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A STUDY OF LICENSED PSYCHOLOGISTS AND THE PROBLEM
OF ADDRESSING SPIRITUAL/RELIGIOUS
ISSUES IN THERAPY

by

Suzanne Lorenz Brennan

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Education
Department of Counselor Education and
Counseling Psychology

Western Michigan University
Kalamazoo, Michigan
April 1988

A STUDY OF LICENSED PSYCHOLOGISTS AND THE PROBLEM
OF ADDRESSING SPIRITUAL/RELIGIOUS
ISSUES IN THERAPY

Suzanne Lorenz Brennan, Ed.D.

Western Michigan University, 1988

The study was done in response to a documented concern in the literature that therapists are unprepared to treat the spiritual concerns of their clients who come from a population in which 95% profess a belief in God.

One objective of the study was to determine the spiritual orientation of licensed psychologists and their attitudes toward religious belief and addressing religious issues in psychotherapy. Other objectives were to determine the amount of help received in addressing these issues during training and supervision and how competent they perceived themselves to be in this regard. Responses of the two license levels, full and limited, were compared. The underlying purpose for the study was to discover if there was evidence for advocating training and education regarding these issues in therapy.

A survey was sent to 10% of all licensed psychologists in Michigan. The return rate was 72% for a total of 202. Results showed that 70% of the total sample claimed a traditional Judeo-Christian spiritual orientation. The concept of religious belief as a neurosis was rejected by

87%. More (48%) agreed than disagreed (32%) that religious belief was relevant to therapy. About equal numbers agreed and disagreed that they felt competent to address religious issues; 15% were uncertain. Nearly 80% claimed they received no help addressing spiritual/religious issues in therapy during their education and supervision. Between license levels, there were no significant differences in attitudes or perceptions despite the differences in gender, age, experience, education, and spiritual/religious orientation.

This was an exploratory study and the problem of validity involved in a study of attitudes in general and religious matters in particular is a signal for cautious interpretation. The results indicate that: (a) There is an interest in the subject (as shown by the 72% response rate, (b) less than a majority of the respondents has a sense of competence in this area, and (c) this problem has not been adequately addressed in the education and training of psychologists. Recommendations include: (a) the need for additional studies with larger sample size and geographical area, (b) studies involving interviews to gather more information and develop validity of terms and issues, and (c) studies of training and education to address this problem.

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Western Michigan University, 1988

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ACKNOWLEDGEMENTS

I would like to dedicate this work to two people whose support, encouragement, and faith in me helped to make it possible: my husband, Edward, and my doctoral committee chairperson, Thelma Urbick.

There have been many people who have contributed to this effort by their support, encouragement, kindness, and help. For this I have often been very thankful.

Above all, I thank God, who has shown his love to me through all these people: my sister, brothers, sisters-in-law, friends, colleagues, teachers, and, among the greatest gifts he has given me, my children, Bob, Sue, Lilli, Shari, Barbie, Patrick, Kathleen, and Karen.

Suzanne Lorenz Brennan

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CHAPTER I

INTRODUCTION

In The Future of an Illusion, originally published in 1927, Freud (1927/1964) stated that the most important item in the psychical inventory of a civilization is its religious ideas (which he considered illusions). He ended this work by reminding us that science is no illusion and is our best path to reality. In 1970 another work of great influence was published: The Structure of Scientific Revolutions. The author, Thomas Kuhn (1970), discussed the evolutionary nature of science and the value-laden subjective nature of scientific paradigms. It was around this same time that the ideal of value-free therapy was generally considered also to be an illusion.

Historically, there has been a great deal of tension, very complex in nature, between religion and science. In their efforts to be true scientists, psychologists have been quite sensitive to this tension. The source of this tension varies according to the different scientific and religious groups. To say that it comes from differences involved in the quest for truth would be simplistic. In addition to this, in our American culture, there has also been tension in the separation between Church and State. Although this separation principle has general support,

the boundaries, issues, and methods are sources of conflict. Religious institutions have conflicting reputations. They are criticized for suppression, oppression and rigidity, on the one hand; on the other hand, they are extolled for dedication and care for the poor and oppressed as well as for their efforts for peace and justice--which involve fighting suppression, oppression, and rigidity. Confounding this even more are many and diverse spiritual/religious expressions of different cultural backgrounds in this country. Until the ecumenical dialogues in the sixties, social etiquette dictated an avoidance of religious matters in social conversation.

The Problem

The problem in this study concerns addressing spiritual/religious issues in psychotherapy. The foregoing paragraphs touched briefly upon the tension between science and religion as well as the complexities involved. There has been an increasing concern over the willingness as well as the competence of psychologists to address religious issues with their clients in the course of psychotherapy (Bergin, 1985; Russo, 1984; Shafranske & Gorsuch, 1984). During this same period there has been the birth and considerable growth of psychologists' professional groups concerned with religion, such as Psychologists

Interested in Religious Issues (Division of the American Psychological Association) and the Association for Religious and Value Issues in Counseling, "one of the fastest growing divisions" (Martin, 1986, p. 3) of the American Association of Counseling and Development. This concern parallels the concern about values and meaning that has received a great deal of attention in the literature during this same period. A client's philosophy of life provides the parameters in which a therapist and client can work together. It is where the client is. Most clients have a religious philosophy of life that can be both a source of pain, confusion, and conflict as well as one of strength, comfort, and hope. The growing concern is that this matter is not addressed in the training and education of psychotherapists.

The late Gordon Allport, a professor of psychology at Harvard University, has been one of the prominent leaders in the field who stressed the importance of the spiritual dimension of people. He wrote in his Preface to Frankl's Man's Search for Meaning (1968):

It is here that we encounter the central theme of existentialism: to live is to suffer, to survive is to find meaning in the suffering. If there is a purpose in life at all, there must be a purpose in suffering and dying. But no man can tell another what this purpose is. Each must find out for himself, and must accept the responsibility that his answer prescribes. If he succeeds he will continue to grow in spite of all indignities. Frankl is fond of quoting Nietzsche, "He who has a why to live can bear with almost any

how." (p. xii)

Berman (1981) wrote, "the fundamental issues confronted by any civilization in its history, or by any person in his or her life, are issues of meaning."

In 1976 Shostrom stated:

In a similar vein, more and more therapists are agreeing with Viktor Frankl's (1963) idea that therapy is a search for meaning and that "meaning" may be defined as personal values. ... when the person begins to actualize, he develops a personal priority system, or a hierarchy of personal needs or personal values. Personal values probably develop primarily from experience but also partly from an examination of the universal values found in religions and philosophical systems. (p. 276) (underlining added)

The literature on values in the same period of time is voluminous--values of the therapist, of the client, of goals, of reinforcers, stressing the importance of values and the impossibility of value-free therapy (Bergin, 1980a; Rokeach & Regan, 1980; Rosenbaum, 1982; Weisskopf-Joelson, 1980). It is evident that there is widespread agreement about the importance of meaning and values as evidenced not only by the large number of books and articles on these subjects but also by the fact that they are addressed, although not systematically, in most training programs. However, in order to determine the roots of many values involving the self, others, and life style, a therapist has to examine the spiritual/religious philosophy of the client. This is usually not addressed in most training programs.

According to Gallup's (1985) research, 95% of Americans believe in God; 72% believe the Bible is the Word of God; 71% believe in heaven; 53% believe in hell; 87% say they pray; and 86% say that their religion is fairly important to very important to them. There is no doubt that there is a strong spiritual component in the belief systems of the clients whom psychologists are trained to serve. Yet, it is claimed that clients' religion and religious loyalties are ignored and invalidated and that therapists tend to avoid or resist addressing spiritual/religious issues in therapy (Bergin, 1980a; Henning & Tirrell, 1982; Krasner, 1981; Theodore, 1984). Some claim that to avoid such issues could be considered unethical (Bergin, 1980a; Cunningham, 1983) since stated in the the ethical standards of the American Psychological Association of 1974 was: the psychologist should show a "sensible regard for the social codes and moral expectations of the community in which he works" (p. 13). Although revised (American Psychological Association, 1982), there is continuing concern in the professional association. In addition to this, much research supports the contention that spirituality/religion can be vitally involved in mental health (Bergin, 1980a; Morrison, 1986; Paloutzian, 1983;).

Research also shows that faith in God is lower among psychologists than among those in the other scientific

disciplines (Cross & Khan, 1983; Lehman, 1973). This has raised the question of whether the study of psychology has a negative affect on religious beliefs or whether the field attracts those who have no strong religious belief, have a nontraditional one, or are looking for something to fill the void left by discarded beliefs.

Purpose of the Study

Since, for licensed psychologists, there is no required training related to addressing spiritual/religious issues in therapy, the underlying purpose of the study was to determine indications of the need for this training. This is an issue that has relevance for practitioners as well as for the academic community. Some basic information was needed. The Religious Issues in Therapy Survey Form (Kivley, 1986) helped formulate some of the following questions:

1. How religious or irreligious are licensed psychologists?
2. What are their attitudes toward religious belief?
3. What are their attitudes toward the usefulness of religious belief for therapy?
4. What are their attitudes toward the relevance of religious issues in therapy?
5. Do they feel competent to address these issues?
6. How much help have they had in addressing these

issues during their training and supervision?

7. Is there a difference between fully and limited licensed psychologists in respect to these questions?

Three additional questions addressed the influence of psychological studies, the rejection of childhood faith, and unresolved spiritual/religious conflict. These questions were considered exploratory for the purpose of investigating possible relationships.

The target population included all licensed psychologists in the state of Michigan. This group was also divided into the two levels of licenses: fully licensed and limited licensed. All known related studies have involved only doctoral level licensed psychologists. Since there are over 1500 limited licensed psychologists in the state of Michigan and since large numbers of them are employed as therapists by our state mental health agencies, it was considered important to study them separately as a group to determine any distinguishing characteristics from the fully licensed psychologists.

Limitations

One limitation of this study has to do with the social desirability aspect of reporting attitudes. For example, people may circle a response because that is the one they want to have or the one they think they (or psychologists) should have rather than the one they actually

do have. Furthermore, religion and spirituality are, in many ways, emotionally-charged subjects, which tend to confound the responses. Nix (1978), in her study of religious values of psychotherapists, reported this emotional component.

Another limitation concerns the generalizability of the results. Since the random samples were drawn from limited and fully licensed psychologists in Michigan, they cannot be generalized to therapists in other areas nor to therapists who are not psychologists. Additional studies will be needed.

