason why that’s important to them, why the problem is thought of in those terms as opposed to others. I think most long-term therapists really recognize that what you need to do is talk to the patient in the terms that they’re most comfortable with and what makes sense to them. So, yeah, I would make the attempt to work with them in their terms and with the frame that they’re bringing.

Three psychiatrists (male and female LP, female CJ and NA) and three psychologists (female LP, male CJ and female RJ) reported staying with the client’s view and asking questions to understand it.

Stay with Clients’ Language and Expand It

A larger group including both psychiatrists (male and female FP, female MP, female CJ and male and female RJ) and psychologists (both male FPs, female MP, male LP, female and male RC, female RJ and female NA) reported starting with clients’ interpretation and meaning and then broadening that view and looking at the problem in a different way if the original way was not helpful to the client. This was accomplished both through reframing the problem in psychological ways, introducing psychiatric and psychological concepts, or staying with clients’ religious language but still broadening it. This illustrated another norm. A major purpose of psychiatry and psychology is to broaden views, to change the narrow thoughts and behaviors causing psychic pain, and to help the client to grow emotionally. The female FP psychiatrist described this norm:

I would start by going with their religious interp [stopped tape for a second for grandfather clock] I—I would start from where that person comes in. So I would start with the religious interpretation and really try to explore what they believe and why they believe it. I would then try to move to a psychiatric model of understanding or trying to widen their perspective on what might be going on. Um, you know, I mean people—if somebody comes in and says, “I’m possessed by demons” I’m still going to think psychosis and I’m really not going to think that we need to call an exorcist. Uh, but getting the patient to that place, I think, can take a while. And I guess I would see part of my role as moving them to uh,
you know, a more—to a broader model—let’s just say that—that might entertain something outside of spiritual, you know, demon possession.

A female FP psychologist presented another view that the therapist may need to stay exclusively with clients’ religious language. Note though that even as she said that, she was also aware of the overlap between religion and psychology and was functioning as a psychologist:

If they’re presenting using religious terminology, I would stay with the religious terminology to begin with, because I think using psychological terms at that point could be a real turn off and the person might not come back. I think—actually as you first have the client and you’re using their terminology, their views with their language, and then gradually you can start incorporating and having them see that maybe psychological and religious can be real similar. But I think you—you have to speak their language, whatever their language is that they’re bringing in, that’s the language you have to stay with initially, or maybe for a long time, or maybe always, depending on the client. And listening to know when, if ever you start integrating that.

What kind of client would you think you’d want to stay with the religious language just about exclusively?

A very fundamentalist, who comes in with their Bible, wants to use passages from the Bible, um, needing to then pretty much stay in their language. Um, I’m trained in hypnosis and this would, I think—and I would not say this to a fundamentalist, but I would say that to me hypnosis and prayer are real similar. And I can—in saying prayer at the end of the session is helping them focus on some of the issues that have been talked about in the session and to have them think about them in a different way. Like a reframing even. Um, so that’s where those two religious— I mean one religious term and um, psychological term in some ways, they’re the same thing. Or if you want to use meditation as a word in here as well, at times it is really is all the same, but its what terminology you’re using.

Parallels

Two psychiatrists (female CJ and male NA) and three psychologists (male LP and female and male NA) described seeing religious issues and language as parallel to
psychological ones. For example, how a relationship with a pastor mirrors other authority relationships or this situation described by the male LP psychologist:

Uh, however, I think when people are talking that way, I think I get a pretty good understanding of the psychology behind it. For example, if a person grows up in a very conservative church that’s um, that’s very big on—on, you know, ‘If you do these behaviors you will be alienated from God.’ Let’s say that’s a theme. Well, it’s not a big jump in my mind to see that that same kind of dynamic is probably playing out in this person’s relationship or playing out within themselves. So from that perspective I’m viewing it psychologically, I guess you can say, but we still may use the religious language because that’s what the client is going to hear and respond to.

I Would Refer Them

Minority views on this issue included the male RJ psychologist who thought it was better to refer a religiously focused client to clergy “Because I think it would be better for the clergyperson to be able to try to translate it into [psychological language], rather than for me to do that.” Similarly, the male MP psychologist said his first question to clients presenting with a religiously framed problem would be if they have spoken with their clergy about this, or they want his view as a psychologist. This showed that he saw the resolution of problems religiously and psychologically as different.

At the other extreme, a male FP psychiatrist thought I was “baiting a question” when I asked this because “if it is from God it is right.” Although the client may need his help to correct flawed religious beliefs.

Sin, Soul, and Salvation

Psychiatrists (male FP, MP, LP, female RJ, and male NA) as well as psychologists (male and female FP and female NA) noted that they would use religious
language such as sin, soul, and salvation with clients, most often when the client used this
language first. It was another example of staying with clients’ framework in an attempt to
understand the meaning they were making of these terms and the role these terms played
in their life. This was described by the female NA psychologist:

I would only initiate that [religious language] if they have already talked to me
about it. I will try to find a common language and a way for them to understand
perhaps, something that I want to convey to them. And if it means using their
language, I’ll do that. But it’s got to be their language, not my language.

So you’re saying you wouldn’t initiate a conversation without them having
brought it up, using this language?

Correct. Because a lot of the terms you just used, mean certain things in different
religions.

So if a client used the word, let’s say, “sin”, what would you do with that?

I would ask them what they mean by that.

Other participants (male CJ and female NA psychiatrists; female LP and RJ
psychologists) reported that they would not initiate a conversation using religious
language. Two of these said this was because they wanted to stay with clients’ language
or as the female NA psychiatrist noted, “we usually let the patients pick the metaphors.”
One therapist [male RC psychologist] noted that he does not use religious or spiritual
language in his everyday speech, although he would discuss Scripture with clients.

Openly Religious Practitioners

The issue of openly religious psychiatrists and psychologists relates back to the
notion of boundaries. The concern among many participants in both fields was the
imposition of beliefs onto the client, as well as the limitation of issues that could be then
explored. Again, it is the notion that the purpose of therapy to explore what is going on
with the client and it is therefore necessary to stay with the client’s frame and help clients
find their own voice and answers. The therapists’ beliefs are not the focus, as illustrated
by this female Reformed Jewish psychiatrist:

If I had a person struggling with homosexuality, I might be hesitant to refer to a
person who has an openly Christian practice, unless I know that person’s stance. And
know them to be open and accepting within a certain framework. Um, and
without an agenda. Because the goal is to help the person, not to have an agenda
and that can get mixed up.

Even among psychiatrists and psychologists who thought those who operate out
of this perspective are “fine” or fill a need in the field, there was the caveat that the client
needed to be warned of the therapist’s perspective and know what they are getting. This
view was expressed by the female LP psychiatrist:

If somebody called and said, ‘Do you know of a Christian psychiatrist?’ I can say
‘Yes. If that’s the perspective you want, absolutely, here’s the name.’ But if
somebody didn’t have that, I would see it as intrusive.

If they didn’t have that desire?

If they didn’t have that desire. They could be kind of buffaloed.

Implicit in the issue of clients being aware of what they are getting is the issue of fit
between psychotherapist and client. Two participants (female LP psychiatrist and female
NA psychologist) specifically named this issue.

One male FP psychiatrist, who was the only participant who was aware of the
American Psychiatric Association’s ethics codes with regards to religion and spirituality,
was aware of the line he walks as a Christian and psychiatrist felt that:

I mean after all it’s psychiatry, right? You realize it’s a big tent. If every—there
are different people out there with different styles. Okay. There are people uh,
who would be able to work with the gay and lesbian populations in ways that I
will not be able to. And we need to have gay and lesbian psychiatrists. I’m—I’m
not going to get into the way of what they do, you know. And I believe that they
would say the same about Christian psychiatrist.
[short pause] So you feel it’s a big enough tent that there’s not animosity?

[sigh, pause] Yeah, I think that’s probably a fair statement. Um, I won’t say there’s not tension.

Although he felt his profession would be open to these types of practitioners, he mentioned earlier that the American Psychiatric Association has strict guidelines about praying with patients, which could be seen as a way this organization gets in the way of Christian psychiatrists. This points out a contradiction in his views.

Etiology of Disease: Two Languages or One?

Languages define a profession. Each profession has a language it calls its own, and makes it distinct. Therefore, an indication of the degree to which participants integrated or separated religion and spirituality with medical-science was if they felt that psychiatry and psychology and religion used two different languages to describe the nature of human beings and the cause of their mental health problems. Participants were asked this question.

They Are Different

A few psychologists reported that these languages describe the cause of mental illness differently and offer different explanations for the cause of behavior. Namely, psychology talks about inner forces whereas religion focuses on external causes of behavior such as God. Two participants (male FP and MP psychologists) offered that they thought religion views illnesses (suffering) as caused by the person sinning and not being faithful, which was not the view of psychology. The female RJ psychologist offered that, “there’s more than different words to describe it [nature of humans and
cause of mental illness], there’s different mindsets to the way it’s thought about it. The
mindsets of the two domains differs."

Three psychiatrists (male MP, female RJ and NA) noted the distinction between
the languages of religion and medical-science and psychiatry’s desire to align itself with
the scientific. For example, the male MP said in answer to this question about languages:

Well, do you think that religion and psychiatry view the nature—view human
nature, like the stuff we’re made out of differently?

Yes. I do think so. But I think again, that involves the transition in psychiatry. I
think psychiatry is seen as [?]seeing us as] more and more as fairly solely
biological entities. And that uh, depending on your religion we see ourselves as
predominantly spiritual entities or um, as uh, spiritual entities that have blood and
bone and brain and that—that we are also animals.

The female NA added:

Oh I think they use real different language. And I think the psychiatry vocabulary
probably is pretty sparse in terms of [pause] being able to capture the richness of
—of —what having a spiritual relationship is all about. Because it is, it still, it
meaning psychiatry, still attempts to try to maintain some stance of objectivity, by
virtue of being a science, and I think —I think none of that applies in the domain of
spirituality.

A number of psychiatrists (but not psychologists) described that their profession
wanted to be seen as a science. Science equals legitimacy, as noted by this male RC
participant, who was very much in favor of this trend:

So we’ve come out the realm of the witch doctor into a some sort of
demonstrated, a profession that is given to recognizing mental diseases,
classifying mental disorders, and uh, and treating those disorders. So uh, you
know, that—but the legitimately—our legitimacy is improving day by day.

The legitimacy of the profession?

What? Of the profession. Of the profession. Provided you keep up with what is
going on... . But this apparent demonstration of brain connections and brain
chemistry is giving us a legitimacy that we really didn’t have until now. We had a
lot of speculation and a lot of wonderful theorizers, and observations over the
years, but uh, up—until after the time of Freud, all we did was classify and
prognostic as to what the outcome would be and all the rest. But now, uh, we really seem to be going to go [some] place.

Religion therefore, was not welcome and seen as a deterrent to this goal as described by this female RJ and male NA:

Um and I think that psychiatrists being medical trained and somewhat scientific, in some false notion, move away from anything that has to do with faith, that can't be empirically proved. There's a bigger umbrella that sort of says, You really need to keep your practice scientific. And if you start talking about religion, then you're not really being scientific, you're being kind of loosey-goosey and that's really not good.

It would—my sense of the profession of psychiatry right now, is that psychiatry is a little insecure, because it wants to be seen as a subspecialty of medicine, and so if psychiatry starts looking overly subjective, and so-called nonscientific, then—I don't think psychiatry wants to get the reputation for being flaky. And so the journals that I've read don't take these sorts of leaps and risks. I've gotta to look outside psychiatry for that.

**I Am a Professional First**

The issue of professional specialization was related to this notion of medical-scientific and religious languages. That is, therapists who were comfortable incorporating religion and spirituality into their sessions also showed that they were psychiatrists and psychologists first, and on the side of science. They were aware of the professional boundary and distinction separating them from clergy when it comes into question. Two female participants (FP psychiatrist and FP psychologist) both dealt with what clergy defined as demon possession and they clearly saw as mental illness. Two other psychiatrists (female RC and male NA) both used the example of demon possession as a religious interpretation of behavior. This was not a view they supported. This alignment with the scientific was expressed by the female FP psychiatrist:
Well do you think that religion and psychiatry use two different languages to describe the nature of human beings and the cause of their mental health problems?

[drawing breath in] Um, at times often then do. Uh, they have—they have language and they have different etiologies for where psychopathology comes from. I vividly remember being a resident and going to a seminar, the minister from Holland did on demons and demon possession. And maybe demon possession was the reason for psychosis. And having everybody go, 'Oh my goodness. You know, this is—where did this come from? We're psychiatrists. You're not possessed by demons.' Um, and [short pause] I mean that's intriguing but I think it can also be, you know, quite misleading. Um, some of the Pentecostal movements in which um, uh, you know, seeing visions, hearing voices might be encouraged. Um, where psychiatrically I would go, 'Wait a minute, you know, that's psychosis. You're really promoting psychosis.'

The male LP psychologist who was fairly involved in his church, showed that he did not have a literal interpretation of religion. He went beyond his religion to use his psychological knowledge and thus was a psychologist first:

I assume what you’re referring is that religion would tend to say our troubles stem from our sin and our sinful nature. Psychology would say there are a whole lot of other reasons that the issue [?]. Um, I don’t believe in the concept of original sin. So. I look at the Scriptures as a document that was written in the first century with the understandings that we had in the first century about how human beings operate. We now live in the 21st century, so we have a lot more understanding about how humans operate and what kind of—look at what’s changed in medicine since the first century to the 21st century... Let me give you an example. In the New Testament there are references to a person having a seizure—seizure activity, and that being referred to as demons and Christ casting out the demons. We probably wouldn’t look at that person today and say he’s possessed by demons. We’d say he’s epileptic and he needs to be on medication. We understand it differently now. Same thing is true with psychological issues. I think uh, certainly people do wrong things and that creates guilt and that can lead to depression or shame or a whole host of other things and that ought to be dealt with. There are a whole lot of other things that lead to depression and shame as well. Um, and that I would say comes more out of psychology as opposed to out of religion.
They Could Overlap

The female RC psychiatrist and male RJ psychologist described ways in which the languages lead to quite different interpretations of the client’s behavior. Both also had a sense that the two languages could be compatible and overlap, but they were unable to articulate how. These participants noted that psychiatry or psychology has a specialized language that made it distinct, as expressed by the male RJ psychologist:

[pause] Well I agree with that just from the standpoint that I think psychology—over-technic—you know, has specialized the language and technolized it. I don’t know if that’s a word, but. And again because you have to make a diagnosis and come up with labels that, [short pause] yes you use different language.