Problem of Definition

Because spiritual/religious matters are not addressed in a licensed psychologist's education, there is no common ground for discussion, no common meaning for terms; this leads to misunderstandings and problems in communication. Pruyser (1968) writes of this problem:

Throughout this book we have been making use of the word "religion" without defining it....Leuba in 1912 discussed no less than forty-eight different definitions of religion and added several more of his own. James, on the other hand, was quite sober in his emphasis on "the belief that there is an unseen order"...Even Ferm's short and unpretentious Encyclopedia of Religion contains a whole list of classes of definitions, together with a critique of each, prefaced by the telling sentence: "The term religion belongs to that large class of popular words which seems acceptable as common coin of communicative exchange but which on closer examination fails to carry the imprint of exact meaning." (p. 329)

The term "spiritual/religious" was used frequently because it tends to convey a broader meaning to some people. "Religion" and "religious" were the expressions used on the questionnaire (Religious Issues in Therapy Survey Form [Kivley, 1986]). Definitions were intentionally left open. This problem of definition is another limitation.

Summary and Overview of the Study

A large percentage of the client population in psychotherapy has a spiritual/religious orientation. Some studies show a smaller percentage of the therapists with a similar orientation. There is concern that therapists are unwilling or unable to address spiritual/religious issues in therapy. Chapter II, the review of the literature, presents the background, concerns, and the questions raised from the studies done and articles written. Chapter III describes the study: the subjects, the contents of the instrument, and the treatment of data. A questionnaire, sent to a randomized sample of both limited and fully licensed psychologists in the state of Michigan, was analyzed to determine the spiritual/religious orientation of licensed psychologists and their attitudes toward religious belief and religious issues in the practice of psychotherapy. Collected data are analyzed in Chapter IV. Summary, discussion, and recommendations are presented in Chapter V.

CHAPTER II

REVIEW OF RELATED LITERATURE

Introduction

Examined in this chapter, first, will be the relationship between religion and psychology and how it affects the attitudes of psychologists. Next, the importance of addressing spiritual/religious issues in psychotherapy will be reviewed. Third, reasons for spiritual/religious issues not being addressed in therapy will be examined and will comprise the major portion of this chapter. Included in this are: therapists' attitudes, countertransference, and training and education.

Relationship Between Religion and Psychology

Some roots of the problem to be studied lie in the history of psychology after it separated itself from philosophy and attempted to establish itself as a scientific discipline beginning at the end of the nineteenth century. There was a thirty-year effort to establish a psychology of religion but it died in 1930 (Beit-Hallahmi, 1974; Paloutzian, 1983). Beit-Hallahmi noted that, "Inside academic psychology in the 20's and the 30's, interest in religious behavior began to be perceived as

evidence of unscientific orientation" (p.88). The first half of this century saw psychology's focus on becoming "scientific." While there were some leaders in the field, such as William James, Edwin Starbuck, and G. Stanley Hall, it is noted by Paloutzian (1983) "that those early pioneers may have regarded it as a novelty which only the top leaders in the field could risk examining" (p. 30).

Religion and religious behavior were criticized by some of the great thinkers in the field of psychology and their influence continues in the present time. Freud (1927/1964) considered religion an obsessional neurosis of society, an illusion based on wish fulfillment which serves to keep man a child. Skinner (1971) criticized religion as a controlling societal force. Ellis (1962) criticized it as a source of irrational thinking.

Clemens and Smith (1973) noted that the effect of all of this is not only to rule out the spiritual dimension of man as unacceptable for scientific psychological study but also to rule out spiritual/religious issues as unworthy of being addressed in a clinical/counseling setting--"unworthy of consideration on an equal footing with the scientific material of psychology" (p. 21).

Allport (1950) noted that sex and religion had reversed themselves as taboo subjects. He wrote:

Whatever the reason may be, the persistence of religion in the modern world appears as an

embarrassment to the scholars of today. Even psychologists, to whom presumably nothing of human concern is alien, are likely to retire into themselves when the subject is broached. (p. 1)

The Importance of Addressing Spiritual/Religious Issues

In order to define what is meant by spiritual/religious issues, Paloutzian (1983) emphasized the importance of regarding religion as a multidimensional variable: "The necessity and utility of separating religion into belief, practice, knowledge, feelings, and effects has been repeatedly illustrated. The usefulness of dividing people into simple religious and nonreligious categories has long since passed" (p. 196). Although there are other conceptual breakdowns for religious material this model serves to illustrate that spiritual/religious issues may involve conflict and anxiety regarding spiritual/religious beliefs, practices, knowledge, feelings, and effects. For many people they form the basis of behavior toward themselves, others, and the world. They also may be involved in a client's sense of "badness," damnation, or guilt resulting from childish misconceptions. They can involve a distorted sense of God. These will continue to be a source of anxiety until they are examined and resolved in some way. The other side of this is that a client's spiritual beliefs can be a source of comfort, strength, and healing. Ostow (1959) writes that the therapist "will

be doing his patient a disservice if he hesitates to examine religious attitudes objectively, just as he would if he assumed that all positive religious attitudes are no more than symptoms of neurosis" (p. 1798).

Oates (1978) stressed the importance of knowing the religious culture and concerns in forming an effective diagnosis and treatment of a patient. He noted that a person's religious belief system can be an "ego-adaptive, integrating, and supportive means of realizing human potential which should not be ignored or circumvented in the course of therapy" (p. 66).

Draper, Meyer, Parzen, and Samuelson (1965) devised a semistructured religious interview that could be conducted in 30 to 45 minutes. This consisted of religious history and projective questions pertaining to the Bible and important religious concepts such as sin, evil, and the afterlife. It was used with 50 randomly selected psychiatric patients from the University of Chicago clinics and hospitals. Diagnoses were made on the basis of this religious material alone and were compared to those diagnoses arrived at through the standard psychiatric method in which the Diagnostic and Statistical Manual of Mental Disorders (cited in Draper et al., 1965, p. 205) was used for symptom and character assessment. The high rate of agreement (92%) between the two indicates the depth and pervasiveness of religious material. It is interesting to

note that none of the patients displayed "religiosity" (an abnormal preoccupation with religion).

The religious data not only enlivened the diagnoses "but also offered keys to the understanding of certain patients' current conflicts that were not easily grasped from the available clinical data" (Draper et al., 1965, p. 205). The authors concluded:

Finally, our study conveys that in the diagnostic realm, religious and philosophical views need not be considered automatically sick or healthy, not avoided, nor overrespected as too personal, nor ignored as irrelevant. They need not be categorized as expressions of one compartment of the mind, such as the superego, nor reduced to pat formulae, such as God is the projection of the infantile prototype of the father. Rather, it would appear that the religious and philosophical convictions of patients offer an intimately private and uniquely personal communication, worthy as any other, not only of respect, but also of diagnostic curiosity. (p. 207)

Lovinger (1984) stated, "In essence, religion gives order and meaning to the physical, social, and interpersonal world" (p. 84). He claimed (1985):

The potential for countertransference reactions in the therapist, the paucity of systematic knowledge in the area of religion and the fact that most of the American population practices some form of religion or maintains some specific religious beliefs all combine to indicate that religion can have a profound impact on therapy even if the patient never mentions it which they won't if they think the therapist doesn't want to hear about it. (p. 182)

Applebaum (1985) wrote:

An increasingly holistic perspective in psychiatry and psychotherapy has developed over the past decades, starting with an appreciation of

the interaction between mind and body and expanding more recently to include the spiritual. The spiritual/religious dimension of the human personality is a vital component in human health. (p. 140)

Jung (1933) criticized Freud and Adler for exclusive concern with drives: "They fail to satisfy the deeper spiritual needs of the patient" (p. 225). He stated (1938):

Since religion is incontestably one of the earliest and most universal activities of the human mind, it is self-evident that any kind of psychology which touches upon the psychological structure of human personality cannot avoid at least observing the fact that religion is not only a sociological or historical phenomenon, but also something of considerable personal concern to a great number of individuals. (p. 1)

Freud indicated his awareness of the importance of religion (Meng & Freud, 1964): He wrote to his friend, Oskar Pfister, who was both a psychoanalyst and a Christian minister, that although he (Freud) was thoroughly irreligious himself Pfister was in "the fortunate position of being able to lead to God young persons faced with conflict...that they were ready for sublimation in its most comfortable form, namely the religious" (p.16).

Allport (1950) maintained that what a man believed, to a large extent, determined his mental and physical health and wrote: "Religious belief, simply because it deals with fundamentals, often turns out to be the most important belief of all" (p. 79).

Quackenbos, Privette, & Klentz (1985) conducted an exploratory study of lay people in a Florida county

regarding the relationship between religion and psychotherapy. Of the total of 86 respondents, 79% thought that religious values were an important topic to be discussed in therapy; 53% indicated they would seek counseling at a pastoral center if one were available; and 35% preferred some form of religious counseling. The population studied was geographically confined and had a strong religious orientation. Nevertheless, the authors concluded that it was "quite clear that a large number of people want religion to be included in psychotherapy" (p.293).

Why Spiritual/Religious Issues Not Addressed

Therapists' Attitudes

In recent years there has been a growing concern in the field of clinical/counseling psychology with the religious/spiritual aspects of human behavior. This concern arises not only from a professional interest in the contributing factors of mental health but also from promptings of society during the past twenty years--there has been an unquestionable surge of interest in spiritual matters. The central problem of this study concerns addressing spiritual/religious issues in psychotherapy. Generally, this is an area of the therapists' training that is neglected and, correspondingly, it is an area neglected in therapy. Over the past several years there has been increasing concern about this issue, as evidenced

by the articles and books during this period (Cunningham, 1983; Henning & Tirrell, 1982; Lovinger, 1984; Quackenbos, Privette, & Klentz, 1985, 1986; Russo, 1984; Sevensky, 1984; Sharkey, 1982; Spero, 1981; Strommen, 1984; Theodore, 1984). One concern is that therapists neglect, resist, or avoid addressing spiritual/religious issues in therapy. Another concern is that, since 95% of the general population profess a belief in God, a therapist is ethically negligent if he/she is unwilling or unable to address this aspect of a client's life. Natale (1985) maintains there is hesitation, avoidance, and even downright fear on the part of the therapist to explore distinctly religious values with a client (p. 106). He adds that there is growing concern that when religious issues are involved, therapists tend to relinquish their dispassionate evaluation of the logical coherence and consistency of a client's belief system.

Scientists as a group have been shown to be less religious than the general population and psychologists the least religious of all academic groups (Lehman, 1973; Lehman & Shriver, 1968). Leuba (1934) hypothesized that natural scientists were more religious as a group than social scientists because their field of study was more distanced from the study of religion. He concluded that social scientists withhold belief because religion is a topic of study to them which requires scientific

objectivity. Lehman and Shriver, in their 1968 study, hypothesized that scholarly distance from religion was positively correlated with personal religiosity. This is sometimes referred to as the "scholarly distance theory."

O'Malley, Gearhart, and Becker (1984) conducted a study of lay and religious counselors from two large Rocky Mountain cities to determine their regard for values and to what extent they were willing to cooperate with one another. The lay counselors classified themselves as Psychodynamic, Behavioral, or Humanistic and the ministers classified themselves as Fundamentalist, Orthodox, or Mainline Protestant. It was discovered that values were not considered important to the therapeutic process by the lay mental health professionals but were by the religious counselors. Behaviorists, Humanists, and Protestant clergy indicated an openness to cooperation between the disciplines. Psychodynamic therapists and Fundamentalist counselors indicated little regard for cooperation. In general, the authors concluded that the results of the survey were encouraging and hopeful for a beneficial exchange between psychology and religion:

The schism between psychology and religion is reflected most in the attitudes of Psychodynamic therapists and fundamentalist counselors. Neither expressed much hope for becoming therapeutic allies. Although the analysis does not permit a causal interpretation, it may be that their respective viewpoints are grounded on theoretical perspectives in which values and spirituality are either categorically accepted (for fundamentalist therapists) or rejected (for

psychodynamic therapists) as a part of the therapeutic regimen. (p. 120)

Cross and Khan (1983) investigated the moral and religious values of three counseling practitioner groups: psychiatrists, psychologists, and social workers. The study was done in Australia where 79% of the general population profess a belief in God. A higher percentage of social workers professed this belief (70%) than psychiatrists (59%) or psychologists (50%). Social workers were distinguished by their strong endorsement of individual rights as opposed to individual responsibility and obligation which were strongly endorsed by psychiatrists (psychologists were somewhere in the middle). Psychologists showed the least regard for social standards while psychiatrists showed the most. This has ramifications both for working together on interdisciplinary treatment teams and for working with the general population. In the latter regard, since therapy is a powerful mechanism for value change, the authors recommend that therapists be "more explicit about what they believe while respecting the value systems of others" (p. 18).

Henry, Sims, and Spray (1971) conducted a survey of close to 4,000 psychotherapists in three large metropolitan areas of New York, Chicago, and Los Angeles. They studied psychoanalysts, psychiatrists, clinical psychologists, and psychiatric social workers to determine differences and similarities among the four groups. Examined

were cultural and social class origins, religious and political biographies, and the evolution of their professional choice. They discovered that, though there were distinguishing differences among the four groups, the similarity among them when compared to the general population, was striking. Of a total of 1338 clinical psychologists about 60% were religious adherents, i.e., they and their parents were Catholic, Protestant, or Jewish; about 27% were religious apostates, i.e., they had rejected their religious backgrounds and were agnostic, atheistic, or claimed no position with regard to religion; and that about 13% were secular adherents, i.e., neither they nor their parents held any religious belief. They found that the strength of religiosity of the parents was positively related to the strength of religiosity of their children. In regard to the evolution of their professional choice, they found that psychologists were more influenced by teachers than other psychotherapists. In regard to motivation for becoming interested in psychotherapy, 23% of the psychologists chose "to understand people," 16% chose "to help people," 11% chose "to gain professional status," and 7% chose "to understand and help oneself." In the over 40% remaining there were 30 categories, none of which amounted to as much as 5%.

Nix (1978) conducted a very extensive and intensive nationwide study of religious values and attitudes of 240

therapists who were members of the American Psychological Association. They had to meet the following criteria: U.S. residency, Ph.D. in psychology, and engaged in doing psychotherapy or providing human services. She used a 15 page religious values questionnaire with an optional introspective exercise which reportedly took from 30 minutes to several hours. She noted that 60.25% of the 240 therapists reported themselves as being religious to some degree. What was interesting was that only about 10% thought that their colleagues were in some way religious or at least held positive attitudes about the subject. She posed the questions:

Do therapists perceive their colleagues as being more negative toward religion than they really are because of the fear, conflict, and silence which many indicated as surrounding this religion issue? Or is it more indicative of therapists projections of their own ambiguous, conflictual, and potentially "unreasonable" and "unprofessional" religious values? (p. 189)

Data from extensive questionnaires and introspective reports indicated that there was a great deal of emotionality, conflict, and defensiveness regarding issues of religion, and that this stems from personal concerns about dependence, control, and authority which is reflected in an often conveyed superior, omnipotent therapist image.

Ragan, Malony, and Beit-Hallahmi (1980) surveyed a two per cent random sample of the 1975 American Psychological Association membership to determine the religiosity of psychologists as a group. The results confirmed that

psychologists were less religious than the general academic population. Compared to a 1972 study in which 23% of academicians in general presented themselves as atheistic, 34% of psychologists in this study were atheistic. Those who believed in a "transcendent deity" were 43%. They also investigated specializations within psychology and found that there were no distinct differences in the religiosity of persons working in different areas of psychology. For example, two clinicians were as likely to differ in this respect as a clinician and an industrial psychologist. They also found that psychologists who personally considered religious phenomena in the course of their work were more religious than those who did not. Another finding was that there was a negative correlation between religious and scholarly values.

From his survey of 57 therapists in East-Central Illinois, Kivley (1986) stated that it cannot be said that therapists in general are religious or irreligious nor do they consciously agree that religious belief is a neurosis. He found that therapists' self-perceived religiosity is significantly related to their dealing with religious issues in therapy, i.e., if they consider it important for themselves they are more apt to consider it an important therapeutic issue. No significant amount of variance of therapists' attitudes toward dealing with religious issues was accounted for by therapists' views of

religious belief as a neurosis nor by therapists' views of the utility of religious belief for therapy once variance related to self-perceived religiosity was noted.

Shafranske and Gorsuch (1984) conducted a survey of 1400 clinical psychologists in California and found that the majority of the research sample (272 out of 406 respondents) reported that spirituality was personally relevant. This same majority tended to perceive spirituality as relevant in their clinical work. Most of these psychologists had belief systems which were outside the traditional mainstream religions. The data also showed that, in the course of a clinical psychologist's education, there was little or no training concerning spirituality or religious issues. The small response rate (29%) was a major limitation of the study and inadequate funding precluded follow-up mailings or investigation of non-respondent bias.

Countertransference

Countertransference refers to the evocation by the client of unconscious personal reactions of the therapist toward the client, thus endangering professional objectivity. Danger of countertransference is strongest when the spiritual/religious beliefs of the client are either very similar to or very different from the therapist. When they are very similar Spero (1981) warned:

Therapists and patients of like religious beliefs represent, on the one hand, a favorable alliance by virtue of shared language and ethos...This would also enhance the therapist's ability to differentiate between legitimate and illegitimate uses of religion. On the other hand, this very belief can be used by a therapist to rationalize a disinterest in monitoring the negative potential of such familiarity. In such instances, the belief itself is a clue to countertransference distortion. (p. 566)

Spero added, "Another manifestation of distortive countertransference occurs when the therapist identifies too strongly with the religious patient's struggles" (p. 570) leading to such therapist behaviors as excessive agreement with rationalizations, too much sympathy with blaming or fault-finding, and too much or too little participation in the client's anxiety.

When spiritual/religious beliefs are very different, such as a religious therapist and an atheistic client or an atheistic therapist and a religious client, the therapist may assume that the religious beliefs are part of the client's problem. Stark (1963) mused that social scientists, the majority being nonbelievers, find it hard to believe that any truly normal person could be religious. It is not a rarity for a therapist to refuse to discuss any religious material. Braun (1982), in regard to countertransference and ethical issues, stated:

Presuming that the therapist already possesses a genuine ethical core, the integrated personality needed to follow his or her ethical sensitivities, and a commitment to uphold the ethical code of his or her profession, then the foundation for working ethically with religious

persons rests in the exploration and monitoring of the therapist's own emotional reactions. This principle applies to therapists of all persuasions....The countertransference can operate within any therapist so that the therapist dislikes religious patients, ignores the individuality of religious persons in treatment, stays blissfully ignorant of the complex dialectic between psychotherapy and religion, or remains unable to appreciate and to help the persons within their religious frame of reference because the therapist cannot deal with that frame. The countertransference forces may keep a therapist further embedded in barren, inaccurate theological notions and a sterile fund of knowledge from which to draw interpretations and understanding. (p.140)

Lovinger (1984) warned, "The practicing therapist may not receive much aid with countertransference on religious issues from other professionals, such as peers or supervisors, unless it is self-identified." Spero (1981) likewise placed an emphasis on self-scrutiny. Henning and Tirrell (1982) listed as sources of countertransference: (1) the fear of religious therapists that their personal, unresolved doubts will be aroused; (2) the fear of the affective aspects of the knowledge of one's mortality; and (3) the fear of not just the unknown but also those matters in our existence that may be unknowable. Mester and Klein (1981) wrote: "The therapist will be confronted with reminders of his own inescapable finiteness and his very human deep ignorance of transcendental meanings and aims" (p. 305).

Training and Education

Concern over the education and training of psychotherapists is widespread and varied in perspective. Strunk (1979) proposed that the general movement toward training versus educating may be contraindicated:

It may be that in the training of psychotherapists a truly liberal education ought to be basic--an education, in other words, that includes far more philosophy, theology, literature, and popular culture than is presently the case....What is needed is a realistic reappraisal of personal and professional strengths and limitations and a greater consideration of referral and consultative courses--including the possible utilization of philosophers, theologians, spiritual directors, and so forth. (p. 195)

Bergin (1980a) maintained that "until the theistic belief systems of a large percentage of the population are sincerely considered and conceptually integrated into our work, we are unlikely to be fully effective professionals" (p. 95). He noted that an examination of psychology texts contained no references to the possible reality of spiritual factors. Bergin (1980a, p. 103) pointed out:

Religion is at the fringe of clinical psychology when it should be at the center. Value questions pervade the field, but discussion of them is dominated by viewpoints that are alien to the religious subcultures of most of the people whose behavior we try to explain and influence. Basic conflicts between value systems of clinical professionals, clients, and the public are dealt with unsystematically or not at all. Too often, we opt for the comforting role of experts applying technologies and obscure our role as moral agents, yet our code of ethics declares that we should show a "sensible regard for the social codes and moral expectations of the

community" (American Psychological Association, 1972, p.2).