Distinct, Yet Overlapping As Well

Several participants (female LP psychiatrist and both male FP psychologists) thought that while there were clear distinctions between the languages and they were also able to give examples of overlaps, even if these were just minor. For instance, the term “discernment” when applied to making a choice or “grace” and unconditional positive regard.

Overlap

Two psychiatrists (both male FPs) and two psychologists (female RC and male NA) said the languages of religion, spirituality, medicine, psychiatry and psychology were able to be integrated and saw an overlap in them. One male FP psychiatrist went as far as saying that the Original Fall explained why we have mental illness, as well as other diseases, although he separated this sin from individual sin.
It Depends

Several practitioners in both fields articulated the complexity of a cut and dry answer to whether religion and psychiatry or psychology explained mental illness in different ways. They noted that the existence of two distinct languages depended on the religion and brand of psychiatry or psychology, as illustrated by this male CJ psychiatrist:

[pause] Um, well I keeping—the key thing that I keep running up against this right here, is that I don’t think religion is so monolithic that I would say that I could just oppose it. Because I think in religious explanations of mental illness, um, especially in Conservative Judaism, you know, the people I’m exposed to and meet with, there’s number one, there lot’s of mental health professionals, so I think there’s a pretty broad view. And the rabbi’s that I hear talk, you know, are pretty liberal and so I don’t think they have some fundamentalist view of mental illness, you know, somehow being based on a religious deficiency or sin or people doing or any sort of thing like that. So, um, I don’t think uh—I think certain religious beliefs, yes, do have a very different and contradictory or mutually exclusive um, explanation of mental illness than psychiatry does. But I think there are lots of religious beliefs and groups that uh, don’t have a contradictory view.

Finally, two male psychologists (CJ, RC) and one female psychologist (NA) replied that they talked in what one termed “human language” and focused on understanding what the client was wrestling with and speaking their language.

Serve Similar Functions

Although not asked as part of the two languages question, several psychologists (female FP and MP; female and male RJ) remarked that religion and spirituality serve similar functions as psychology: understanding human behavior as well as finding inner comfort and peace. The contradiction was that, except for the female FP who did not answer the question about two languages, these same people answered that they thought religious and spiritual and medical-science language did not overlap or it depended on the
religion or psychological theory.

Contradiction

The female RJ psychiatrist said she did not see a need for an overlap of languages because “Each serves its own purpose and that’s okay.” A couple of sentences later, when talking about a patient with a neurobiological depression she said that, “I think medicines could be the cure and then how they live with this illness and how they construct their life in a—and get meaning from it, may be in a psychiatrist’s office or may be through prayer.” These statements taken together showed her lack of clarity of her view and with this issue.

Professional Specialization and Distinction

The most blatant form of setting boundaries and division of labor was the distinction between religious professions and secular mental health ones. Quite a few psychologists (male and female FP, female MP, male LP, female RC and CJ) and three psychiatrists (male FP, MP, and LP) articulated an awareness of the division of labor and specialization between professions in duties and what was appropriate. It was the role of the clergy to teach about the religious, not mental health practitioners. One psychiatrist (male RC) noted that clergy have the ability to offer forgiveness, whereas psychiatrists do not have this societal function. One male FP psychiatrist made a clear distinction between two types of ministries:

I think if one has a strong personal Christian faith for example, that um, I believe that uh, I am called to a ministry of healing, not a ministry of evangelism.

What’s the difference, so I understand.
Well, evangelism would be to um, say things and do things to convert the individual you’re with to your particular faith system.

Okay.

I believe that is fraudulent for me to do. People come to me as a physician for healing. So, even though the spiritual part of the person’s life is part of my area to take a peak at professionally, yet for me to preach to a person or to judge a person I think is uh, fraudulent. And ministers are in the business of evangelizing people. I’m in the business of healing people.

When you say it’s fraudulent—fraudulent against your Christian principles or against professional ethics or both?

Professional ethics. It’s—it’s—what I would define fraud is that you are using your MD degree to evangelize.

So if you were to evangelize you’re saying that’d be fraudulent because you’d be representing yourself as a minister not as a —

I would be practicing a form of ministry or evangelism under the disguise of being a physician, and it’s fraudulent to my patient who expects me to be a physician and does not expect me to relate to them as a minister.

Okay.

So that’s why I prescribe medicine for people instead of praying with people. And that’s why a minister should pray with people and not prescribe medicine.

The male MP psychiatrist echoed this view:

And—although I can speak, I think, very knowledgeably with my clients and my patients about their religious concerns and uh, religious worries, I am not a mental health practitioner that then says, ‘Okay, we’ve talked about that now let’s pray about it.’ I don’t do that. I think that’s a hard thing to sort of keep clear boundaries around. And people come to see me as a psychiatrist not as a pastoral counselor. Most people don’t expect prayer from me, they’d be thrown off a little bit by prayer. Uh, and those who might expect it from me don’t seem to mind if it doesn’t happen.

All of the therapists in the study, including those psychologists and psychiatrists who described using religious and Biblical language with clients, were quick to add that they were mental health professionals and not clergy, nor did they present themselves as
that latter profession. Therefore, the extent to which religion and spirituality were discussed by some therapists and the use of referral to clergy is understandable. For example, if therapists judged that the client needed more spiritual guidance than they were able to offer, such as around issues of sin and salvation, or the client wants to keep the issue focused strictly in religious terms without any openness to psychological processes, a referral to clergy was deemed warranted. Where therapists drew this line, of course, varied.

Diagnosis

Although the relationship between how the participants’ profession thinks about religion and spirituality and their subsequent behavior with it was complex and not direct, there could be ways in which the profession framed the issue so that it did not allow or made it harder for practitioners to integrate religion and spirituality into their work. Diagnosing is an example. It is a necessary component of psychotherapy not only for case formulation but for insurance reimbursement. As noted in a previous chapter, only with the most recent revision of the Diagnostic and Statistical Manual of Mental Disorders-IV (1994) has religion and spirituality been acknowledged as a V code (Religious or Spiritual Problem). This is not a major diagnostic code but more minor as the female NA psychiatrist commented:

Actually, [short pause] religious or spiritual problems would never be paid for by insurance. And I think diagnostically they’re on some peculiar V code that is. . .

Is that a diagnosis code?

There is a place to put it. Um, if it’s—if it’s an issue in treatment. But I think it’s called maybe “religion problem.” Do you know? [short laugh]. But I’ve never used it.

146
Additionally, only three psychiatrists (female and male LP and male NA) but no psychologists knew about the code and two of them only had a vague notion of it. None of the psychiatrists who knew about the V code used it.

The majority of psychiatrists and psychologists reported that religious understanding about human nature and God do not influence their thinking when making a diagnosis. This group included therapists who both saw humans having a spiritual nature and lived out their religious principles in their work. This is an indication of religion and spirituality being set aside in favor of science and professionalism in the diagnostic process. A clear example of this separation was seen in the answer to this question from the male LP psychologist who earlier in the interview said he thought humans have a spiritual nature and described comfort with discussing clients’ religious and spiritual issues:

[pause] I don’t think so. I mean, when you’re trying to make a diagnosis you’re primarily dealing with what, where the client hurts and what brought them in. You’re looking at symptomatology. Um, so I’m not seeing a connection there right now.

What do you use then—do you use DSM IV to make a diagnosis?

Yes, DSM-IV criteria, looking primarily at Axis I and Axis II.

It is important to note that “where the client hurts” could also be seen as spiritual in nature as well as psychological. This is evidence of a mind-mind split.

That Is the Line I Walk

Four participants (male MP and female LP psychiatrists; female and male FP psychologists) all very devout, made it clear that in making diagnoses they acted as scientists and played by the same rules as other mental health professionals. This can be
seen in these answers from a male FP psychologist, the male MP psychiatrist, and the female LP:

[male FP psychologist]

[pause] Uh [pause] [short laugh] Um. No I just try to [laugh] find a diagnosis that feels accurate.

Okay.

[still laughing] It’s one of those tasks that you just have to do. I mean again, [short pause] my faith is part of who I am but—I—I [short laugh] I’m not sure how I could—I go by the same symptom clusters that everybody else looks at.

[male MP psychiatrist]

Um, my spiritual/religious beliefs do not affect my diagnosis because um, I’m pretty much a mainstream American psychiatrist who uses DSM-IV diagnostic criteria to make [short laugh] diagnoses. And so that’s what I make the diagnosis off of. Uh, uh, you know, that’s more or less scientific depending on how you feel about DSM-IV. But in that area, I try to be as science, evidenced based as I can. Yeah.

[female LP psychiatrist]

Well following up some more questions about clients, um, when you’re making a diagnosis of a client, does your religious or spiritual understanding about God or human nature enter in?

No.

It’s strict DSM-IV.

There you go. That’s what I—that’s that line I have to walk for insurance purposes, and to be in the medical world. So they have a diagnosis of major depression, or anxiety or PTSD.

Only a few incorporated their religious and spiritual understandings about human nature and God either in terms of a cultural awareness, treatment, or rarely, as part of their diagnosis. Two female participants (FP psychiatrist and NA psychologist) noted that
while it did not enter into their thinking about diagnosis but it did with treatment. Again, religion was separated out from the scientific.

The female NA psychiatrists noted the biases in diagnoses against certain religions:

Right now, the most time that we give any thought to someone’s religion or their religious beliefs is when we think it’ll have an impact on what we think is someone’s diagnosis. Most of the time that happens really in a cross-culture setting, maybe a cross-ethnic setting. The thing that will be mentioned the most often, the situation that’s mentioned most often I think in psychiatry, is-- has to do with working with African American clients. . . . But it is often the case that people in the African-American community are misdiagnosed because they have that attitude about their religion and their sense of what evil is and how it lives in their lives, how it acts in their lives. And it’s sad to say, that many a person who I think would be speaking in terms that would not be strange to other members of the African American community would come across as looking psychotic and get a psychotic diagnosis and would receive anti-psychotic medication. So it’s been recognized in hindsight that that was really inappropriate, and that we were missing something very important. It’s in that sense that psychiatry will usually make a reference to religion in respect to a client.

The minority of participants, five psychiatrists (male FP, female RC, male and female RJ and female NA) and two psychologist (female MP and RC) noted religion and spirituality influenced their diagnosis. Two described it in terms of being aware of how religion might impact on their diagnosis in the case of a patient who appeared psychotic but would not be within the context of their religion. The other five described their own religious beliefs about human nature and God influencing the diagnostic process. The female RC psychiatrist reported using her understanding about God and human nature but not in a conscious way. The female MP psychologist noted that her view of human nature and God, her humanism, how people should be treated, extends to all areas of her life, including diagnosis. Finally, the male FP psychiatrist was much more explicit and the only one in the group to say this:
Well, given all that, when making a diagnosis of a client, does your religious or spiritual understanding about human nature and God influence your thinking?

Certainly.

In what ways?

[pause] Well, again, um, by thinking in terms of God, a spirituality or realm, and that as human creatures we have spiritual nature, I look into those natures for the strengths and conflict areas as they play themselves out in the person’s persons or in the person’s treatment.

The male nonaffiliated psychologist noted both using the nomenclature of *DSM-IV* (1994) when required, but also thought about clients’ situations in more holistic terms to understand why clients ended up as they did.

**Client Driven Factors**

Both professions tried to accommodate clients’ requests in terms of the content and focus of therapy. Indeed, as noted in the section on professional norms, this client-focused approach is part of the fabric of the profession. The most blatant way clients introduced religion and spirituality into the session was by asking therapists if they were Christian counselors.

**Are You a Christian Counselor?**

As discussed in the section on openly religious practitioners, a norm of the profession is fit. A good fit with the therapist is essential for a productive therapeutic process. It is important that clients are comfortable with the therapist, and in the case of religion and spirituality, that the therapist is comfortable discussing these issues. A male FP psychologist, who described himself as a Christian counselor, described the concern
of clients and why they come to his practice: “But there are—there are many who want to
know that the therapist is going to have a Christian value system if they do, and so that
the therapist is not going to be suggesting that they do things that go against their value
system.” Therefore, an explicit way clients addressed religion and spirituality in the
session was by asking if the therapist is a Christian counselor.

A large number of psychiatrists (male FP, female and male LP, female NA) and
psychologists (female MP, female and male CJ) described getting this question. The
majority in this group reported a matter-of-fact handling of the question and told potential
clients or clients that this description did not fit them and referred to someone else if
possible. Although one psychiatrist (female NA) noted discomfort with the question.

The question arises, if by the client asking this question was the therapist more
likely to integrate religion and spirituality into therapy because they felt permission to do
so. The answer is no. All of the people who were asked if they were “Christian” were not
in the sense the client meant it and therefore did not become clients. However, all people
who said they would refer to such therapists indicated in general that if religion or
spirituality was important to the client, it was discussed. For five of the participants, this
was a null issue because they were either self-described as Christian or could be assumed
as such by the client based on where they worked.