Lovinger (1984), who has a background as a supervisor in a clinical psychology training program, claimed that the training tends either to discourage or to undermine a religious orientation. He stated, "Rarely, if ever, do such programs attend to religious matters in patients, leaving most therapists unprepared on both a conceptual and practical basis" (p. x). Lovinger referred to the academic bias against religion because of its unscientific nature and maintained:

Even if the educational experiences of the therapist do not include direct critiques of religious beliefs or practices, the overall intellectual atmosphere of higher education and professional training militates against a religious orientation. There are more overt selective processes as well. Observations of the reactions of admissions committees reviewing an applicant with strong, overt religious beliefs for entry to a graduate psychology program show that some faculty regard these expressions of belief as neurosis, poor judgment, or "bad taste" (Gartner 1982; Sollod 1978)....religious feelings and values are more important to many patients than to most psychotherapists. The therapist needs to be as free as possible of constraints stemming from emotional limitations and informational deficits. The academic study of religion is rarely an aspect of the therapist's training and the overall attitudinal matrix of a psychology-oriented education tends to foster a negative attitude toward religions. (p. 3)

Russo (1984), another counseling trainer and supervisor, in reference to the "widely discussed" hesitancy on the part of counselors and psychotherapists to discuss spiritual issues with clients stated:

There are many possible reasons why such hesitancies exist among therapists. Counselors may fear imposing their own religious values, have negative attitudes toward organized religions, lack specific in-depth knowledge of spiritual concerns, or simply lack a facilitative theoretical training model. My own experience as a supervisor and trainer of counselors and therapists suggest that lacking a facilitative framework is often the main hindrance. Students often recognize the potential importance of enhancing client functioning through exploration of religious and spiritual values but lack the necessary guidelines. (p. 42)

Summary

The purpose of this chapter was to examine the tension that has traditionally existed between religion and psychology. This provides the background for the psychologist's attitude toward dealing with spiritual/religious issues in therapy. In the literature there has been a great deal of concern expressed over the neglect of spiritual/religious issues in therapy, which are considered to be of prime importance by a growing number of professionals as well as by a large percentage of clients. Psychologists have been shown to be less religious as a group, at least in the traditional sense. However, there appears to be a sizable, and growing, group for whom spiritual beliefs are important. Not many studies are available and the subject is a multifaceted, complex one. Psychologists' attitudes, countertransference, and the lack of training and education appear to be the primary

contributors to the emerging problem of addressing
spiritual/religious issues in therapy.

CHAPTER III

METHOD

Population

The population for this study included all limited and fully licensed psychologists in the state of Michigan as of May, 1987. Limited licensed psychologists are required to have a master's degree with 75% of the studies being psychological in nature; fully (regular) licensed psychologists are presently required to have a doctoral degree also with 75% of these studies being psychological in nature. In addition, both programs of study are required to include certain courses considered necessary for the practice of psychotherapy as required by the Michigan Department of Licensing and Regulation Public Acts of 1978. These populations were selected for the purpose of investigating the spiritual/religious orientation of licensed psychologists and their attitudes toward religious belief, the utility of religious belief for therapy, and toward addressing spiritual/religious issues in therapy. A secondary objective was to compare the two license levels on each of these points.

Instrumentation and Treatment of Data

The instrument used in the study (see Appendix A) was comprised of two sides: The front side, Preliminary Questions To Religious Issues In Therapy Survey (PQ), consisted of seven demographic variables and five questions formulated by the researcher (see Appendix A); the back side consisted of the Religious Issues in Therapy Survey Form (RITSF). The latter was developed by Lowell Kivley (1986) at The University of Illinois and was used with his permission (see Appendix B).

The demographic variables and the rationale for inclusion are as follows:

Kind of License (limited or full)--in addition to comparing these two professional levels, this served as an additional check on the amount of education and psychological studies. License level was determined by a code number on the questionnaire.

PQ 1. Age--certain attitudes can be attributed to age or life experience.

PQ 2. Gender--females are usually considered more religious than males in our culture.

PQ 3. Highest Degree Completed--this variable and Preliminary Question (PQ) #8 were examined together and separately for possible effects of both education and psychological studies.

PQ 4. Experience--experience in itself (length of practice) sometimes accounts for differences in attitudes.

PQ 5. Primary Professional Occupation--studies indicate that academicians are more negatively disposed toward religion than practitioners (see Chapter II).

PQ 6. Theoretical Preference--studies show that therapists with a Freudian or Behavioral orientation are more negatively disposed toward religion (see Chapter II).

PQ 7. Spiritual/Religious Orientation--this was included for comparison with other studies and with the general population.

Preliminary Question (PQ) #8 was included to determine the strength of influence of psychological studies on the present spiritual/religious orientation of the respondent. Is there a relationship between the influence of psychological studies and the spiritual/religious orientation of respondents?

PQ 8. My psychological studies have influenced my present spiritual/religious orientation... SD D U A SA (5-point Likert scale)

Preliminary Question #9 was included to determine the proportion of psychologists who have rejected their childhood faith and to determine whether there is a relationship between this and the influence of psychological studies on the respondents' spiritual/religious orientation, their theoretical orientation, their view of

religious belief, and their self-perceived religiosity (considering oneself deeply religious).

PQ 9. I have rejected my childhood religious faith...
SD D U A SA (5-point Likert scale)

Preliminary Question #10 addressed the perception of unresolved spiritual/religious conflict to determine its relationship with attitudes toward religious belief and toward addressing religious issues in therapy.

PQ 10. I perceive unresolved spiritual/religious conflict within myself... SD D U A SA (5-point Likert scale)

Preliminary Question #11 was included to determine whether there is a different pattern of responses for those who do not consider themselves deeply religious (RITSF #19) but whose spiritual or philosophical beliefs are important to them. For example, how does their pattern of responses (if there is one) compare with those who do consider themselves deeply religious--how are they similar and how are they different? Is there a traditional and a nontraditional spirituality discernible?

PQ 11. My spiritual and/or philosophical beliefs are important in my life... SD D U A SA (5-point Likert scale)

Preliminary Question #12 was included to determine whether help in addressing spiritual/religious issues is provided during professional training and supervision. Do they perceive themselves as being competent more than

those who have not received any help? In addressing education and training needs in this area this would serve to provide some baseline information.

PQ 12. In my academic training and professional supervision I was helped to address spiritual/religious issues in therapy... SD D U A SA (5-point Likert scale)

The Religious Issues In Therapy Survey Form (RITSF) contains three scales with a total of 19 items. Responses are made on a 5-point Likert-type scale (as used with the last five PQ items)--from Strongly Disagree to Strongly Agree.

The first subscale is View of Religious Belief and is based on Freud's views (cited in Kivley, 1986, p. 38). It consists of five items which correspond to Freud's rationale for considering religious belief as neurotic plus the neurosis summary statement:

1. Religious belief tends to detract from one's intellectual development.
2. Religious belief tends to encourage self-responsibility.
3. Religious belief tends to be a way of avoiding reality.
4. Religious belief often prevents people from making effective attempts at changing themselves or their environment.
5. Religious belief provides a moral base for those who would rather not establish moral guidelines themselves.
6. Religious belief is a neurosis. (Kivley, 1986, p.39)

Kivley (1986) found that the majority of therapists in his study (n=57 in East-Central Illinois) held at least one belief that indicates religious belief is neurotic yet did not agree with item #6.

The second subscale is Utility of Religious Belief. Kivley stated that this is based on what Spilka (cited in Kivley, 1986, p. 39) considered to be key resources which religious belief offers the therapeutic process. They can: (a) help control expressions of personal disorder, (b) aid in social integration, (c) effectively change one's perception of circumstances, (d) aid in solving problems of perceived helplessness, and (e) foster high self esteem. The RITSF questions are as follows:

7. Religious belief helps control expressions of personal disorders.
9. Religious belief aids in integrating people with their society.
10. Religious activities effectively change one's perceptions of circumstances.
11. Religious belief promotes a sense of helplessness. (Stated in a negative direction.)
12. Religious belief tends to foster high self-esteem. (Kivley, 1986, p. 39)

The third subscale is Therapist Attitude Toward Religious Belief in Therapy (Kivley, 1986, p. 39). This is based on the premise that those who have positive attitudes will maintain that: (a) religious belief is not too subjective to be useful in therapy, (b) religious

belief is relevant to the therapy process (used as a summary statement), (c) the strengthening of spiritual expressions is a legitimate goal of therapy, (d) the introduction of religious issues by the therapist is ethical; (e) they, themselves, are competent in dealing with religious issues in therapy; and (f) referral to clergy for religious concerns is not necessary (Kivley, 1986). The RITSF items are:

8. Religious belief is too subjective to be useful in therapy.
13. Religious belief is very relevant to the therapy process.
14. Helping clients strengthen spiritual expressions is a legitimate goal for therapy.
15. Therapists who introduce religious issues into therapy are acting unethically.
16. Counseling clients on religious issues is within my therapeutic competence.
17. Referral to clergy is usually the best way to handle any religious issue. (Kivley, 1986, p. 39)

The two single item variables are as follows:

18. Few clients wish to discuss their religious beliefs. (Kivley, 1986, p.39)

This item will be examined for a relationship with the following item: Do those who are religious tend to more receptive to such discussion?

19. I consider myself deeply religious. (Kivley, 1986, p. 39)

This item will be examined for a prominence of

relationship with other variables. Some studies have found that personal spiritual disposition is the main determining factor in the attitude toward the relevance of spiritual/religious issues in therapy.

Summary of the Variables

Major dependent variables of the questionnaire are:

1. View of religious belief
2. Attitude toward the usefulness of religious beliefs in therapy
3. Attitude toward the relevance of religious belief to therapy
4. Competence in addressing religious issues

The independent variables that will be examined in relation to these are:

1. License level
2. Personal religiousness
3. Help during professional training in addressing spiritual/religious issues
4. Age
5. Gender
6. Theoretical preference
7. Spiritual/religious orientation
8. Influence of psychological studies
9. Rejection of childhood faith
10. Unresolved spiritual/religious conflict

Data will be used to analyze all psychologists as a group and also to determine any distinguishing characteristics of limited licensed psychologists versus fully licensed psychologists.