Another version of a client asking if the therapist is Christian was a therapist
being thought of by clergy as “Christian” or receiving referrals from Christian oriented
schools. As the male RC psychologist put it, he is thought of as a “a card carrying
Catholic and that they can be assured that I’m not going to do anything—far out, you
know—unChristian kind of thing to them.”
On the other hand, two therapists (female RJ psychiatrist and male MP psychologist) noted clients who they needed to refer to other mental health professionals stated that they did not want religion and spirituality as part of their therapy. Both therapists were respectful of this preference as well.

Practice of Psychotherapy

How do religion and spirituality and medical-scientific conceptions play out in the process of therapy? In what situations were there more likely to be a separation or integration of the paradigms? In this section I describe how religion and spirituality are allowed into and not allowed into sessions through prayer, view of the role of the therapist, the assessment process, and in discussion of existential crises. In addition, tensions between the roles of Christian and therapist, as well as therapists’ own level of discomfort with religion and spirituality and its impact on therapy is explored. Finally, how therapists have changed in their views about religion, spirituality, and psychotherapy since they first started to practice is reported

Prayer in the Work Space

Ways Allowed in

There were a variety of strategies for allowing prayer in the therapeutic space. They can be divided into those that allowed prayer to remain private and in the realm of the therapist, and those that included the client where prayer was more explicit. In the former category, the strategies included praying for guidance for a session either before, during, or between sessions. Praying for guidance for a session was a way psychiatrists

152
and psychologists integrated their own beliefs into the session without imposing these beliefs on the clients and maintaining professional boundaries. This view was clearly expressed by this participant (male MP psychologist):

Because first of all, I start out praying that what I do share is going to be driven by God, you know. But—but I don't necessarily tell the person that that's what I'm doing, you know. So uh, whatever therapeutic recommendations I make, uh, it is cloaked in my religious beliefs, if that makes sense.

Whatever psychological recommendations you make is cloaked in your religious beliefs.

Right, because it's God driven. Meaning that, you know, I've—I've asked God to reveal to me what's the best uh, services I can render or provide uh, to this person, . . . But—But I would not say to a person 'God wants you to do ta-da-ta-da-ta-da.'

The latter, more public category, included mostly psychologists (both female FPs, male FP, female LP, female RC, male RJ) with three psychiatrists (male and female FP and female LP). These practitioners noted praying with and for clients at their request, both individually and at support group meetings. Only three participants (all FPs) described offering to pray with clients. However, one male psychiatrist added that he would only do this if he was in a non-therapeutic relationship. Interestingly, for the female LP psychologist, praying for clients at their request was the only way prayer enters her therapeutic practice, as she said it was not a part of her workday.

There are slightly more Protestants (female and male FP and female LP psychiatrists; female and male FP and female LP psychologists) for whom prayer was a part of their personal life and also made public, than those Protestants (male FP and male MP psychiatrists; male FP and male MP psychologists) for whom prayer was a part of their life and kept private in the therapy session.

153

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A final way prayer was allowed in the session was exploring its role for clients or supporting clients' use of prayer. This female NA psychiatrist described her hesitation to do much more than this:

Um, [pause] I think in some ways I feel like I’m not on terribly solid ground about what to believe or how to believe. I think I wouldn’t take a chance on [pause] doing something like that during a therapy session. What I have done and what I do feel comfortable doing with a client is acknowledging what their relationship to their God and how that’s helped them and how their beliefs in religion and in their own spirituality has an impact on their lives. And particularly when that’s helpful for them to acknowledge that in some way so that’s [pause] at least as much a part of the things they do for themselves as anything else I would recommend they do. Um, but praying in a session, probably not. It would be [pause] be something I guess I would consider almost too personal to do with somebody else.

Not Allowed in

Several psychiatrists and psychologists (male CJ and male RJ psychiatrists; female LP, and male CJ psychologists) noted that prayer was not a part of their workday. Reasons for this were that it does not further the aims of therapy and potential discomfort with what the client might say in prayer.

Not Reflected upon

A participant referred to above, (male CJ psychiatrist) at first had a hard time explaining why prayer in the session was detrimental. This was a sign of the extent to which religion and spirituality was not part of his conception of professional practices. Similarly, the degree to which prayer was not reflected upon can be seen in the female FP psychiatrist who at first said she prayed with clients, albeit infrequently, but upon further questioning she realized she meant she talked about prayer versus prays with clients.
Another participant who prayed to himself for the sessions said that while he was uncomfortable with an out loud prayer in a session, a Muslim greeting (he is a convert from Islam) was acceptable. This contradiction points out a way in which religion was allowed in, if it has nothing to do with either party's religious beliefs or specifics of beliefs.

Religion and Spirituality Integrated into Role As Therapist

Not a Blank Slate

Participants did not feel that they had a separate self at work religiously, but described a number of subtle ways that their religious and spiritual beliefs and knowledge are in the session without violating boundaries. Religion and spirituality were most often on in the background versus overt proselytizing. For instance, the majority of therapists, both psychiatrists and psychologists, as well as Protestants, RCs and Jews, noted that who they are as a person influenced what they brought to therapy and what interventions they made with clients. These therapists noted or implied that they were not a blank slate but they brought their values, religious and spiritual beliefs, and beliefs about religion and spirituality to therapy. Their beliefs influenced who they are and how they work, as articulated by the male LP psychologist:

I don't talk to the client a whole lot about my own religious views or I certainly don't try tell a client, 'You need to believe the way I believe' or try to convert them to my perspective. But I believe that my views have to color what I think is important. For example, I think the issue of grace is very important. I think it is very lacking in our churches, especially our Conservative churches. Um, so I'd like to think that when people come here, grace is going to be a part of the experience. They're not going to be judged by me, um, hopefully they will experience acceptance in this office. So I would like—so [short pause] my perspective that grace in a religious perspective is important, I hope that I live
that out with my clients. That doesn’t necessarily mean then [short pause] talking about it in that religious perspective, although I might.

The male NA psychologist echoed the importance of being clear about one’s perspective coloring one’s view:

I want to be very transparent to my clients. I want to transparent in terms of uh, this is who I am. That is not to say that I’m going to tell them about my spirituality, but I want it to be—I want to be conscious of it. I don’t want to uh, hang it outside the door, so that I’m pretending in here that it doesn’t have an impact on what I think or what the person just said to me, or how I hear what they’re saying, and uh, how I reflect back, what I reflect back.

Values therapists ascribed their religion as teaching included: having tolerance for different points of view, questioning, teaching people should be treated with dignity, respect, and compassion, and hoping client’s can experience grace or acceptance.

The majority of participants did not describe these values overtly impacting the client. In fact, they were quick to point this out. However, a male FP psychologist described doing this to a degree:

So what is the relationship of religion and the practice of psychology for you?

[short pause] Uh, again for me, it’s uh, it’s as totally integrated as I can [short laugh] as I can make it. My beliefs, my value systems guide what I do, what I don’t do, guide how I treat people. Um, but that—but that then includes respecting those people who have no particular faith. I respect those people as people. But I—I still in working with someone in another faith coming in with marital problems, I’m not going to be quick to encourage them to get a divorce [short laugh]. Uh, we may—we may get to that point and where that’s the choice that they make, and I certainly recognize those realities. But I’m not going to be hasty [encouraging] that direction because I don’t believe that’s the direction that they should be doing. Now that’s my value system coming out without talking about my value system.

A couple of psychiatrists (female FP, female RC, and male NA) commented that their religion or spiritual beliefs bring a richer, deeper, broader view of their work and
helps them to see themselves as part of a larger scheme. Psychiatry and religion
illuminated each other and had a synthesis for the male NA psychiatrist:

Um [pause] well I'm thinking that I really hope that the religious seeking and
interest and curiosity informs the psychiatry. Um, and I hope that the psychiatry,
at least some part of it, can inform um, the religious interest and experience. I
think they're both kind of inner flashlights and can help to illuminate each other.
So I like it. I think that they [short pause]—they both have meaning and they
seem to go pretty well together.

One FP psychiatrist felt that his ability to listen well to patients as a gift from God.

Three psychologists (male and female FP and female RC) noted the explicit
model of Christ quietly guiding their work, as described by this male FP psychologist:

Um. [pause] I think of my psychotherapy as uh, [pause] you would never see this
from, unless I told you, but my frame of reference I have is the model of Christ.
And that is, it's an incarnational work. And I'll explain what that means. Um, in
my theological um, background or beliefs system, Christ arrived on Earth in the
flesh. He was a real person. It wasn't tablets thrown down from the sky or a
message or a vision given to somebody that was communicated, it was flesh and
blood interaction. And that—and that was the healing part of it. That was one
aspect of the healing that went on was that there was this relationship, this
transformational relationship that occurred between Christ and the people that he
touched, and obviously changed the world, because of that relationship. It wasn't
just an idea, it was flesh. And I think of psychotherapy as being that. That's where
my interpersonal um, perspective comes in. That what happens in the relationship
is a mirror image of—not a mirror image, but sort of a recapitulation of that same
powerful interaction that um, Christ had with people. That there's a
transformation that occurs in relationship. And hopefully, this is where my
Rogerian approach comes in, the unconditional regard, the respect that I show to
people, that that's transformative. On the other hand, Christ didn't just hang out
and have meals with people, he spoke um—he spoke words. He gave people
insights into what was going on with them and he—sometimes they were insights
that were—were uncomfortable and sometimes they were very affirming, but they
were--there always was the desire was to be true, to speak the truth. So when I sit
down in a therapy session, I think of, what's happening is, there's two forces at
work here. One is the relationship that I'm having with the person. The other is
the words that I'm saying. And hopefully some healing insights or words that they
can take, take away with this. So it's happening on two levels, the change and the
transformation. And that flows out of my theology and personal beliefs.
Some therapists described not only religion and spiritually informing them but their religion as part of their fabric of who they are, best summarized by these male FP psychologists:

What does it mean to you be—what does it mean to you to be a Christian and a psychologist?

[short pause] Um, [short pause] I would go back to that—that incarnational view that I described. That’s how I think—when I think of who I am and what I do, um, clinically, that’s how I think about it. That’s what it means to be a Christian clinical clinician. Okay. In terms of overall, I guess, it also means that I keep my records—my medical records up, that I take good notes, that I’m very rigid about confidentiality, and about release of information. That was part of my program too. That was just pounded into us, and which is great. I’m very cautious about that, so. To me that’s an expression of who I am as a Christian and trying to have integrity in that area. Because that ultimately, [short pause] respecting confidentiality, being ethical in my practice, um, is—is—is an expression of respect and caring for a person ultimately, they’re not just rules. And so that—that flows from my, who I am as a Christian as well. It’s clinical part, but it’s also the practice, integrity part as well.

And:

And how did you then get—how did you then learn to bring in religion and really your spirituality it sounds like into—merge that with your psychology?

Well I think that’s—uh, I mean [short pause] it’s just always been a part of my thinking. There’s not a separation so integrating those two is always been there. My undergraduate was done at a Christian college. That helped, it certainly helped with that integration of faith and life because the emphasis of the Reformed church background is that your faith does affect all of your life. And so that’s always been a way of thinking for me. And then there are lots of good Christian psychology books around to help you integrate the two, address issues from the Christian perspective.

Theological Knowledge Informs

Another way religion and spirituality was at work in the background and informed the work was through one’s theological knowledge. This strategy was described by three psychiatrists (female FP, male MP and female RJ) and two psychologists (male FP and
LP). Like other secular knowledge therapists drew upon to inform their interaction with
clients, therapists used this information. The female RJ psychiatrist explained this
concept:

The idea of disclosure runs into that, and how much do I put myself in versus use
what I know to help a person talk more about what they know, and to draw them
out more. They don't need to know what I do specifically, but I can use what I
know or my interests or my comfort level to help them to talk through how they
think through things.

Ways in which theological knowledge was used included building upon a Bible
story the client presented, understanding when a client talks about the Rapture, or being
able to speak about religious worries and God. The therapists who described using their
theological knowledge in the session were very comfortable with religion and spirituality
being present in the session.

**Just Who I Am**

Religion and spirituality are so woven into participant's lives and not thought
about that three psychologists (female FP, female LP, and male RC) answered “It’s just
who I am” in answer to the question, “What does it mean to be a (denomination) and
psychiatrist/psychologist?” Similarly, the female CJ psychologist had a hard time teasing
out the effect of Judaism on being a therapist. One psychologist who struggled personally
with religion answered in this way, that psychology functions for her as religion does
and it is who she is. At the same time, all of these practitioners adhered to the *DSM-IV*
(1994) diagnostic categories and saw clear limits between their professional role and
that of clergy.
An initial step in the process of therapy is an assessment of the client. A number of psychiatrists (male FP, MP; female RC; female and male NA) and psychologists (both female FPs, both male FPs, male MP, male LP, female RC and NA) noted that they asked about the role of religion and/or spirituality in their clients’ lives in this stage of therapy. The fact that it was addressed shows that it was deemed an important part of clients. It was a way religion and spirituality were front and center.

This was done most commonly through an intake form. Other methods for including religion into the process were specifically asking about it as part of a genogram. The most explicit integration of religion and spirituality into the assessment process was described by a male FP psychiatrist who viewed a complete psychiatric evaluation as including questions about the client’s spiritual life, along with other areas of the clients’ life.

whenever a patient comes to me they come for a psychiatric evaluation. And a psychiatric evaluation is a structured interview that requires exploring specific areas of that individual’s life and functioning. One of which is their spiritual life. So, um, I’m initiating it [religion and spirituality] in the sense that I am practicing my profession by doing a structured evaluation at the time of the interview, in order to identify um, the nature of the problem, arrive at an accurate diagnosis, establish a formulation of why the symptoms are formed in this fashion at this point in time, and then upon that formulation base a treatment plan that may include anywhere along the armamentarium of the biological intervention, psychotherapeutic intervention or spiritual interventions.

He earlier described a spiritual history as including questions “about their religious orientation, their religious life and what role their religious beliefs plays in their life, either as a strength to build on or as a conflict area that needs to have some therapeutic
attention.” Only one participant, a female NA psychiatrist) noted that she asked about it only in service of a five-axis diagnosis.

Several of these participants also noted that religion and spirituality was one thing among many that they listen for in the assessment and that they do not attach any special significance to it. They also stated that they were careful to not make clients feel as if they have to talk about it. Perhaps these reactions could be seen as an indication of not wanting to be seen as pushing religion and wanting to maintain professional identity. For example, this female FP psychologist noted:

Um, because I—we will briefly discuss that issue [religion and spirituality], just as we will briefly discuss their family, briefly discuss their medical history, briefly discuss the medications that they’re on, briefly discuss the history of the problems that they’re presenting for. Um, and some of that depends on how that assessment goes. For some people the church is um, a source of support and comfort for them. For some it’s innocuous, you know they could take it or leave it. For some, they’ve got a lot of pain associated with their experience. And so some it—like it depends how things filter through that assessment process, how much that’s raised.

Existential Crisis

Almost half the participants reported that they would discuss clients’ religious and spiritual beliefs when faced with an existential crisis such as divorce, death, or depression. The majority in this group brought up religion or spirituality in this context without waiting for the client. This included almost equal numbers of psychiatrists (female FP, male MP, female LP, male RC and RJ, and female NA) and psychologists (female LP, male and female RC, male RJ, and female NA). A few (female RC psychiatrists and male CJ psychologist) said they would wait for the client to discuss it
first. It was not just those who were comfortable with religion and spirituality who
discussed it in this context, but those who were reluctant to bring it up unless the client
did, as well.

Contrary to Beliefs

A few participants (male FP psychiatrist, female RJ psychiatrist, and female FP
psychologist) showed their comfort discussing religion with clients to the extent that they
would point out to clients if they were living contrary to their professed beliefs.

Tension between Roles

Two Fundamentalist Protestant psychiatrists (male and female) noted tension
between the norms and expectations of their roles as Christians and psychiatrists. To
some degree both articulated that they fell short as Christians in terms of Christian values
and actions because of the conflict with the norms of their role as psychiatrists. As the
male psychiatrist described:

[short pause] It is an ongoing struggle in how you bring your faith into your work
environment. Um, there are, and I say that only in the sense that the more that uh,
that I see how I fall short, the more embarrassed I am to be a Christian
psychiatrist. I lose my temper, I don’t always give people as much time as I
should.

Later in the interview he added:

I mean, I’m trying to be a psychiatrist who has a certain set of values which
ideally would completely encapsulate around my Christian faith and I’m yet a
psychiatrist in this world and the world is a fallen place. And where do I finally
say, ‘I will not practice or do things of that nature.’ And I um continuing to
struggle with that kind of boundaries.

The female psychiatrist echoed this sentiment:
I—guess I don’t see them [Christian and psychiatrist] as two separate hats. Um, short pause I mean, my Christianity is so much a part of who I am from infancy. I mean that belief has been altered along the way, but um, I see the world through those eyes. And I wish I was more sensitive to being able to be responsive um, as a Christian for those needs that you know, you get busy, you can’t talk to somebody that you need to do. You can’t spend the amount of time that you’d like to do. I mean the push for psychiatry is seeing patients. And I think in the Christian realm compassion would sort of want you to able to spend a lot more time with patients and you know, bring them home for supper. And I mean really take the needs of those patients to heart. And psychiatrically the boundary issue says you can’t do that. So there’s some tension there, but I think, you know, I’ve got both hats on at the same time. Um, I think it adds a richness to my clinical practice um, that is—that is good. That I think is something that patients appreciate.

You say you have both hats on at the same time?

Yeah. Sometimes there’s a tension, but I don’t think there’s—I have two different selves.

Note that this psychiatrist’s resolution of this tension is to wear “two hats” versus to divide into two separate selves. Neither solution though, is a clear example of blending the medical-scientific and religious and spiritual paradigms. The male psychiatrist seemed to experience a great deal more conflict between these roles, as evidenced by his lack of clarity if he is a Christian who is a psychiatrist who is a Christian or a Christian psychiatrist. Although in the passage below he made the distinction between these two and aligned himself with the former role, at several places in the interview subsequent to this he referred to himself as a “Christian psychiatrist.” He noted that if the opportunity arose he might be a Christian psychiatrist. Additionally, if a client asked him to practice in this role he would not turn it down.

But uh, my practice is not a uh, Christian therapy practice, where I think that’s something different. And you can be a Christian who’s a psychiatrist or you can be a Christian psychiatrist. And if you’re a Christian psychiatrist you have an absolute standard that you hold, which we’ve talked about as being the Bible. And we talk then initially about what truth is and we talk on the other hand about grace. And we bring people to the truth by grace, and a Christian psychiatrist. But
I am not a Christian psychiatrist. I’m a psychiatrist who’s a Christian. Which means I’m a psychiatrist first. And psychiatry believes in whatever will help you feel better is right. And if you want to live this lifestyle and it makes you happy, that’s okay. And I will work that role with you because I’m a psychiatrist and that’s the role that I’m [?you know,] I may not agree with it personally, but I will work with you.

The other Fundamentalist and Moderate Protestant participants did not describe division between their Christian values and roles as therapists. In fact, the other male Fundamentalist Protestant psychiatrist described realizing that he had three compartmentalized bodies of knowledge: (1) medicine; (2) psychiatry; and (3) Christianity, and developed a theoretical model that integrated them. He not only used this model in his work as a therapist but for lecturing and teaching.

So your three roles, we’ll say, psychiatrist, physician and Christian, you’re saying you integrate them as you treat your patients.

Right. And I go in at the level where my evaluation and diagnosis tells me the problem areas lie. And it’s all integrated in the sense that it starts out, first of all with a theory of personality. That the theory of personality is based around the trichotomous concept that we are one nature but three expressions of having a body, having a soul and having a spiritual part.

Other ways that religion and science were reconciled were to see that God and medicine were not in conflict. Examples of this included the female FP psychiatrist quoted above who when asked how she reconciled her scientific training with religion replied, “Well, I mean, I think God made your brain, so, it is amazing. We’re discovering all this stuff He put in your brain.” Other strategies were to use a similar logic with patients such as the therapist and medication might be a part of God’s plan to heal them, or medicine is one of God’s tools. This was a view the female CJ psychiatrist sometimes used with religious clients who were resistant to taking medication.
Therapists' Own Level of Discomfort with Religion Influencing Therapy

There were mixed results in terms of the impact of therapists' own level of discomfort with religion and spirituality and how this impacted on the inclusion or exclusion of religion and spirituality from therapy. Three psychiatrists (male RC, male RJ, and female NA) and two psychologists (male CJ and female RJ) reported ambivalence about religion or spirituality for themselves in the sense of being unsure what to believe, if they believe, or the optimal level of belief. Three of these participants seemed to be less comfortable discussing religion and spirituality with clients, even when clients' brought it up. They did not see is as a major issue for clients. The other two described no bias against religion and seemed more willing to talk about it if it was an issue for clients.

What Has Changed Since First Started to Practice

The main question of this study is if psychiatrists and psychologists integrated or separated religion and spirituality from their scientific training. By asking participants if their view of the relationship between religion and practices of psychiatry or psychology has changed since they first started to practice, I was hoping to find out if the role or pull of the institution lessened as they practiced longer. Newer practitioners and members of institutions or organizations are often the most orthodox in belief and behaviors. Do they feel less restraint and more comfortable combining the two paradigms as practiced longer?

The majority of therapists described a greater openness to religion and spirituality in therapy than when they first started to practice. The continuum runs from those who
noted having a broader view overall in terms of religion, spirituality, diversity, and
cultures to those who are more comfortable talking about it.

A large number (four psychiatrists: female LP, RC, RJ, and NA; three
psychologists: female FP, male LP and, male) described feeling more comfortable and
confident discussing it with clients and have integrated it into their practice. They did not
see that religion and spirituality and their profession need to be separate as this female
NA psychiatrist remarked in answering this question:

[pause] I think so in the sense that um, I naively believed that good psychiatry
meant that you kept things non-psychiatric or non-scientific separate. In other
words, it would never occur to me to include religion. Um, or to even discuss
things religious with a client, because that was a separate domain. What I’m
recognizing is that there’s no way that they’re not connected. And um, [pause] that
it would be—that there’s more benefit that actually we could offer our clients if
there was some way we could incorporate that. So yes that has changed. That has
changed much. It hasn’t changed much in practice for me, except to be open to
those times when I think I’m getting some triggers, some cues from a client that
that might be something that’s really important for them to talk about. And I’m
much more open to pursuing that than I was before.

A few (male RJ and NA psychiatrist and female LP) described realizing the importance
and power of religion and spirituality in client’s lives.

Not surprisingly, five FP (two psychiatrists and three psychologists) described no
major shifts from their original integrated view, but more settled in their integration and
more able to blend the two creatively. The other male FP psychiatrist reported no change
from his initial integrated view and theoretical perspective. At the other extreme, the
female CJ psychiatrist who said she was uncomfortable discussing religion and
spirituality with clients, also described no change in how she thought about religion and
spirituality, but said “My ability to talk about more things with patients is better.”
Two participants described themselves as “more mature” in their treatment of religion and spirituality in the session. That is, they were less apt to jump in and comment on clients’ religious views and remain more neutral instead.

Participants’ Reactions to the Interview

As briefly noted in the previous chapter, respondents expressed varied reactions to the interview. Ideas and concepts taken-for-granted in everyday professional life, as well as the answers to specific questions were investigated in this study. Therefore, how and in what context participants reacted was important to note and in keeping with the ethnomethodological spirit of this study.

Positive Responses

There was a general positive attitude of participants toward this topic and study. The majority of participants expressed interest in the study, thought it was an important and “good” topic, and many offered to extend the allotted time. These positive responses even came from those who seemed annoyed or bored during the interview. A large number were anxious to receive a copy of the results, as illustrated by this comment from the male MP psychiatrist at the conclusion of the interview when I asked if he wanted to add anything:

Um, only that I enjoyed this. And um you know, if—if you keep people’s names and addresses and feel like uh, sharing any of what you’re coming out with—

That’s my next statement.

I’d be interested in it.
When I offered to send a summary of the results to the female RJ psychiatrist, who spoke to me very openly and at length, she asked for a copy of the transcript because: “I’d be interested about what I said. I mean to read it and think about it, yet differently.”

One participant (male FP psychiatrist) even asked for a copy of my dissertation when completed.

Several found the interview served as an impetus to think more about both their own religiosity and spirituality and also how it interfaced with their profession. For example the female RC psychiatrist noted:

And um, turning now to your own religion, what role or importance does it play in your life currently? Your religious beliefs and spirituality.

It’s something that I’m struggling with actually and I’ve been more aware of that I think, given that we’re going to do our talk. And I notice that you mention that in the paper [informed consent form], that’s something about personal sort of reflection.

Another participant (female CJ psychologist) said at the conclusion of the interview that, “this was really interesting to do. I don’t think I ever really thought about this stuff, not in this context until I got the call from you.”

Other participants described the impact of the interview on how they think about religion and spirituality with regards to colleagues as with this male CJ psychologist:

I’m not so sure, you know I kind of wonder, maybe it would be good—actually talk to—good to kind of like sit there and pick their [colleagues] brains and really understand more about what is their view of God, how different is that than mine?

Other participants appreciated questions (“good question”, “great question”) about how prayer is a part of work and non-work life, or why religion and spirituality is a small part of the American Psychiatric Association meetings.
Sorry for Being Complex

At the same time, some participants apologized for long and complex answers, as if the issues raised were simple. For instance, when I commented on the complex relationship between psyche and brain for the female RC psychiatrist she stated:

For me, I guess it is. Yeah.

I appreciate you articulating that complexity.

Sorry.

No, that’s great. It’s complex, so it’s complex.

Right.

Like this psychiatrist, other participants seemed relieved when I reassured them that the issues are indeed complex as for this male MP psychiatrist:

Do you think religion and psychiatry explain people’s mental illness in different ways?

Well, you know, I got to say that I keep giving you complicated answers to simple questions. . . .I think our society sees them [religion and psychiatry] as having very [?] explanations, but I think in some ways that’s almost a caricature. And uh, it’s much more complex than that.

[skipping the next interchange]

I appreciate your complex answers actually.

Okay.

Because they’re complex questions.

Yeah, they are.
Did I Answer Your Question?

Another reaction of both psychiatrists and psychologists was being unsure if they answered my questions or were being clear in their answers as with questions about two languages, how their profession views religion and spirituality, and how they combine religion and spirituality in their practice. This reaction could point to uncertainty about the topic so participants were not sure when they said enough, the topic and question was not clear to the participant, or that I asked questions not usually thought about. The male LP psychologist’s response illustrated this:

Do you see any kind of an ethical implication then of bringing religion and spirituality into your work?

[short pause] In what ways, I’m confused by that.

[I asked it differently and he answered it and concluded:]

Um, [short pause] I’m not sure if I’m getting at --

You’re getting at my question, yeah.

Some participants acknowledged both not giving clear answers because they were not clear themselves and also not knowing enough about the topic to answer. Questions about two languages and should religion be integrated into mental health sparked these answers. The male CJ psychologist commented that:

You can see that on a lot of these questions you ask, you know—I just—it’s hard for me to really give you clear answers because I’m not that clear on them myself. And I’m okay with not being that clear on them.

A large number were confused over a question or did not understand a question such as about two languages, how religion and spirituality is viewed by the profession, the rethink question, or asked me to define “openly religious.” For example, the male CJ
psychiatrist had given me an example of “going along with a religious interpretation or rethink in psychiatric terms” earlier in the interview (a social worker saying a child was possessed) yet asked for an example of this when I asked the question.