Validation, and Reliability

The RITSF was judged to have content validity by three advanced graduate students at the University of Illinois. In addition to this the complete instrument was examined and found to be acceptable for the purposes of the study by two Ph. D. academicians and by two Ph. D. practitioners (Kivley, 1986, p. 38). Kivley reported that interitem consistency (as measured by coefficient alpha) on each of the three scales (View of Religious Belief, Utility of Religious Belief, and Therapist Attitude Toward Including Religious Issues in Therapy) was found to be .77, .54, and .68 respectively (Kivley, 1986, p. 38).

Procedure

The research protocol was reviewed by the Human Subjects Institutional Review Board of Western Michigan University and considered exempt (see Appendix C [title was changed]). The lists of fully licensed and limited licensed psychologists were obtained from the State of Michigan Department of Licensing and Regulation. Two lists of random numbers were obtained from Minitab (a

statistical package for computers; Ryan, Joiner, & Ryan, 1976). Ten per cent of the names on each list were randomly selected, 127 from a total of 1265 fully licensed psychologists and 153 from a total of 1530 limited licensed psychologists. This gave a total sample of 280 psychologists licensed to practice psychotherapy in Michigan. Questionnaires with a cover letter and a stamped, self-addressed return envelope were sent to each subject. They were asked to complete and return the questionnaires and were assured of confidentiality (see Appendix D). Each instrument was numbered. When returned the number was recorded and then clipped off the questionnaire. In this way confidentiality was maintained and the recorded numbers aided in identifying names for follow-up mailings. Two weeks after the first mailing 48% response was received and reminder cards were sent (see Appendix E for follow-up card). This brought in about 12% more within an additional two weeks when a third mailing went out with another copy of the questionnaire and another stamped return envelope (see Appendix F for follow-up letter). Of the original 280, two were deceased and six could not be located. Responses were received from 202 licensed psychologists for a return rate of 72%. The data were entered into the Vax computer system at Western Michigan University for analyses by SPSSx (Norusis, 1986).

CHAPTER IV

RESULTS

Organization of the Results

The purpose of this chapter is to organize and present the results of the survey to facilitate a description of the populations and determine any relationships which may affect addressing spiritual/religious issues in psychotherapy. The focus of the chapter will be on the results relating to the six main research questions and their corresponding null hypotheses:

1. What is the spiritual orientation of licensed psychologists? Is there a difference between the two levels of licensed psychologists, the full license and the limited license?

2. What is the attitude of licensed psychologists toward religious belief as a neurosis? Is there a difference between the two levels of licenses?

3. What is the attitude of licensed psychologists toward the utility of religious belief for therapy? Is there a difference between the two levels of licenses?

4. What is the attitude of licensed psychologists toward the relevance of addressing religious issues in therapy? Is there a difference between the two levels of licenses?

5. Do licensed psychologists perceive themselves as competent in addressing religious issues in psychotherapy? Is there a difference in this respect between the two levels of licenses?

6. In their training and supervision, have licensed psychologists received help addressing spiritual/religious issues in therapy? Is there a difference in this respect between the two levels of licenses?

In addition, a summary of the other items will be given: influence of psychological studies on spiritual orientation, rejection of childhood faith, unresolved conflict, summary of comments, and requests for results. A summary of all the raw scores can be referred to in Appendix D.

The responses to the Likert scale items are not normally distributed. Most of them resemble a bimodal distribution or are skewed. This is demonstrated by the frequencies and percentages given. The hypotheses will be tested with a chi square statistic for a significant difference with a probability of less than .01 ($p < .01$). For the Likert scale items the differences will be between the combined agreement responses (strongly agree plus agree) and the combined disagreement responses (strongly disagree plus disagree).

Descriptive Profile

Of the 202 responses received all but two were identifiable as to license and gender. Missing responses to the other demographic questions ranged from 10 to 16. Missing responses on the Likert scale items ranged from 17 to 22. Tables 1, 2, and 3 contain the demographic information for the total respondents and are broken down into level of license. In Table 1, means and percentages are given for age, gender, degree, and years of practice. There is about a five-year difference in mean age with the fully licensed being older and having practiced an average of seven years longer. Of the total subjects there are about two males to each female. This increases to three to one among the fully licensed and drops to one and a half males to each female among the limited licensed. About 85% of the subjects are practitioners. The majority of the rest of the fully licensed psychologists are academicians, and of the limited licensed, administrators.

Table 1

Age, Gender, Experience, and Primary Occupation:
Means, Percentages, and License Level

	Total Respondents (n=202)	Full License (n=87)	Limited License (n=115)
Mean Age in Years	44.851	48.099	42.453
Males	66.5% (n=133)	75.9% (n=66)	60.4% (n=67)
Females	33.5% (n=67)	24.1% (n=23)	39.6% (n=44)
Experience Mean Years	12.906 (n=190)	16.767 (n=82)	10.073 (n=108)
Practitioner as Primary Occupation	85.3%	84.1%	86.0%

In Table 2 are listed the theoretical preferences of licensed psychologists as a whole and by type of license. The preference for an eclectic theoretical approach is more than three times greater than for any other preference.

Table 2

Theoretical Preference: Frequencies and Percentages

	Total Respondents	Full License	Limited License
Behavioral	17	7	10
	8.9%	8.5%	9.4%
Psychodynamic (Freudian)	22	12	10
	11.6%	14.6%	9.4%
Psychodynamic (Other)	25	9	16
	13.2%	11.0%	15.1%
Humanistic	20	8	12
	10.5%	9.8%	11.3%
Eclectic	93	39	52
	48.9%	47.6%	49.1%
Other	13	7	6
	6.8%	8.5%	5.7%
Total	190	82	106

The spiritual orientations of the total respondents and both license levels are indicated in Table 3. The largest single group represented is Protestant--for the total group and also for each license level. However, the second largest group for the total and for the limited licensed is Catholic but for the fully licensed it is Agnostic.

Table 3
Spiritual/Religious Orientation:
Frequencies and Percentages

	Total Respondents	Full License	Limited License
Jewish	24 12.9%	11 13.9%	13 12.3%
Catholic	38 20.4%	9 11.4%	29 27.4%
Protestant	70 37.6%	26 32.9%	44 41.5%
Non- traditional	16 8.6%	6 7.6%	9 8.5%
Agnostic	21 11.3%	14 17.7%	7 6.6%
Atheist	8 4.3%	7 8.9%	1 .9%
Other	9 4.8%	6 7.6%	3 2.8%
Total	186	79	106

Personal Spiritual/Religious Orientation

Null Hypotheses 1a and 1b

1a. Licensed psychologists as a group are not religious in a traditional way as determined by a traditional spiritual/religious orientation.

1b. There is no difference between fully and limited licensed psychologists in regard to the proportion with a traditional spiritual/religious orientation.

The responses showing spiritual/religious orientation are given in Table 4. To analyze the data for this hypothesis a chi-square analysis was used to determine whether the difference between the proportion in the traditional group was significantly greater than would be theoretically expected, with a probability of less than .01. The same analysis was performed to test for a significant difference between the two license levels. chi-square values, degrees of freedom, and the chi-square significance level are given in Table 4 for both analyses.

The null hypothesis, 1a, is rejected. It cannot be said that licensed psychologists as a group are not religious in a traditional way as measured by their traditional spiritual/religious orientation. The finding indicates that the obtained chi-square value is significant at the .01 level. The proportion of licensed psychologists who claim a traditional religious orientation is

significantly larger than those who do not.

The null hypothesis, 1b, is also rejected; the obtained chi-square value is significant at the .01 level. It cannot be said that there is no difference between the two license levels in their traditional spiritual/religious orientation. The probability that the observed difference is due to chance is less than one per cent. A significantly greater proportion of limited licensed psychologists claim a traditional religion than do the fully licensed.

Table 4

Chi-square Analysis:
Traditional Religious Orientation Versus All Others
Frequencies and Percentages Shown

	Total Respondents	Full License	Limited License
Traditional Judeo- Christian Belief	132 70.9%	46 58.2%	86 81.2%
Non-trad. & Other	25 13.4%	12 15.2%	12 11.3%
Agnostic & Atheistic	29 15.6%	21 26.6%	8 7.5%
Total: chi-square=65.89 df=1 p<.01			
Full vs. Limited: chi-square=11.617 df=1 p<.01			

Attitude Toward Religious Belief

Null Hypotheses 2a and 2b

2a. Licensed psychologists do not consider religious belief a neurosis.

2b. There is no difference between the levels of license in this respect.

As explained in Chapter III, Religious Issues in Therapy Survey Form (RITSF) items #1 through #6 were used to determine the therapists' attitudes toward religious belief as a neurosis. (See Appendix F for raw scores and Appendix A for questions.) These six items state that religious belief (#1) detracts from intellectual development, (#2) encourages self-responsibility (this item is reversed), (#3) is a way of avoiding reality, (#4) prevents people from making effective changes, (#5) provides a moral base for those who would rather not do it themselves, and (#6) is a neurosis. Item #6 was used to test the hypothesis, 2a. The other items were analyzed to determine how many neurosis-supporting statements were endorsed. The chi-square statistic was used to test the difference between the agreement and the disagreement for each of these items. A summary of the responses and the chi-square analyses are given in Table 5.