This Is a Hard Question

Other psychiatrists and psychologists found questions hard but also interesting as noted by the male NA psychiatrist who struggled to describe spirituality: “Well I suppose it’s a [short pause]--what is spirituality? Ellen, these are really hard questions.” A female RJ psychologist commented, after I thanked her for her candor in answering my questions and acknowledging the questions were hard, that, “They are hard questions. They are good questions.”

Still others, like the male MP psychologist, described not thinking about the questions I asked and enjoying the challenge, “you’re asking me some things that I do but never think about so [laugh] I’m struggling with them, which I don’t have a problem with, uh, because I like, for my mind to be provoked.”

Caught Off Guard

In addition to those who were caught off guard by the questions “What is psychiatry/psychology?” and “What is the psyche to you?”, a good number of psychiatrists (female FP, male LP, female CJ and male NA) and psychologists (male and female CJ and female RJ) were caught off guard and surprised by other questions as well. For instance, the questions what does it mean to be both a (denomination) and profession, diagnosis, two languages, and the extent to which religion and spirituality is in the
session and how it comes up, were surprising for some participants. This was an indication of ideas not normally thought about. A clear example of this was when the female FP psychiatrist struggled to find a good example of how psychiatrists have combined religion in not-okay ways: “Um, I mean, I—I’m trying to think of a good example of this. Now you’re really going to rock my memory.”

Annoyance and Defensiveness

Only a few participants (male RJ psychiatrist, male RC and female NA psychologists) expressed annoyance with some questions as indicated both by tone of voice and short answers. The male RC psychologist in particular was this way. I therefore was hesitant at times to push for more complete answers. For example, when I asked if he had a separate self at work in terms of his religion he commented:

[pause] I don’t think so.

Would it be accurate to say that it’s a—that religion is just a more integral part of yourself. Is that what you’re thinking?

[pause] I presume. You’re going in directions that I guess I haven’t really thought that much about.

It was surprising that this psychologist who said he was a life-long practicing Catholic does not think much about religion being an integral part of himself.

Besides annoyance, another reaction was to reply defensively. This came from two FP males (one psychiatrist and one psychologist).

So that [prayer] sounds like a real resource for you.

[short pause] I don’t know. It’s something I do—[pause] I don’t know how I would quantify it if it works, you know, but it’s—it’s a part of who I am and so it’s just something I would naturally do as a way of—you can look at two ways, I’m either evoking Divine guidance or I’m sort of quickly centering myself and
uh [pause] and acknowledging where I'm at right now with this client. And then, like a just a momentary break from the situation. So you can look at it from two different ways. But—yeah I would say it's a resource—I've never thought of it as—prayer is a resource to me in therapy, but I suppose it is.

When I suggested to a male FP psychiatrist some literature I had read suggested that psychiatry and religion use two different languages to describe the nature of human beings and the cause of their mental illness and asked for his opinion he became defensive:

I'd like you tell me more. I mean I don't know how religion—I don't know how religion talks about the cause of mental illness. Every—every pastor I've ever talked to seemed to understand what mental illness is.

Perhaps this attitude reflects a concern of Fundamentalists or those who believe strongly in God of judgment from other people for their beliefs.

Conclusion

The fact that participants were caught off guard and apologized was interpreted as an indication of the unfamiliarity of everyday concepts. These psychiatrists and psychologists disregard these questions in everyday practice. I therefore addressed non-obvious and taken-for-granted beliefs.

Ideal Types

Description of Types

As discussed earlier, because of professional norms, therapists were encouraged to keep their religious and spiritual beliefs out of therapy. Therefore, in that sense they separated their own religiosity and spirituality from their professional life. At the same
time, professional norms also dictated that if clients want to frame their issues religiously or spiritually it should be discussed. No one said that they would totally disregard clients’ religious or spiritual language. Even those least supportive of religion and spirituality in the session and as a part of client’s therapeutic work, said they would first start with clients’ language and then expand using psychological concepts. That said, participants tended to fall into three categories: (1) High, (2) Medium, and (3) Low, with regards to integration of two paradigms. (See Table 4).

**High**

This category contained the most participants. Psychiatrists and psychologists in this category believed that religion and spirituality should be integrated into psychotherapy and saw them as a big part of clients’ lives. They valued the power of faith. They were comfortable and willing to dive in and discuss these issues in detail with clients, thereby signaling that those topics are appropriate for psychotherapy. They were often comfortable using religious language like sin, soul, and salvation or discussing the Bible with clients. They included religion and spirituality as part of their assessment. Their own religious teachings and theological knowledge often informed their work. In addition, they saw a reciprocity between their religion and work as a psychotherapist. That is, each informed the other. Prayer entered into their session either silently or with clients. The psychiatrists in this group were the only participants in this study who knew about the V code for Religious and Spiritual Problem. Additionally, the majority knew about and often read journal articles on religion and spirituality and some in this group...
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*African-American

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attended sessions on religion and spirituality at the American Psychiatric Association meeting.

**Medium**

This middle category included only psychologists. The difference between this and the above group is the degree of intensity. While there was an acknowledgement of the importance of religion and spirituality in clients’ lives and some degree of comfort discussing it, it was not a primary way therapists thought about the client. Religion or spirituality were not made as large a part of the session. These psychologists were also far less apt to use religious language or discuss theology with clients. They may refer clients to clergy because of discomfort with a clients’ religious framing of a problem, whereas those in the above category would be more willing to stay with the clients religious language exclusively, if that was necessary. At the same time, the majority in this group prayed either with clients or to themselves. Some in this group also read articles on religion and spirituality.

**Low**

Therapists in the last group were cautious and slightly skeptical of and uncomfortable discussing religion and spirituality with clients. They discussed these topics only if necessary. Religion and spirituality were not seen as a major theme in clients’ lives and was not part of their assessment. Religion was most often viewed as important for social support at best, versus seeing the intrinsic value in it as was the case with the High group.
For the devout members of this group, religion was a private matter. The other participants in this group were not settled into their religion. That is, they were unsure about the optimal level of religion in their lives and what they believe. Therefore, prayer in any form was not a part of their professional practice.

**Interpretation**

As discussed in the methods section, the matrix was designed to see the potential affect of the following seven variables on the integration or separation of religious and medical-scientific paradigms: (1) profession; (2) denomination; (3) sex; (4) race; (5) theoretical perspective, (6) years in practice, and (7) age.

**Profession**

A major question of this study was the impact of professional view on the integration or separation of the religious and spiritual and medical-scientific paradigms. More psychiatrists (10) than psychologists (8) were found in the category with the most integrated perspective on these paradigms. The *Medium* category contained exclusively psychologists. The results of the *Low* category conformed to the view that psychiatrists have a more scientific view than psychologists and would therefore be more likely to have an exclusive scientific view.

**Denominational Affiliation**

It was assumed that Fundamentalist Protestants would show the greatest integration of their private religiosity with their professional life due to their degree of
orthodoxy. This proved to be the case. All Fundamentalist Protestants in the study were in the *High* category. In addition, all nonaffiliated believers, as well as half the Roman Catholics were in this category. One Moderate Protestant and three out of four Liberal Protestants were in this group. Conservative Jews were most represented in the *Low* category. This is surprising given the assumption that this group would be devout and therefore be more likely to integrate their religion into their professional work. While their religion was important to these Conservative Jews, it was kept separate from their work. As noted above, in part this came out of knowing as Jews they were often perceived as outsiders by the Christian clients they treat. In contrast, Reform Jews were in all three categories but most represented in the *Medium* category.

Contrary to the literature on sex and religiosity described in the Methods chapter, there was no pattern in terms of women showing a greater degree of religiosity than men, as evidenced by a higher level of integration. Women and men were evenly split in the *High* category. In the *Medium* category there was one more woman than men. The only slight evidence for an affect of sex on religiosity was in the *Low* category where there was only one woman, thereby supporting the idea that men have a lower level of religiosity than women.

**Race**

Unlike the literature quoted in the previous chapter that found African Americans have a higher religiosity than whites, that did not prove to be the case in this study. Only one African-American was in the *High* category, with the remaining two in the *Medium* category. There were no distinguishing features of their answers compared to white
participants. However, as noted earlier, a much larger and representative sample would be needed to make inferences about race and ethnic viewpoints.

**Theoretical Perspective**

Traditionally, the psychoanalytic viewpoint has been negative toward religion. It is surprising then that the *High* category contained the most therapists professing this perspective. Perhaps this can be explained by psychoanalysis’ emphasis on meanings and associations clients make, of which religion and spirituality could be a big part. The most practitioners who had cognitive-behavioral theoretical orientation, a behavioristic and scientific perspective, were in the *Medium* category. It might be assumed that practitioners in the *Low* category would have very scientific perspective such as biological or cognitive-behavioral. In fact, two participants reported having a biological or pharmacological perspective, two had a psychodynamic approach and one had a cognitive-behavioral view.

**Years in Practice**

It was suggested in the Methods chapter that those newest to a field are often the most orthodox in their views. If that were the case, practitioners with the least amount of experience would be in the *Low* category showing the greatest amount of separation of the two paradigms. In fact, the *High* category contained those who practiced the least amount. It had the most practitioners who have practiced under fifteen years. The *Medium* and *Low* categories had a wide range of years in practice from 5-30 and 5-36+, respectively.
Age

The *High* category also had the largest concentration of 36-45 year old practitioners. In contrast, the *Medium* category was skewed more toward the older end, with four out of the seven participants in the 56-65 range. The *Low* category was skewed toward the old end with four out of five practitioners 46 or older. Therefore, the negative impact of age on degree of integration was not found. Those younger tended toward an integrated view of religion and spirituality and medical-science.
CHAPTER VI

CONTENT ANALYSIS FINDINGS

Professional literature and associations are important tools for socialization. They communicate group adherence, standards, and norms. What role do these institutions play in the integration or separation of religious and spiritual versus medical-scientific paradigms? An indication of professional institutional norms is what is published in journals, especially those of the two main professional organizations in psychiatry and psychology, the American Psychiatric Association and American Psychological Association.

Participants noted a lack of emphasis on religion and spirituality in their training and mixed views of how religion and spirituality were viewed by their professions. Additionally, for many in the study, religion and spirituality were not discussed with peers or only with a select few. According to these participants, institutionally it was in the background versus foreground. In order to see if and how substantiated were participants’ perception of the treatment of religion and spirituality in their field, a content analysis of The American Journal of Psychiatry and Psychotherapy, from 1990-2000 was completed. Ten years of each journal were analyzed to see what trends existed in the presentation of religion and spirituality.

Data

The American Journal of Psychiatry and Psychotherapy were chosen because they focus on the treatment of mental health problems and are published by the American
Psychiatric Association and American Psychological Association, respectively. Although both journals contained both core (e.g., articles) and peripheral publications (e.g., calendars and book reviews) I focused my analysis on the core publications because they are the main ways in which information is transmitted to readers.

*The American Journal of Psychiatry* contained an average of 25 articles per issue with 120 issues published over the 10 year period, totaling 3,000 articles. Of those, 34 (1.1 percent) involved religion and spirituality in some way and 0.8 percent were specifically about some aspect of religion. The analysis of *Psychotherapy* covered 40 issues with an average of 17 articles per issue. Out of these 680 articles, 62 (11.0 percent) at least mentioned religion or spirituality. Thirty-six articles (5.3 percent) had religion either as its focus or it figured in prominently. Almost two-thirds of the “religion articles” were in these categories.

**Types of Articles**

*The American Journal of Psychiatry* contains three types of articles, each serving a different purpose and having different levels of prestige and importance attached to them. Although the definition and size of Regular Articles changed slightly over the 10 year period, they were most often defined as: “reports of original work that embodies scientific excellence in psychiatric medicine and advances in clinical research. Typically, Regular Articles will contain new data derived from a sizable series of patients or subjects” (January 2000: A62). Special Articles were defined as, “overview articles that bring together important information on a topic of general interest to psychiatry” (January 2000: A62). Authors who wished to write such articles were advised to send their idea to
the Editorial Office first. Clinical and Research Reports were succeeded by Brief Reports in March 1993. These types of articles were quite similar. The Information for Authors described the Clinical and Research Reports as presenting: “1) data from pilot or uncontrolled studies with suggestive findings warranting further, more definitive investigation, 2) worthwhile replication of studies, and 3) clinical studies involving a small number of patients” (November 1992: A27).

Articles in Psychotherapy were not distinguished in terms of Regular, Special, Brief Reports as in The American Journal of Psychiatry. Additionally, the range of types of articles in this journal was more limited. Psychotherapy contained a mixture of research on best practices, clinical technique, theoretical, and training articles.

Method

This thematic content analysis was carried out according to the methods proposed by Holsti (1969). Articles were analyzed for the appearance of the words “religion” and “spirituality.” In order to locate these terms I read all titles, abstracts, tables, and graphics looking for the words “religion” and “spirituality” and skimmed the rest of the article. The title showed if religion and spirituality were a central theme and the abstract showed if religion and spirituality were considered an important aspect of analysis. In The American Journal of Psychiatry I looked at the index under both “religion” and “spirituality” to double-check that I did not miss any articles. December 1998 was the last year that included subject indexing. Psychotherapy just had an author index, so this was not utilized as a check of my work.
Thematic categories were inductively derived by reading the articles and seeing in what context the words appeared. Because the two journals differed in terms of range of topics addressed, the thematic scheme was slightly different for these journals. For *The American Journal of Psychiatry* I divided the articles into the following four categories: (1) those that had religion as their subject (religion was almost always in their title); (2) those that used religious affiliation as a sociodemographic descriptor and it was used in the analysis (e.g., religious affiliation was correlated with the topic of study and used to test the association between affiliation and mental health status); (3) those that used religious affiliation as a descriptor (e.g., x percent of the study were Catholic), but was not part of the analysis; and (4) those articles that briefly mentioned religion.

*Psychotherapy* articles were placed into the following four thematic categories: (1) religion as its subject; (2) religion prominent, but not focus; (3) religious affiliation/religious aspect as descriptor; and (4) religion briefly mentioned. The frequency with which themes appeared by article type was treated as an indication of the role and status of religion and spirituality in the journal.

Findings

Looking at the number of articles, distribution chronologically of articles, the type of article, and whether featured or not in the journal gave an indication of the role and status of religion and spirituality in the disciplines of psychiatry and psychology.
The American Journal of Psychiatry

Regular Articles

The lack of institutional support described by participants was reflected in the journals. For example, there were 23 Regular Articles that included religion or spirituality. The degree of salience and centrality of these concepts to the article was divided almost evenly between the four thematic categories (see Table 5).

Table 5. Regular Articles in The American Journal of Psychiatry Themes by Year

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number</th>
<th>Year and Number</th>
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<tbody>
<tr>
<td>Religion As Its Subject</td>
<td>6</td>
<td>1990</td>
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<td></td>
<td>1991</td>
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<td>1998</td>
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<tr>
<td>Religious Affiliation As Sociodemographic</td>
<td>5</td>
<td>1996 (2)</td>
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<tr>
<td>Descriptor and Used in Analysis</td>
<td></td>
<td>1999</td>
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<tr>
<td></td>
<td></td>
<td>2000 (2)</td>
</tr>
<tr>
<td>Religious Affiliation As a Descriptor</td>
<td>6</td>
<td>1995 (2)</td>
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<td>1997</td>
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<td>2000 (2)</td>
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<tr>
<td>Religion Briefly Mentioned</td>
<td>7</td>
<td>1994</td>
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<td>2000</td>
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<td>Total:</td>
<td>24</td>
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</table>

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Those articles that had religion as its subject tended to suggest that religion was an appropriate component to psychiatry and needed to be examined in more research studies. These articles focused on topics such as the role of religious belief in recovery from hip surgery, and a survey of psychiatrists in the Christian Medical and Dental Society in order to understand the role of religious beliefs in this type of psychiatrist. Other articles dealt with the relationship of religiosity, substance use and psychiatric disorders, and religion and remission of depression, respectively.

Even though in five articles religious affiliation was part of their analysis and it was used as more than just a descriptor of the sample, in two of these studies the impact of this was not expounded upon, but left in a table. It is important to note that these articles were not published until the latter half of the 10 year study, suggesting the value of the variable was not considered until recently. Topics in which religious affiliation was used included: (1) characteristics of patients and physicians interested in physician assisted suicide; (2) the relationship between religious affiliation and physiologic dependence to alcohol; and (3) religiosity as a factor in attempted suicide and depression among female physicians in the United States. It was also used as an independent variable to assess if breast cancer survivors who are off-spring of Holocaust survivors react to their illness similarly to Holocaust survivors. Another article used religious denomination as a variable in those that did and did not attempt suicide.

The number of articles that included religious affiliation as a sociodemographic factor could indicate an awareness of religious affiliation, as well as the importance of religion in the lives of clients, and therefore important to use in the conceptualization of clients and their lives. However, the small number of studies that recognized this speaks...
to its continued marginalization. That is, the number of articles that included religious affiliation as a sociodemographic factor were more the exception than the rule as compared to all the articles and studies published. In addition, religious affiliation was often confined to a table in these articles and was not part of the narrative. As with the prior category, religion was not included in the demographic description until the later half of the 1990s.

The final category of articles (seven articles) were those that briefly mentioned religion. For example, (1) reporting a client's religious statement in passing and without comment, (2) mentioning 12-step programs, (3) listing spiritual healing as one Complementary and Alternative Medicine modality used by patients, or (4) using Biblical text as a literary device.

**Special Articles**

There were four Special Articles specifically about either an aspect of religion and psychiatry or where religion was a prominent part of the article (see Table 6). Topics of these articles included cults and the positive role of religion in theory building in the era of moral treatment. Another article described the way spirituality and religion was reflected in a sample of 15 of the mid-20th century Abstract Expressionists artists of the New York School. Finally, an article included the Bible, in addition to philosophical and medical sources, as describing the healing role of listening to another person.

Of the remaining two articles published in this venue, one briefly mentioned spirituality as part of psychoeducational treatment for substance abuse. The other article described the case of forced cesarean sections that often occur with foreign, poor, or
women “whose religious beliefs differ from those of the physician” and the need for
greater multicultural understanding and empathy (Nadelson 1993:1312).

Table 6. Special Articles in *The American Journal of Psychiatry* Themes by Year

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number</th>
<th>Year and Number</th>
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<tbody>
<tr>
<td>Religion As Its Subject</td>
<td>4</td>
<td>1990</td>
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<tr>
<td></td>
<td></td>
<td>1992</td>
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<td></td>
<td></td>
<td>1994</td>
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<td>1998</td>
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<tr>
<td>Religion Briefly Mentioned</td>
<td>2</td>
<td>1991</td>
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<td></td>
<td></td>
<td>1993</td>
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<td><strong>Total:</strong></td>
<td><strong>6</strong></td>
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**Clinical and Research Reports/Brief Reports**

Religion was the subject in three articles in this category (see Table 7). The first,
"Psychiatric Patients’ Belief in General Health Factors and Sin as Causes of Illness" by
Sheehan and Kroll in Jan 1990, was a study of 52 psychiatric inpatients. The authors

Table 7. Clinical and Research Reports and Brief Reports in *The American Journal of Psychiatry* Themes by Year

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number</th>
<th>Year and Number</th>
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<tbody>
<tr>
<td>Religion As Its Subject</td>
<td>3</td>
<td>1990</td>
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<tr>
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<td>1992</td>
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<td></td>
<td></td>
<td>1993</td>
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<tr>
<td>Religious Affiliation As a Descriptor</td>
<td>1</td>
<td>1998</td>
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<tr>
<td><strong>Total:</strong></td>
<td><strong>4</strong></td>
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concluded that it was important to understand patients’ religious framework and attribution of cause of illness. Larson, Sherrill, Lyons, Craigie, Jr., Thielman, Greenwold, and Larson (1992) reported the results of their content analysis of measures of religious commitment over an 11 year period in “Associations Between Dimensions of Religious Commitment and Mental Health Reported in the American Journal of Psychiatry and Archives of General Psychiatry: 1978-1989.” Finally, the ways religion was portrayed in the DSM-III-R Glossary of Technical Terms was described by Larson, Thielman, Greenwold, Lyons, Post, Sherrill, Wood, Larson in the December 1993 issue. However, in a 1998 article, religion was simply used as a descriptor of medical psychoanalysts’ patients in a survey of these practitioners.

Discussion

Combining all article types in The American Journal of Psychiatry (Regular, Special, Clinical and Research Report/Brief Report), religion was mentioned in 1.1 percent of articles published (n=3,000) and was in the forefront in less than 1 percent. Thus, while religion was not a totally neglected topic, it was peripheral to the journal. This shows a lack of emphasis on integrating religion into the mainstream sciences. It was not surprising then that a few participants said they were unsure if they had seen articles on religion and spirituality. The limited focus on religion as compared to biology and neurology in journals was summed up by this female RC psychiatrist:

There are journals about it. There are journals—articles and things that talk about it, but not as much as all the rest of it. You know, the biological pieces, the “how are these receptors affecting this”, I mean you see that so much more. And um, it’s not often that you see “Okay, how is religion affecting psychiatry?” and a whole, like the Annals of Psychiatry or the green journal [The American Journal of Psychiatry] I mean they just don’t—certainly biological psychiatry isn’t, that’s
just more, as the title I guess, states, it’s just more of a biological kind of thing. So I don’t see a lot of it as discussing all the different issues about it. So I don’t think it’s a big, um, encouraging kind of embracing.

The 1996 National Survey of Psychiatric Practice, a random sample of American Psychiatric Association members described in the article by Zarin, Pincus, Peterson, West, Suarez, Marcus, and McIntyre (1998) did not include psychiatrists denomination among its survey questions. These included characteristics of psychiatrists such as sex, age, race, domestic or international training, board certification, and questions about practice setting and content of work. Perhaps an indication of the institutional separation of religion and psychiatry could be seen in the omission of the psychiatrists’ religious denomination from this survey.

The notion that religion was present in this journal but not prominently so was supported by the inclusion of two articles with religion as its focus included in the “In the Issue” section begun in 1997. They were: “Religion, Psychopathology, and Substance Use and Abuse: A Multimeasure, Genetic-Epidemiologic Study” by Kendler, Gardner, and Prescott (March 1997) and “Religiosity and Remission of Depression in Medically Ill Older Patients” by Koenig, George, and Peterson (April 1998). This might be seen as an indication of a warming of psychiatry to the value of religion to psychiatric practice.

Psychotherapy

The psychology journal was more positively inclined toward religion and spirituality than the psychiatric journal. Almost twice as many articles were published than in The American Journal of Psychiatry using religion in some way, with one-third fewer issues. Out of those, in slightly more than half (36 out of 62), religion figured in
prominently (see Table 8).

Table 8. Articles in *Psychotherapy* Themes by Year

<table>
<thead>
<tr>
<th>Theme</th>
<th>Number</th>
<th>Year and Number</th>
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<tr>
<td>Religion As Its Subject</td>
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<td>1998 (2)</td>
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<td></td>
<td></td>
<td>1999 (2)</td>
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<tr>
<td>Religion Prominent but Not Focus</td>
<td>12</td>
<td>1991</td>
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<td>1992</td>
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<td>Religious Affiliation/Descriptor</td>
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<td>1997</td>
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<tr>
<td>Religion Briefly Mentioned</td>
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<td>1991</td>
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Total: 62

A special issue in Spring 1990 on Psychotherapy and Religion contained 16 articles on the treatment of clients of various faiths, as well as a survey by Bergin and
Jensen on religiosity of psychotherapists. In addition to this special issue, this journal published 24 articles where religion was the main topic. Other articles published in other years dealt with the following three topics: (1) the client's religiosity and impact on therapy, (2) attitudes of psychotherapists' toward clients reporting mystical experiences, and (3) 12-step programs and impact on therapy. Two articles specifically focused on the appropriateness of integrating religion into therapy.

From 1991 to 2000, 12 articles were published where religion was prominent but not the focus (see Table 8). Articles in this category include those in which religion was either mentioned in the abstract and/or religion or spirituality had a separate heading and a few paragraphs in the article. The context in which religion or spirituality appeared included therapists inquiring about and supporting clients' spirituality or religiosity in the context of Post-Trauma therapy, and awareness of multiculturalism in treatment. Other articles described how change occurs in Alcoholics Anonymous, how Judeo-Christianity traditionally views homosexuality, suggesting and supporting clients' use of religion and spirituality when facing HIV, and clergy as often not supportive of battered women.

Five articles were published in which religion is used only as a demographic variable or in another way part of the research study (see Table 8). For example, a study in the Winter 1991 issue evaluated the "dangerousness" of self-help books and listed the Bible and Christian books as a category of books. Religious affiliation was noted in articles on breast augmentation patients and never-married men. In addition, clergy were a category of possible sources of social support in the process of realizing that a problem exists and deciding to pursue treatment in a survey of patients who were seeking psychotherapy.
Finally, religion was briefly mentioned in 21 articles (see Table 8). Examples of articles in this category were those on Alcoholics Anonymous and the 12-step programs. In these articles, such programs were either described as having a religious or spiritual component, criticized as being “religious,” or intellectual/ethical/spirituality development was listed as part of a curriculum for the training of drug-dependency personnel. Another way religion appeared was in a list along with other factors. For example, “faith in Christianity” was listed as one possible source of stress of college students. It was also listed along with race, class, age, and sexual orientation as one type of diversity to be respected in clients. In another article, religious communities were included in a list of historical sources of stigmatization of homosexuals. Spiritual experiences were given as example of transpersonal experiences in an article on Holotropic Breathwork. Finally, religion marginally appeared in an article on forgiveness after marital infidelity with the mention of Jewish and Christian views on forgiveness. Another category in this group of “briefly mentioned” were those articles in which the client’s religion was mentioned in a case description and not discussed further. Finally, in two articles religious beliefs or Biblical text were used as a literary devices.

**Discussion**

Compared to *The American Journal of Psychiatry* more articles were published where religion or spiritual was in the foreground, showing a greater acknowledgement of the relevance of religion and spirituality. However, it was still a relatively small part of the articles published.
Psychologists in the study believed their profession had a favorable view of religion and spirituality. Their answers ranged from describing their field’s acknowledgement of the importance of these factors in clients’ lives to acceptance of religion and spirituality. Given the small number of articles that had religion or spirituality as focus or in which they figured prominently this view was surprising and seems to suggest these participants were not adversely influenced by this expression of their profession.

Although equal numbers of psychiatrists (six) and psychologists (six) reported in the interview seeing articles on religion and spirituality, more psychiatrists (four) than psychologists (one) reported not seeing articles on this topic. This appears to suggest that articles on religion and spirituality were more prominent in psychology journals.

Conclusion

While far from being a mainstay in *The American Journal of Psychiatry*, a little attention was paid to religion and spirituality and the positive role it plays in clients’ lives. The various editors through the years have deemed it important enough that articles have been published, although the type of article and ways in which religion and spirituality were discussed varied. It is noteworthy that given the small number of articles published in both journals, slightly more than one-third of participants noted having seen or read these types of articles in journals they have read.