Table 5

Chi-square Analyses: Religious Belief as a Neurosis
Percentages and Frequencies Shown

SD = Strongly Disagree D = Disagree U = Uncertain
A = Agree SA = Strongly Agree

1.					
Detracts from intel. development					
	SD	D	U	SA	A
Total n=185	40%	38.9%	9.2%	9.2%	2.7%
	74	72	17	17	5
Full License n=79	40.5%	35.4%	6.3%	12.7%	5.1%
	32	28	5	10	4
Limited License n=104	40.4%	41.3%	10.6%	6.7%	1.0%
	42	43	11	7	1

Total: chi-square=91.523 df=1 p<.01

Full vs. Limited: chi-square=2.986 df=1 not significant

2. Self-responsibility					
	SD	D	U	SA	A
Total n=185	5.4%	22.7%	19.5%	40.5%	11.9%
	10	42	36	75	22
Full License n=79	8.9%	19.0%	19.0%	41.8%	11.4%
	7	15	15	33	9
Limited License n=104	2.9%	25.0%	19.2%	40.4%	12.5%
	3	26	20	42	13

Total: chi-square=32.752 df=1 p<.01

Full vs. Limited: chi-square=.016 df=1 not significant

Table 5--Continued

Chi-square Analyses: Religious Belief as a Neurosis

3. Avoid reality	SD	D	U	A	SA
Total n=183	23.0%	39.9%	15.3%	19.1%	2.7%
	42	73	28	35	5
Full License n=78	26.9%	35.9%	11.5%	19.2%	6.4%
	21	28	9	15	5
Limited License n=103	20.4%	43.7%	18.4%	17.5%	
	21	45	19	18	
Total: chi-square=36.29 df=1 p<.01					
Full vs. Limited: chi-square=.789 df=1 not significant					

4. Prevents change	SD	D	U	A	SA
Total n=184	14.7%	35.3%	12.0%	34.2%	3.8%
	27	65	22	63	7
Full License n=78	14.1%	30.8%	15.4%	35.9%	3.8%
	11	24	12	28	3
Limited License n=104	15.4%	39.4%	9.6%	32.7%	2.9%
	16	41	10	34	3
Total: chi-square=2.99 df=1 not significant					
Full vs. Limited: chi-square=.633 df=1 not significant					

Table 5--Continued

Chi-square Analyses: Religious Belief as a Neurosis

5. Provides moral base	SD	D	U	A	SA
Total n=183	6.0%	36.1%	19.1%	34.4%	4.4%
	11	66	35	63	8
Full License n=78	7.7%	25.6%	17.9%	39.7%	9.0%
	6	20	14	31	7
Limited License n=103	4.9%	43.7%	19.4%	31.1%	1.0%
	5	45	20	32	1

Total: chi-square=.243 df=1 not significant

Full vs. Limited: chi-square=4.810 df=1 not significant

6. Is a neurosis	SD	D	U	A	SA
Total n=185	45.9%	41.1%	9.2%	2.2%	1.6%
	85	76	17	4	3
Full License n=78	48.7%	30.8%	14.1%	2.6%	3.8%
	38	24	11	2	3
Limited License n=105	43.8%	48.6%	5.7%	1.9%	0.0
	46	51	6	2	

Total: chi-square=141.167 df=1 p<.01

Full vs. Limited: chi-square=1.737 df=1 not significant

Hypothesis 2a is rejected on the basis of the neurosis summary statement, RITSF #6. It cannot be said that licensed psychologists consider religious belief a neurosis. The finding indicates that the obtained chi-square value is significant at the .01 level. Three of the five neurosis subgroup items were rejected at a .01 significance level. Hypothesis 2b is retained. The probability is less than one per cent that there is a difference between the two groups in this respect. Both levels do not consider religious belief a neurosis.

Utility of Religious Belief in Therapy

Null Hypothesis 3a and 3b

3a. Licensed psychologists do not find religious belief useful to psychotherapy.

3b. There is no difference between fully and limited licensed psychologists in this respect.

The hypotheses were tested with a chi-square analysis of the responses to the subgroup of RITSF items concerning the utility of religious belief for psychotherapy. These five items state that (#7) religious belief helps control expressions of personal disorders, (#9) aids in integrating people with society, (#10) changes one's perceptions of circumstances, (#11) promotes a sense of helplessness (stated in a negative direction), and (#12) fosters high self-esteem. Responses are given in Table 6.

Table 6

Chi-square Analyses: Utility of Religious Belief
Percentages and Frequencies Shown

S D = Strongly Disagree D = Disagree U = Uncertain
S A = Strongly Agree A = Agree

7. Helps control					
	SD	D	U	A	SA
Total n=182	6.0%	25.3%	27.5%	37.9%	3.3%
	11	46	50	69	6
Full License n=77	5.2%	20.8%	27.3%	42.9%	3.9%
	4	16	21	33	3
Limited License n=103	6.8%	29.1%	26.2%	35.0%	2.9%
	7	30	27	36	3

Total: chi-square=2.455 df=1 not significant

Full vs. Limited: chi-square=1.713 df=1 not significant

9. Integrates people					
	SD	D	U	A	SA
Total n=181	1.1%	9.4%	16.6%	61.9%	11.0%
	2	17	30	112	20
Full License n=75	2.7%	6.7%	16.0%	62.7%	12.0%
	2	5	12	47	9
Limited License n=104	00.0%	10.6%	16.3%	62.5%	10.6%
		11	17	65	11

Total: chi-square=84.562 df=1 $p < .01$

Full vs. Limited: chi-square=.001 df=1 not significant

Table 6--Continued

Chi-square Analyses: Utility of Religious Belief

10. Changes percep- tions	SD	D	U	A	SA
Total n=181	0.6%	7.2%	21.0%	61.3%	9.9%
	1	13	38	111	18
Full License n=76	1.3%	2.6%	18.4%	61.8%	15.8%
	1	2	14	47	12
Limited License n=103	00.0%	10.7%	22.3%	61.2%	5.8%
		11	23	63	6

Total: chi-square=92.483 df=1 p<.01

Full vs. Limited: chi-square=2.199 df=1 not significant

11. Promotes Helpless- ness	SD	D	U	A	SA
Total n=180	17.8%	55.6%	13.9%	12.2%	.6%
	32	100	25	22	1
Full License n=77	23.4%	42.9%	16.9%	15.6%	1.3%
	18	33	13	12	1
Limited License n=192	13.9%	66.3%	9.9%	9.9%	00.0%
	14	67	100	10	1

Total: chi-square=76.652 df=1 p<.01

Full vs. Limited chi-square=1.433 df=1 not significant

Table 6--Continued

Chi-square Analyses: Utility of Religious Belief

12. High self- esteem	SD	D	U	A	SA
Total n=180	1.1%	23.3%	28.3%	40.6%	6.7%
	2	42	51	73	12
Full n=76	2.6%	14.5%	31.6%	46.1%	5.3%
	2	11	24	35	4
Limited License n=102	00.0%	29.4%	25.5%	37.3%	7.8%
		30	26	38	8

Total: chi-square=13.031 df=1 $p < .01$

Full vs. Limited: chi-square=2.287 df=1 not significant

The chi-square statistic for significant differences, with a probability of less than .01, was used to test the differences between the agreement and disagreement of the total respondents on the items in table 6. This statistical procedure was used to test the difference in the kind of responses (agreement vs. disagreement) given by the two levels of license. Null hypothesis 3a was rejected. Psychologists as a group agreed with four of the five items endorsing the usefulness of religious belief for therapy. There is a one per cent probability that the observed proportion of agreement was due to chance alone. Null hypothesis 3b was retained: There is no difference between the two license levels in finding religious belief useful

to therapy. The probability is less than one per cent that there is a true difference in the proportion of their responses.

Relevance of Religious Issues to Therapy

Null Hypothesis 4a and 4b

4a. Licensed psychologists do not consider religious issues relevant to psychotherapy.

4b. There is no difference between the two levels of licenses in this respect.

The hypotheses were tested by the responses to the RITSF subgroup concerning attitudes toward religious issues in psychotherapy. These five items state that (#9) religious belief is too subjective, (#13) is very relevant, (#14) helping strengthen spiritual expressions is a legitimate goal, (#15) introducing religious issues is unethical, and (#17) referral is the best way to handle religious issues. The responses are given in Table 7.

Null hypothesis 4a is retained on the basis of the responses to #13, the relevance summary statement. There is no significant difference in the proportion of responses that agree or disagree with this item. This is true also for # 17 in regard to referral. Both of these items show over 20% uncertainty. The other three items show a significant difference in the proportion that agrees with relevance-supporting statements. A significantly larger

proportion of licensed psychologists disagree that religious belief is too subjective for therapy, or that it is unethical to introduce religious issues, and agree that strengthening spiritual expressions is a legitimate goal. Null hypothesis 4b is also retained. The probability is less than one per cent that there is a difference between the proportion of the responses of the two groups in this respect.

Table 7

Chi-square Analyses:
Attitude Toward Relevance of Religious Issues to Therapy

SD = Strongly Disagree D = Disagree U = Uncertain
A = Agree S A = Strongly Agree

9. Too subjective	SD	D	U	A	SA
Total n=181	19.9%	56.9%	10.5%	10.5%	2.2%
	36	103	19	19	4
Full License n=76	23.7%	55.3%	7.9%	10.5%	2.6%
	18	42	6	8	2
Limited License n=103	17.5%	58.3%	12.6%	10.7%	1.0%
	18	60	13	11	1

Total: chi-square=83.061 df=1 $p < .01$

Full vs. Limited: chi-square=.003 df=1 not significant

Table 7--Continued

Chi-square Analyses:
Attitude Toward Relevance of Religious Issues to Therapy

13. Very Relevant	SD	D	U	A	SA
Total n=182	8.2%	24.2%	20.3%	35.7%	11.5%
	15	44	37	65	21
Full License n=76	10.5%	21.1%	18.4%	39.5%	10.5%
	8	16	14	30	8
Limited License n=104	5.8%	26.9%	22.1%	32.7%	12.5%
	6	28	23	34	13

Total: chi-square=5.028 df=1 not significant

Full vs. Limited: chi-square=.05 not significant

14. Legitimate goal	SD	D	U	A	SA
Total n=183	10.4%	21.9%	15.3%	43.7%	8.7%
	19	40	28	80	16
Full License n=77	14.3%	20.8%	14.3%	44.2%	6.5%
	11	16	11	34	5
Limited License n=104	7.7%	22.1%	15.4%	44.2%	10.6%
	8	23	16	46	11

Total: chi-square=8.832 df=1 $p < .01$

Full vs. Limited: chi-square=.305 df=1 not significant

Table 7--Continued

Chi-square Analyses:
Attitude Toward Relevance of Religious Issues to Therapy

15. Unethical	SD	D	U	A	SA
Total n=182	12.1%	41.8%	19.2%	17.6%	9.3%
	22	76	35	32	17
Full License n=76	11.8%	36.8%	22.4%	14.5%	14.5%
	9	28	17	11	11
Limited License n=104	12.5%	44.2%	17.3%	20.2%	5.8%
	13	46	18	21	6

Total: chi-square=16.333 df=1 p<.01

Full vs. Limited: chi-square=.312 df=1 not significant

17. Refer	SD	D	U	A	SA
Total n=182	6.6%	37.9%	24.2%	27.5%	3.8%
	12	69	44	50	7
Full License n=76	10.5%	31.6%	26.3%	28.9%	2.6%
	8	24	20	22	2
Limited License n=104	3.8%	42.3%	23.1%	26.9%	3.8%
	4	44	24	28	4

Total: chi-square=4.174 df=1 not significant

Full vs. Limited: chi-square=.024 df=1 not significant

Competence With Spiritual/Religious Issues in Therapy

Null Hypothesis 5a and 5b

5a. It cannot be said that licensed psychologists perceive themselves competent to address religious issues in psychotherapy.

5b. There is no difference between the two levels of licenses in this respect.

RITSF question #16 states, "Counseling clients on religious issues is within my therapeutic competence". Responses are given in Table 8.

Table 8

Chi-square Analysis:
Therapeutic Competence With Religious Issues
Percentages and Frequencies Shown

SD = Strongly Disagree D = Disagree U = Uncertain
A = Agree SA = Strongly Agree

	SD	D	U	A	SA
Total n=182	11.1%	31.1%	15.0%	33.9%	8.9%
	20	56	27	61	16
Full License n=76	15.8%	30.3%	13.2%	31.6%	9.2%
	12	23	10	24	7
Limited License n=102	6.9%	32.4%	16.7%	35.3%	8.8%
	7	33	17	36	9

Total: chi-square=0.007 df=1 not significant
Full vs. Limited: chi-square=.318 df=1 not significant

The chi-square test for significant differences with a probability of less than .01 was used to test the differences between the agreement and disagreement for this item. It was also used to test the differences in the kind of response given by the two levels of licenses. Null hypothesis 5a could not be rejected. The proportion of licensed psychologists who disagreed that counseling clients on religious issues was within their therapeutic competence ~~was~~ not significantly greater than those who agreed, with a one per cent probability that this was due to chance alone. Null hypothesis 5b also cannot be rejected. There is no significant difference between the proportion of the fully licensed who disagree and the limited licensed who disagree nor between the proportions who agree.

Related Training and Supervision

Null Hypothesis 6a and 6b

6a. It cannot be said that licensed psychologists do not receive help in addressing spiritual/religious issues during their academic training and professional supervision.

6b. There is no difference between the two license levels in this respect.

Chi-square analysis was used to test the differences between the proportion who agreed that they received help

and the proportion who disagreed. It was also used to test the difference between the kind of responses made by the two license levels. The responses and the results of the chi-square analyses are given in Table 9.

Table 9

Chi-square Analysis: Help During Training and Supervision

SD = Strongly Disagree D = Disagree U = Uncertain
A = Agree SA = Strongly Agree

	SD	D	U	A	SA
Total n=187	33.7% 63	45.5% 85	4.3% 8	14.4% 27	2.1% 4
Full License n=80	40.0% 32	38.8% 31	5.05 4	15.0% 12	1.3% 1
Limited License n=105	28.6% 30	50.5% 53	3.8% 4	14.3% 15	2.9% 3

Total: chi square=76.475 df=1 p<.01

Full vs. Limited: chi square=.005 not significant

Null hypothesis 6a was rejected. The proportion of psychologists who disagreed that they received help was significantly greater than those who agreed. The probability that this difference occurred by chance is less than one per cent. Null hypothesis 6b cannot be rejected. There is no significant difference between the agreement responses and the disagreement responses. There is less than one per cent probability that no

significant difference occurred by chance.

Subsidiary Analysis

Relationships

Since responses were not normally distributed and crosstabulation cells were less than five, relationship of responses was determined in the following way: After crosstabulation on an SPSSx program, a chi-square statistic was performed to test for independence among the combined strongly disagree/disagree and the strongly agree/agree cells. This was done to determine if the observed frequencies were significantly different from what would be expected if the variables were independent, at a significance level of .01.

The following relationships were tested:

1. Considering oneself deeply religious and considering religious belief relevant to therapy.

The 2x2 corrected chi-square was 53.23. The probability is less than one per cent that these combinations of responses would have occurred if they were independent.

2. Considering oneself deeply religious and considering oneself competent to address religious issues.

The 2x2 corrected chi-square was 30.765. The probability is less than one per cent that these combinations of responses would have occurred if they were independent of each other.

3. Considering oneself competent to address religious issues and having had help to do so during training and supervision.

The 2x2 corrected chi-square was 1.338. The value is not large enough to indicate a significant relationship between the variables. No other noteworthy relationships were found between the independent variables (age, gender, years of practice, primary occupation, theoretical preference, spiritual orientation, influence of psychological studies, rejection of childhood faith, unresolved conflict, and importance of beliefs) and the dependent variables (view of religious belief, attitude toward the usefulness and the relevance of religious belief to therapy, perceived competence in addressing related issues, and perception of clients' desires to discuss these issues). This was true even at a .05 level of significance.

In addition, no relationship was found between theoretical preference or spiritual orientation and the following variables: influence of psychological studies, unresolved conflict, and rejection of childhood faith.

Other Results

To the statement "My spiritual and/or philosophical beliefs are important in my life", 93% of the total sample agreed. Broken down into the two groups, 92.6% fully

licensed and 93.3% limited licensed psychologists agreed. To the statement "I consider myself deeply religious," about 38% of the total sample as well as both license levels agreed; about 10% were uncertain. What was noteworthy was that the strong agreement was about twice as much for the fully licensed as for the limited licensed. Licensed psychologists were equally divided on whether their psychological studies have influenced their present spiritual orientation with about 10% uncertain. Slightly over 60% disagreed that they had rejected their childhood faith. Sixty-three per cent disagreed that they had unresolved spiritual/religious conflict. Ninety-three per cent agreed that their spiritual and /or philosophical beliefs were important in their lives--55% of this was strong agreement.

Requests for Results and Comments

From the total sample 43 (21%) requested the results of the survey, 13 (15%) of whom were fully licensed and 30 (27%) limited licensed. Comments were made by 64 (33%) in the total sample, 29 (33%) fully and 35 (32%) limited licensed. Out of the 64 who commented, 31 qualified their answers to the Likert scale items with "sometimes" or "depends." Thirteen commented that the complexity of the subject made answering difficult to impossible on a five-point scale and seven of these did not complete the

form. Six noted that their philosophical, not spiritual, beliefs were important; three, that spiritual should be differentiated from religious.

Most comments were favorably disposed to the subject of addressing religious issues in therapy:

"Long overdue research..."

"Therapy itself is a spiritual issue..."

"The question is not whether to address them but when to address them."

"I believe issues of religious values and belief are important and overlooked."

"I appreciate your raising these important issues."

"Religion like any other material is 'meat for the grinder', open to analysis and understanding."

"Thank you for your provocative questionnaire on spiritual and religious issues in therapy."

"I believe a primary goal of therapy is often to have the individual sort out and develop his/her own personal religious/spiritual meaning to life."

"Good and needed area of study".

CHAPTER V

SUMMARY, DISCUSSION, AND RECOMMENDATIONS

This chapter will restate the purpose of the study and the problem that was addressed. The data will be summarized and discussed. Recommendations will then be presented.

Summary of Problem and Purpose of Study

The problem of this study concerns addressing spiritual/religious issues in psychotherapy. There is concern that such issues are neglected (Bergin, 1980a; Natale, 1985; Russo, 1984) for various possible reasons: therapists' personal bias and conflicts, incompatible beliefs, fear of existential issues, or inadequate training, education, and knowledge. The importance of this study is based on (1) a Gallup report (1985) that found 95% of the general population have religious beliefs and (2) the implications of this for treatment if the training and education of licensed psychologists do not address the impact of religious beliefs.

The study involved examining licensed psychologists in Michigan, as a group and according to level of license, to determine (1) their personal spiritual orientation, (2)

their view of religious belief as a neurosis, (3) their view of the usefulness of religious belief for therapy, (4) their attitudes toward addressing religious issues in therapy, (5) their sense of competence in dealing with these issues, and (6) how much help they had received in addressing spiritual/religious issues during their training and supervision. The purpose of the study was to discover whether there was evidence for advocating training and education in understanding and addressing spiritual/religious issues in psychotherapy. In addition, the research process was to provide information for recommendations for further research.

Discussion of Results

The image of the psychologist as an atheist who considers religious belief a neurosis is an outdated one. In this sample, atheists are rare, about 1%, among limited licensed psychologists and about 9% among fully licensed psychologists. Their responses indicate their spiritual/philosophical beliefs are very important to them (about 93% in both groups), and 38% of each group consider themselves deeply religious. There is less traditional belief among the fully licensed. This was a significant difference found between the two license levels in this respect. This variable (spiritual orientation), however, had no relationship with the dependent variables regarding

religious belief and addressing religious issues in therapy, nor with considering oneself deeply religious. There were other significant differences in the independent variables of age, experience, gender, and education--the fully licensed in the sample have more education, have a larger proportion of males to females, and, on the average, are older and more experienced. These differences had no discernible effects on the attitudes of the two license levels. This would support the conclusions of the Henry, Sims, and Spray study (1971) that despite differences among therapists, their similarities were striking. This could indicate the presence of a personality or value factor characteristic of the licensed psychologist.

The Henry et al. study (1971) also found that the psychologist placed the highest value on knowledge and understanding. This may be the basis for agnosticism among the fully licensed. The agnostic stance could range from arrogant disdain of belief in something that cannot be scientifically proven to a humble awe of how relatively little is known. However, no relationship was found between spiritual orientation and attitude toward religious belief or relevance of religious issues to therapy.

There is strong agreement that religious belief is not a neurosis (87%). There is more agreement than disagreement that it can be useful for therapy and has relevance but there is also, in some instances, over 20%

uncertainty. What is of greater significance and implication for professional practice is that less than 43% of the total sample have a sense of competence in dealing with religious issues. This item of competence brought a different response emphasis from the two license levels, even though there was no significant difference between the combined agreement responses and the combined disagreement responses. Of the 46% fully licensed who disagreed they were competent, 30% was "Disagree" and 16% was "Strongly Disagree." For the limited licensed 32% of the 39% disagreement was "Disagree;" 7% was "Strongly Disagree." The responses of the fully licensed showed a similar trend for the item regarding help during training and supervision: Over half of the disagreement (that help in addressing spiritual/religious issues had been received) was "Strongly Disagree." This more intense response may be due to the possibility that fully licensed psychologists, with doctoral degrees, think they should be knowledgeable--they have over twice as much training and education as the limited licensed psychologists. The high response rate and the nature of the responses indicate an interest in the subject.