Perhaps *Psychotherapy*'s dedication of a special issue to this topic and the greater number of articles with religion as its subject than *The American Journal of Psychiatry* could be accounted for by the differences in professional emphases. Clinical psychology
by definition deals with psychotherapy, where the topic of religion and spirituality is likely to arise. However, psychiatrists are both doctors and for some, therapists. Therefore, religion and spirituality could be seen as less germane a topic, especially with those in the field who define psychiatry as a brain science. Compared to psychologists, more psychiatrists thought their profession had a negative or cool view of religion and spirituality. This opinion seemed to be substantiated by the smaller number of articles published in this journal as compared to the psychology journal.
CHAPTER VII

DISCUSSION

The overall question of this study was if, how, and to what extent do psychiatrists and psychologists reconcile their medical-scientific training with their personal religious and spiritual beliefs and practices in their work. That is, to paraphrase Shafranske and Malony (1996), to what extent do therapists leave their faith commitment at the treatment room door prior to entering. Was it feasible to integrate paradigms given the institutional structures of peers, discourses, norms, theories of human development and pathology, and diagnosis? The answer to these questions, as expected, is complex.

The Normative Discourses of Integration and Separation

A number of professional and political discourses were used to legitimate both the incorporation of religious and spiritual content into psychotherapy and its exclusion. The norms emphasized by such discourses justified the shared agreements about the proper role of medical-science, religion, and spirituality in the practice of psychotherapy. They also served as an explanation for both the acceptability and exclusion of religion and spirituality from psychotherapeutic practice. For example, many times therapists, even those who were comfortable discussing clients' religious and spiritual issues, were clear that imposing their beliefs on clients and proselytizing were not acceptable behaviors. Not only is this a major tenet of the profession, but it is also an important principle of political and religious pluralism. Behind this concern can be seen the larger political and social norms of separation of church and state (explicitly named by a few participants),
respect of religious diversity and inclusion, and endorsing the moral principle to not
inflict harm intentionally. This respect for diversity and support of the separation of
church and state was clearly seen in the view that it was safer to discuss both clients’ and
colleagues’ spirituality versus specific religion.

Separation of Paradigms

On the whole, the majority of the participants saw the paradigms as compatible.
However, there were definite areas of separation. In their work, participants believed they
served a professional versus spiritual function and pointed to the norm of clear limits of
professional boundaries. This was seen in the distinction participants made between
themselves and clergy. Although religious and spiritual issues were seen by all those
interviewed as in the purview of their profession, they were ultimately psychiatrists and
psychologists and not clergy and would refer if necessary. Thus, the division of the roles
and professional boundaries served as a foundation for the separation of paradigms.

The situations in which a medical-scientific versus a religious and spiritual
paradigm exerted greater influence (was paramount) and explained more to psychiatrists
and psychologists were those where the discourse of “scientist first” was at play. The two
main situations in which this occurred were diagnosis and seeing demonic possession as
psychiatric versus religious in etiology. Psychotherapists reported that their religious and
spiritual ideas about the nature of humans did not impact on their diagnosis of clients, but
instead, diagnostic criteria from DSM-IV (1994) were crucial and solely important.

A paradigm, as defined by Kuhn (1996), is not just an outlook, but a model for
solving problems. It is a part of the culture and rooted in broader ways of thinking about
how the world works. It becomes institutionalized because it is a “patterned way of living together” (Bellah’s, Madsen’s, Sullivan’s, Swidler’s, and Tipton’s 1991:4 definition of institutions) and is established together. Therefore, it becomes normative to use certain language, such as found in *DSM-IV* (1994), to define the nature of the problems clients have and then propose appropriate treatments (provide solutions). Thus, diagnoses represent a paradigm because behaviors and thoughts officially recognized as problems requiring treatment are codified. Even though many participants noted bringing in religious ideas or behaviors into the session, such as discussing Scripture or praying with or for clients, they still were bounded by the logic of the profession and were a representative of the profession.

An awareness of the separation between religion and psychotherapeutic practice was expressed by Jewish and Fundamentalist Protestant practitioners who noted concern that their religion might impede the therapeutic process and be a potential stumbling block for clients. That said, all of these psychiatrists and psychologists were at least willing to discuss clients’ religious and spiritual concerns even if to varying degrees.

Finally, as indicated by participants’ comments that some of the central questions of this study were hard, required complex answers, and caught them off guard, pointed to the extent to which religion and spirituality was not part of their conception of professional practice.

Integration of Paradigms

Therapists integrated their medical-scientific and religious and spiritual paradigms into their practice in a number of ways. The justification of this was the central
professional norm to follow the client’s lead and to talk about what is of importance to them. Therefore, by following this norm, therapists justified the introduction of religion and spirituality into their practice. In addition, when clients presented their problems in religious or spiritual terms this was not discounted in the conception of the problem. Therapists used this language, in some way, often in parallel with psychiatric or psychological views. In addition, for many the languages of religion and psychiatry or psychology overlapped and for some, they served similar functions. Thus, to an extent this client driven form of integration is in reality an instrumental approach to therapy.

As noted in the literature review, many authors believed that it is impossible for psychotherapists to not bring their values into the session. This was seen in this study as well. A number of participants noted this and added that their theological knowledge informed their work with clients, although not all would necessarily use it explicitly in terms of quoting Scripture. Similarly, some psychiatrists and psychologists reported praying for clients with or without their knowledge. Others prayed with clients, at their request.

Clients’ religious and spiritual beliefs and history were included in the assessment by a number of therapists and brought up in the discussion of existential crises. Another way participants reconciled the two paradigms was to see God and psychiatry in harmony because, “God made your brain.” In addition, methods of psychiatric care were created by God, and in this way, medication was not in violation with belief. The most integrative approach was developed by a Fundamentalist Protestant psychiatrists who determined early in his psychiatric career that he possessed three bodies of knowledge and developed a theory that showed their relationship to one another.
Role of the Institution

It was posited that professional institutional barriers might preclude the integration of a religious and spiritual paradigm into psychotherapy. This occurred to a degree. The great extent to which psychotherapists were aware of professional role separation, adherence to standardized and institutional diagnostic practices, and adherence to norms, all of which come out of an institutional structure, was evidence of the impact of the institution. In addition, many participants described caution about sharing their religious and spiritual beliefs with colleagues, as well as their integration of this into professional practice.

However, as was seen in the prior chapter, the majority of participants fell into the High or Medium categories of ideal types, indicating a comfort with the introduction of religious and spiritual paradigms into medical-scientific practice. The norms of the profession did not stop practitioners from bringing religion and spirituality into the session as they deemed necessary. There is a difference between what one says in public and what one does in one’s private office. Therefore, this is evidence of bypassing the institutional structures. At a more informal level, between the client and therapist behind closed doors, there may be an agreement about the use and degree of religious and spiritual language in the session. However, official elements such as diagnosis, not proselytizing, and for some, prescribing medicine, can only be bypassed. In order to be a member of the profession, therapists still have to play by the rules, as was noted in Chapter V by a number of participants. Let us note, however, that this study has dealt exclusively with practitioners who identified themselves as religious or spiritual. That
most of them were placed in the *High* category hardly reflects the situation in professions in general, or psychiatry or psychology, in particular.

When dealing with non-obvious things, people need others to validate their beliefs. This concept of plausibility structures was defined by Berger ([1967] 1969) as, “a social ‘base’ for its [subjective and objective world] continuing existence as a world that is real to actual human beings. This ‘base’ may be called its plausibility structure.” (p. 45). Both science and religion have plausibility structures in which people participate. Everyone in the study used scientific language to a degree. Most of the participants had fellow congregants at church to validate their religious beliefs. However, in order to maintain a belief in an integrated view, one that combines religion, spirituality and medical-scientific ideas, it is necessary to have a network of like-minded people. Those who worked in explicitly religious settings were more likely to find a network of like-minded people. In contrast, the two psychiatrists who expressed wanting a group of like-minded people with whom to discuss religion and psychiatry were those who worked in academic settings and incidentally, were Fundamentalist Protestants.

Also, almost all the psychiatrists and psychologists noted limited or no training discussing clients' religious and spiritual concerns in their medical school or doctoral program, and very little, although slightly more, in residencies and internships. Therefore, being a “professional” did not include these domains. These were powerful institutional impediments that had to be overcome. Practitioners for whom this was important learned about how to work with clients' religious and spiritual issues on their own and acted despite institutional arrangements.
As discussed in the literature review, ethics codes are a mainstay of a profession and a means of controlling of members. There are statements in both the American Psychiatric Association and American Psychological Association ethics codes concerning religion. However, other than a few explicitly religious therapists who noted that they were practicing within ethical guidelines, the vast majority did not even know what the codes said with respect to religion and in therapeutic practice. Therefore, the impact of this “arm” of the professional institution seems minimal.

The finding that the majority of participants were more open to religion and spirituality in therapy the longer they practiced, is interpreted more as an indication of a general comfort that occurs the longer one is in a job, versus an indication of a lessening of institutional influence. A number of practitioners reported feeling more settled in their practice or their original integrated position becoming clearer.

Contribution to Existing Literature

As noted in the literature review, the majority of literature on religion, spirituality, and health is focused on the impact of the former two on patients’ health. This study adds to the gap in the literature on whether clinicians have differing beliefs from the medical model and if so, how they integrate them, and the role of larger professional institutions in this process.

Participants in this study were generally in agreement with the literature supporting the inclusion of religious and spiritual issues in psychotherapy. In addition, this study has shown the extent to which it is in fact included by both therapists who do and do not market themselves to clients as religious. The degree to which and under what
circumstances prayer, religious and spiritual language, and theological knowledge was used by psychiatrists and psychologists was an example of this. As was found in previous studies, the majority of participants reported praying daily. Also as was reported in prior research, the majority disapproved of praying with clients. The number who prayed for clients was lower than studies cited in the literature review. In contrast, very few studies were found that documented the use of religious and spiritual language and theological knowledge in psychotherapy, as was revealed in this research.

This research also contributes new knowledge to the role of colleagues in therapists’ integration or separation of medical-scientific and religious paradigms. As documented in the literature review and content analysis, books and articles have been published by the two main professional associations in psychiatry and psychology (American Psychiatric Association and American Psychological Association). However, prior to this study, it was unclear how aware therapists were of such publications and the influence of these publications on their ability and desire to integrate or separate religious and medical-scientific paradigms into their professional practice.

The tensions and specialization of knowledge explored in this study and the role of professional institutions is applicable to other professions. For example, a study of 70 faculty from four California colleges and universities found that, “academic institutions provide few, if any, structure or opportunities for faculty to discuss or otherwise reflect on this [spiritual development] very critical aspect of their personal and professional lives” (Astin and Astin 1999:12).

The findings of this study also supports previous research that religious and spiritual issues are rarely included in psychiatric or psychological training and the desire
on the part of the majority of respondents for this to have been included in their training. While the results support the commonsense notion that psychotherapists use the *DSM-IV* (1994) to diagnosis patients, it went further and showed how it is used even by practitioners professing religious beliefs.

**Conclusion**

As the above discussion shows, the answer to the question, "Which finite province of meaning, medical-scientific or religious and spiritual has greater influence on the form of participants’ paramount reality of their everyday life as professionals?" is "neither." Rather, these institutional forms exist side-by-side. Participants thought of themselves as professionals, and most defined their field of practice in scientific and behavioristic terms, yet a number still viewed religion and spirituality as legitimately incorporated into psychotherapy.

Many reported not discussing clients’ religious and spiritual issues or their own with colleagues and one psychologist noted concern if colleagues found out he discussed such issues with clients. In this sense, some therapists violated the norm of not discussing such issues. However, the lack of support of colleagues did not stop those therapists who wanted to discuss religious and spiritual issues in therapy from doing so. Additionally, this did not lead to feelings of alienation from one’s profession or one’s self in the sense of no longer belonging to or a separation. Instead, these professionals found ways to go between the paradigms. They did not describe thinking of themselves as less of a scientist because they also held religious and spiritual beliefs, and to varying degrees utilized these in their practice. For example, a number of participants said combining their professional
role (psychotherapist) with their religious denomination was “Just who I am.” Although it is important to note that there were limits to what they could do at work, given their religious and spiritual beliefs. Others noted that they were not a separate self at work and hiding their religious and spiritual beliefs but simply maintaining healthy therapeutic boundaries, as defined by their profession. However, two Fundamentalist Protestants articulated that they fell short as Christians and felt conflict between the values of psychiatry and Christianity.

Given that the role of the institution seemed to be not a complete deterrent to the integration of religion and spirituality into psychotherapeutic practice, what accounted for the high degree of integration that did occur? Two factors seem to most strongly account for this. First, the professional norm of “start where the client is.” Second, these psychiatrists and psychologists were motivated for the most part to include this domain into their practice.

Although there are examples of practitioners’ support for integration, there also seems to be much evidence of powerful institutional obstacles. That these obstacles are not completely effective insofar as the religious and spiritual therapists in this study, does not mean that they do not impede integration.
CHAPTER VIII

CONCLUSION

This project explored a little studied aspect of the relationship between religion and mental health practices in the United States. Through qualitative interviews and content analysis of two professional journals, this study investigated how mind was seen and the problem of mind was defined by psychiatrists and psychologists of various Judeo-Christian denominations and nonaffiliated believers in the State of Michigan. The role of professional institutions in this process was also described. For the majority of psychiatrists and psychologists, the medical-scientific and religious and spiritual paradigms were able to coexist as equal knowledges, although powerful institutional forces existed which limited true integration or blending of the paradigms.

Limitations and Directions for Future Research

The limitations of this study point to next steps in the research. For example, participants for this exploratory study were drawn from a limited geographic area. Building upon this qualitative study, I would like to next conduct a national quantitative survey to see the impact of region on this question. In addition, this study solely focused on Judeo-Christian faiths. Expansion to include non-Western religious traditions such as Buddhism and Islam to see how these faiths, with their different cultural discourses, reconcile the medical-scientific and religious and spiritual paradigms could prove important in this age of multiculturalism. Additionally, these non-Western religions may
have different paradigms that make it easier or harder to see mind in distinctly medical-
scientific or religious terms.

This study focused solely on psychiatrists and psychologists in outpatient practice
with adults. Given Bergin’s and Jensen’s (1990) finding that marriage and family
therapists and clinical social workers had a higher level of religious involvement than
clinical psychologists and psychiatrists, and the high number of marriage and family
therapists in Carlson et al. (2002) study who considered themselves religious, it could be
useful to understand how other mental health professions differ with respect to this
question and would advance our understanding of this phenomenon. In addition, a
comparison of specialized type of psychologists and psychiatrists, such as those whose
work focuses on children and adolescents, inpatient, rehabilitation, or addictions would
be fruitful to fine tune the impact of profession on this question.

Practical Implications

Broadly stated, the practical significance of this study is a more complete
understanding of if, how, and why psychiatrists and psychologists integrate religious and
spiritual beliefs, training, and views of human nature into their traditionally scientific-
based work. How they thought about these competing knowledge systems and how
psychiatrists and psychologists differ in these respects was addressed. Additionally, this
study provided a greater understanding of the ways in which institutions shape
professionals’ thoughts and actions. How some professionals resist the pull of the
institution and expand the boundaries of what it means to be a psychiatrist or
psychologist was explored.
The extent to which therapists are able to bracket their own beliefs in the therapeutic relationship because of the potential for these to influence the therapeutic relationship are important issues. On the other hand, the risk of alienation of the therapists’ self through this bracketing deserves attention as well.

But these are broader social issues than can be resolved in a profession. Therapists in this study encountered institutional impediments in their integration attempts. For example, only Axis I and II diagnoses were reimbursed by insurance companies, not V codes, where the acknowledgement of the role of religion and spirituality in clients’ difficulties was placed. Practical matters such as reimbursement demands a medical-scientific perspective. Other issues such as the legal system (separation of church and state), government approaches (what is supported by federal dollars) are all part of the equation.

I hope that this research creates greater awareness of tensions between religion and science and blind spots of psychiatry and psychology. For example, as many authors noted in the literature review, there is both a need for increased training in psychiatric and psychological programs and better models of how to discuss clients’ religious and spiritual beliefs in therapy. In addition, therapists in this study indicated that their training rarely included a place for them to explore their own religious and spiritual beliefs and prejudices. This is needed as well. These changes could benefit therapists in their practice of psychotherapy and fill a consumer-driven demand.
Appendix A

Telephone Script
Hello. My name is Ellen Wagenfeld-Heintz. I am a doctoral candidate in sociology at Western Michigan University. _____ suggested I call you. My dissertation research project will explore how religion influences psychiatry and clinical psychology, and your opinion about these issues is very important. I am interested in conducting qualitative interviews with psychiatrists [OR doctoral level clinical psychologists] having various religious orientations (but not necessarily members of specific denominations) and whose practice focuses primarily on adults. Interviews are expected to last one hour and can be done either at your office or the Kercher Center for Social Research at Western Michigan University. All information collected from you will be confidential.

Would you be interested in learning more about this study?

<If yes, then I will answer questions about the study and ask if they would like to participate and then schedule an interview.>

<If no, “Thank you very much for your time.”>
Appendix B

Interview Guide
Interview Guide

Introduction
These first couple of questions are designed to help me to understand your practice of psychotherapy

Training
1. What school did you attend?
2. Where did you complete your residency/internship?
3. When did you graduate?

Current practice
1. Is this [private practice/community mental health] your primary practice site?
2. How many people do you see a week?
3. What types of clients do you treat in terms of diagnosis?
4. What is the make-up of your practice in terms of socioeconomic status and race?
5. How would you describe your theoretical perspective?
6. How much autonomy do you have in terms of your approach to psychotherapy?

Professional organizations
1. Do you belong to the APA? State branch?
2. Do you attend the APA annual conference?
   • If yes: Are there sessions on religion and psychotherapy?
3. What journals do you read?
4. Are you interested specifically in reading articles about religion and spirituality?
5. Do you see articles on these topics in the journals you read?

Practice of Psychiatry or Psychology
1. What is psychiatry or psychology in your view?
2. If you look at the word—both psychology and psychiatry come from the same root, “psyche”. So, psychology is the study of human psyche. What does that mean to you that psychology studies the human psyche?. What is the psyche to you?
   • Follow-up: How is the psyche related to the mind?
3. What do you see as the endpoint of therapy? What are you trying to achieve?

Own religious upbringing
1. First let's talk about the words religion and spirituality. Some writers use them interchangeably and some don't. So my question is do you see them as the same or different?
   • If different, then what is religion as opposed to spirituality?
   • If the same, how do you define them?

2. What role or importance does religion or spirituality play in your life currently?
   • How often do you attend church or synagogue?
   • How often do you pray or engage in another spiritual practice?
   • Do you pray, meditate, or otherwise engage in spiritual practice between sessions? During?

Religion and Profession
1. Turning back to your training, to what extent was religion and spirituality discussed in the program, either implicitly or explicitly?
   • Were client's religious/spiritual issues addressed?
   • Were your own religious and/or spiritual issues addressed?

2. What about in the internship?

3. To what extent is religion (or spirituality) involved in your therapy session?
   • Do you discuss religion and/or spirituality in your initial assessment?
   • What are other circumstances or times you chose to introduce religion into the therapy session?

4. From your training, journal articles, and conferences attended, what is your understanding of how religion and spirituality is viewed by your profession?
   • What guidelines do you think APA provides?
   • What is the position of the APA?

5. Thinking about APA meetings and APA journals, on a scale from small, moderate, large, how much of time and space do you think is devoted to issues of religion and spirituality?

6. Some literature that I've read suggests that psychiatry/psychology and religion use two different languages to describe the nature of humans and the cause of their mental health problems. Do you see the languages as different or similar?
• Do you think this is a minority view?
• What is APA’s position?

7. Do you think the languages are incompatible or compatible? That is, can they be combined in mental health practice?
   • Why or not?

8. What is the relationship of religion and the practice of psychiatry or psychology for you?
   • Does it belong in psychiatry/psychology?

9. Do you think your view of religion and psychotherapy is shared by your professional community or is it a minority view? Is it shared within your organization?
   • If it is a minority view, do you feel comfortable sharing your view with your colleagues?
   • Are there some people with whom you are hesitant to share these ideas?

10. What if a colleague worked from an openly religious perspective, how do you think others in your profession would react?

11. There have been publications that suggest religion and psychiatry or psychology should be integrated in mental health, whereas others disagree. What is your opinion of this debate?

12. Take this a step further, do you talk to clients about their condition in religious language?
   • Would you like to use this language or do you have an urge to use this language?

13. Are there peers or colleagues you talk with about the issues of psychotherapy and religion?
   • Do they usually agree or disagree with your view?
   • If disagree, then what are the disagreements?

14. Some authors have suggested that one’s own faith should not be concealed but brought to work. Do you do this?
   • If so, how?

15. Do you feel you have to hide yourself and beliefs? That is, are you a separate self at work?

16. What does it mean to you to be a [denominational affiliation] and a psychiatrist or psychologist?
17. When making a diagnosis, does your religious and/or spiritual understanding about human nature and God influence your thinking?

18. Do you think there’s a professional ethical issue in separating religion and spirituality and psychotherapy? That is, do feel like that’s part of the ethical code of being a psychiatrist or psychologist?

19. Has your view of the relationship between religion and the practice of psychiatry or psychology changed since you started to practice?

20. How do you deal with these conflicting ideas about the nature of humans and illness when interacting with a patient/client?

Demographic
1. In what age range do you fall:
   - 26-35
   - 36-45
   - 46-55
   - 56-65
   - 66+

Closing
1. I have no further questions. Do you have anything more you want to bring up, or ask about, before we finish the interview?

2. I will be mailing a summary of my finding to participants. Could I have a business card so I could mail this to you?

3. Are there others you could suggest that might want to participate?

Thank you very much for your time.
Appendix C

Human Subjects Institutional Review Board Approval Letters
Date: November 1, 2001

To: Vyacheslav Karpov, Principal Investigator
    Ellen Wagenfeld-Heintz, Student Investigator for dissertation

From: Mary Lagerwey, Chair

Re: HSERB Project Number 01-10-22

This letter will serve as confirmation that your research project entitled "Mental Health Practice and Religion" has been reviewed under the exempt category of review by the Human Subjects Institutional Review Board. Before final approval can be given the following concerns should be addressed and revisions submitted for HSIRB review:

1. Application form, page 2:
   - Please provide an upper limit in the age range (e.g., 26-99)
   - Length of participation refers to how long each subject will be involved in the study (e.g., 1 interview lasting 2 hours).

2. Consent Document Development Checklist: Since this is not a therapeutic study, the "alternate procedures" item should not be checked.

3. Research Design section of the protocol outline:
   - Your demographic form includes Reformed Jewish. Do you mean for it to be included among the religious orientations in your design? Please clarify.
   - Potential subjects should have an opportunity to discuss the project with you before signing a consent form or giving information about themselves. Please revise your method of having subjects return both the consent form and the demographics sheet. Consider having potential subjects contact you if they want to learn more about your study.

4. Benefits of Research section of the protocol outline: Are there possible benefits for the study participants?

5. Confidentiality of Data section of the protocol outline: Please state that you will remove all identifying information from write-ups, presentations, etc.

6. Recruitment Letter: You should make this an invitation to learn more about participating. Include a contact telephone number or another way they can contact you to discuss participation before they return their consent forms and data.

7. Demographics Sheet:
   - How will you notify respondents that they are not eligible? Perhaps you could ask in your recruitment letter that they contact you only if their practice focuses on adults.
• As above, Reformed Jewish is not mentioned in the protocol.

8. Consent Document:
• In the risks paragraph, include that they can choose to not answer any question and that there is no penalty for either discontinuing or for skipping questions.
• Please include an explanation of your procedures for maintaining confidentiality.

Please submit one copy of the above changes in writing to the HSIRB, 251W Walwood Hall (East Campus). Remember to include the HSIRB project number (above) and to mark the changes within the document. To avoid delays, please do not send revisions addressed to me. Revisions should be submitted within the next month.

Conducting this research without final approval from the HSIRB is a violation of university policy as well as state and federal regulations.

If you have any questions, please call the research compliance coordinator at 387-8293.
Date: November 12, 2001

To: Vyacheslav Karpov, Principal Investigator
   Ellen Wagenfeld-Heintz, Student Investigator for dissertation

From: Mary Lagerwey, Chair

Re: HSIRB Project Number 01-10-22

This letter will serve as confirmation that your research project entitled "Mental Health Practice and Religion" has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: November 12, 2002
Date: November 28, 2001

To: Vyacheslav Karpov, Principal Investigator
   Ellen Wagenfeld-Heintz, Student Investigator for dissertation

From: Mary Lagerwey, Chair

Re: HSIRB Project Number 01-10-22

This letter will serve as confirmation that the changes to your research project "Mental Health Practice and Religion" requested in your memo dated November 27, 2001, have been approved by the Human Subjects Institutional Review Board.

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: November 12, 2002
To: Vyacheslav Karpov, Principal Investigator
   Ellen Wagenfeld-Heintz, Student Investigator dissertation

From: Mary Lagerwey, Chair

Re: Changes to HSIRB Project Number: 01-10-22

This letter will serve as confirmation that the changes to your research project “Mental Health Practice and Religion” requested in your memo dated December 10, 2001, have been approved by the Human Subjects Institutional Review Board.

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: November 12, 2002
Appendix D

Informed Consent Form
I have been invited to participate in a research project entitled Mental Health Practice and Religion. This research is intended to study the relationship between religion and mental health practices in the United States and the role of religion in the professional lives of psychiatrists and fully license psychologists. This project is Ellen Wagenfeld-Heintz's dissertation project.

I will be interviewed for 1 hour by Ellen Wagenfeld-Heintz in either my office or the Kercher Center for Social Research at Western Michigan University, whichever I choose. The interviews will be tape recorded and transcribed. Additional handwritten notes may be taken during the interview.

There are no foreseen risks associated with this research. However, as in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or treatment will be made available to me except as otherwise specified in this consent form. I can choose to not answer any question and there is no penalty for either discontinuing or for skipping questions.

One way in which I may benefit from this activity is having the opportunity to reflect upon my personal and professional lives.

All of the information collected from me is confidential. Each participant will be assigned a number. This list will be kept in a separate locked file cabinet in Dr. Karpov's office from the cassette tapes. This number will be used for identifying information on the tapes. All identifying information will be removed from write-ups and presentation of data obtained from this study. The cassette tapes and transcription of tapes, as well as my analysis, will be kept for a minimum of 3 years in a locked file cabinet in Dr. Karpov’s office.
I may refuse to participate or quit at any time during the study without prejudice or penalty. If I have any questions or concerns about this study, I may contact either Ellen Wagenfeld-Heintz at (616) 387-5293, Dr. Vyacheslav Karpov at (616) 387-5243. I may also contact the chair of the Human Subjects Institutional Review Board at (616) 387-8293 or the vice president for research at (616) 387-8298 with any concerns that I have.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Subjects should not sign this document if the corner does not have a stamped date and signature.

My signature below indicates that I have read and/or had explained to me the purpose and requirements of the study and that I agree to participate.

Signature ____________________________ Date

Consent obtained by: ____________________________
Initials of researcher ____________________________ Date
REFERENCES


Ehman, John W., Barbara B. Ott, Thomas H. Short, Ralph C. Ciampa and John Hansen-Flaschen. 1999. "Do Patients Want Physicians to Inquire About Their Spiritual or Religious Beliefs if They Become Gravely Ill?" Archives of Internal Medicine 159:1803-1806.


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229

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234