It is possible that those who marked "uncertain" were uncertain about the interpretation of the questionnaire item and there were comments to that effect. Uncertainty could also include lack of clear understanding of one's

own thoughts and feelings or uncertainty of how one "should" feel as a good, intelligent licensed psychologist. Validity is a problem both in the subject matter of spiritual/religious concerns as well as in the measurement of attitudes. The results of a study with both of these problems present are, therefore, questionable.

The return rate of 72% leaves 28% not accounted for. It has been suggested that no-return responses are similar to the last group of responses received. The last 10% were less interested as measured by number of comments and requests for results, but the pattern of answers was as mixed at the end as it was at the beginning.

No relationship was found between the dependent variables (attitude toward religious belief, toward relevance of religious issues to therapy, and competence in addressing religious issues) and the preliminary questions (the influence of psychological studies on spiritual orientation, the rejection of childhood faith, unresolved spiritual/religious conflict, importance of beliefs) and the demographic variables (gender, age, spiritual orientation, theoretical preference, experience, and degree). This does not mean that there is no relationship. It does mean that as defined, understood, responded to, and measured, there was no relationship.

The one variable, that did show a positive relationship to considering religious issues relevant to therapy

and to considering oneself competent to address these issues, was considering oneself deeply religious. This affirmed results of other studies (Kivley, 1986; Nix, 1978; and Shafranske & Gorsuch, 1984), i.e., if therapists find religion/spirituality relevant in their own lives they will find it relevant to therapy.

Conclusion and Recommendations

Less than half of the licensed psychologists in the sample considered themselves competent to address religious issues in therapy; a strong majority (79%) disagreed that they had received help during training and supervision in addressing these issues. This raises the question as to whether the training and education of licensed psychologists are adequate preparation to treat clients, 95% of whom profess a belief in God, according to Gallup (1985).

This was an exploratory study, not designed to measure competence nor training and education related to addressing spiritual/religious issues in therapy. Therefore, recommendation for further research include:

1. Additional studies with larger sample sizes and a wider geographical range are needed to verify present findings.
2. Related attitude measurement needs to be developed and studied.

3. Studies are needed to address the nature and extent of related competence and lack of competence.

4. Studies are needed to investigate the kind of basic information, knowledge, and training that is necessary for therapists to consider themselves competent to address spiritual/religious issues in therapy.

5. Studies are needed to address the definitions of words, terms, and concepts relating to spiritual/religious issues to assist in the validity of scholarly communication and research in this area.

6. Studies are recommended to investigate attitudes and views of curriculum committees, instructors, and supervisors regarding spiritual/religious matters and their relation to education and training of licensed psychologists.

7. The spiritual/religious concerns of clients need to be studied.

Studies involving interviews of academicians, practitioners, students, and clients would be valuable to define and shed light on what may be a complex, multidimensional problem. Without more specific information studies may lack validity and contribute little toward resolution or solution of the problem studied.

APPENDIX A
QUESTIONNAIRE

PRELIMINARY QUESTIONS TO RELIGIOUS ISSUES IN THERAPY SURVEY

Please CHECK or FILL IN the answers that apply to you

1. Age: _____
2. Sex:
 _____ 1. Male
 _____ 2. Female
3. Highest Degree Completed:
 _____ 1. Bachelor's
 _____ 2. Master's
 _____ 3. Ph. D.
 _____ 4. Ed. D.
 _____ 5. Psy. D.
 _____ 6. Other (specify):
4. How Many Years of Psychotherapy Practice?
 _____ 1. Yrs. Full Time (35 hrs. or more per week)
 _____ 2. Yrs. Part Time
5. Primary professional occupation:
 _____ 1. Academician
 _____ 2. Practitioner
 _____ 3. Other (specify):
6. Theoretical Preference:
 _____ 1. Behavioral
 _____ 2. Psychodynamic (Freudian)
 _____ 3. Psychodynamic (Other)
 _____ 4. Humanistic
 _____ 5. Eclectic
 _____ 6. Other (specify):
7. Spiritual/Religious Orientation:
 _____ 1. Jewish
 _____ 2. Catholic
 _____ 3. Protestant
 _____ 4. Nontraditional
 _____ 5. Agnostic
 _____ 6. Atheistic
 _____ 7. Other (specify):

CIRCLE the following statements that come closest to your level of agreement

SD = Strongly Disagree D = Disagree U = Uncertain A = Agree SA = Strongly Agree

8. My psychological studies have influenced my present spiritual/religious orientation SD D U A SA
9. I have rejected my childhood religious faith SD D U A SA
10. I perceive unresolved spiritual/religious conflict within myself SD D U A SA
11. My spiritual and/or philosophical beliefs are important in my life SD D U A SA
12. In my academic training and professional supervision I was helped to address spiritual/religious issues in therapy SD D U A SA

PLEASE TURN PAPER OVER AND CONTINUE ON OTHER SIDE

RELIGIOUS ISSUES IN THERAPY SURVEY FORM

76

CIRCLE the following statements that come closest to your level of agreement

SD = Strongly Disagree D = Disagree U = Uncertain A = Agree SA = Strongly Agree

- | | | | | | |
|--|----|---|---|---|----|
| 1. Religious belief tends to detract from one's intellectual development | SD | D | U | A | SA |
| 2. Religious belief tends to encourage self-responsibility | SD | D | U | A | SA |
| 3. Religious belief tends to be a way of avoiding reality | SD | D | U | A | SA |
| 4. Religious belief often prevents people from making effective attempts at changing themselves or their environment | SD | D | U | A | SA |
| 5. Religious belief provides a moral base for those who would rather not establish moral guidelines themselves | SD | D | U | A | SA |
| 6. Religious belief is a neurosis | SD | D | U | A | SA |
| 7. Religious belief helps control expressions of personal disorders . . | SD | D | U | A | SA |
| 8. Religious belief is too subjective to be useful in therapy | SD | D | U | A | SA |
| 9. Religious belief aids in integrating people with their society | SD | D | U | A | SA |
| 10. Religious activities effectively change one's perceptions of circumstances | SD | D | U | A | SA |
| 11. Religious belief promotes a sense of helplessness | SD | D | U | A | SA |
| 12. Religious belief tends to foster high self-esteem | SD | D | U | A | SA |
| 13. Religious belief is very relevant to the therapy process | SD | D | U | A | SA |
| 14. Helping clients strengthen spiritual expressions is a legitimate goal for therapy | SD | D | U | A | SA |
| 15. Therapists who introduce religious issues into therapy are acting unethically | SD | D | U | A | SA |
| 16. Counseling clients on religious issues is within my therapeutic competence | SD | D | U | A | SA |
| 17. Referral to clergy is usually the best way to handle any religious issue | SD | D | U | A | SA |
| 18. Few clients wish to discuss their religious beliefs | SD | D | U | A | SA |
| 19. I consider myself deeply religious | SD | D | U | A | SA |

APPENDIX B
LETTER OF PERMISSION

2407 Stoner Dr. East
Charleston, IL 61920

December 10, 1987

Mrs. Suzanne Brennan
650 N. Kalamazoo St.
Paw Paw, MI 49079

Dear Mrs. Brennan,

You now have my written permission to use my instrument which appeared in Journal of Psychology and Christianity (vol. 5, no. 3).

Sincerely,



Lowell R. Kivley

APPENDIX C

LETTER FROM HUMAN SUBJECTS INSTITUTIONAL REVIEW BOARD



*Human Subjects
Institutional Review Board*

TO: Suzanne L. Brennan
FROM: Ellen Page-Robin, Chair *EP-R*
RE: Research Protocol
DATE: September 18, 1987

This letter will serve as confirmation that your research protocol, "Dissertation for Ed.D., Counseling Psychology: Some Factors Affecting Therapists Attitudes Toward Addressing Spiritual/Religious Issues in Therapy," has been signed off as exempt by the HSIRB.

If you have any further questions, please contact me at 383-4917.

APPENDIX D
INITIAL COVER LETTER



Western Michigan University
Kalamazoo, Michigan 49008-3899

*Department of
Counselor Education and
Counseling Psychology
(616) 383-1975*

650 N. Kalamazoo St.
Paw Paw, MI 49079
January 1, 1988

Dear fellow psychologist,

Addressing spiritual/religious issues in therapy is controversial. More information is needed from practicing psychologists themselves on this complex subject. The enclosed questionnaire is part of a study to determine some factors involved. You have been selected as one of a small group to represent the viewpoint of fully (regular) licensed and limited licensed psychologists in Michigan.

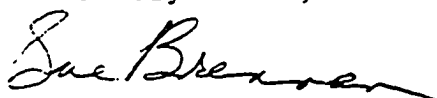
The enclosed questionnaire was designed to be completed in little time to enable you to complete it quickly and return it in the stamped, self-addressed envelope.

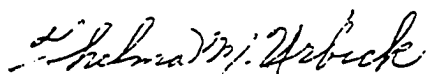
Confidentiality will be maintained by clipping the number on the questionnaire as it is recorded (for analysis of or follow-up letters to those who do not respond).

Since you were randomly selected your response is very important. If you do not intend to respond please send the form back anyway. It would be helpful to indicate your reason, such as "too busy", "annoying", etc.

If interested in the results, indicate this on a slip of paper with your name and address.

Sincerely Yours,


Sue Brennan, M.A.



Thelma M. Urbick, Ph.D.
Doctoral Committee Chairperson

~~SECRET~~

APPENDIX E
FOLLOW-UP CARD

***** REMINDER *****

1/15/88

Recently you were sent a RELIGIOUS ISSUES IN THERAPY
SURVEY FORM.

Your response is very important to this study.

A prompt return will be appreciated!

Please call me collect if you need another form.

Phone: (616) 657-5022 Sue Brennan, M.A.
650 N. Kalamazoo St.
Paw Paw, MI 49079

Disregard this if response is in the mail & Thank you!

APPENDIX F
FOLLOW-UP LETTER

Department of
Counselor Education and
Counseling Psychology
(616) 383-1975

650 N. Kalamazoo St.
Paw Paw, MI 49079
January 28, 1988

Dear fellow psychologist,

In the past few weeks you were mailed a RELIGIOUS ISSUES IN THERAPY SURVEY FORM. To this date your response is missing. If your response crossed this in the mail or if you tore off the code number, please disregard this and we thank you for your cooperation.

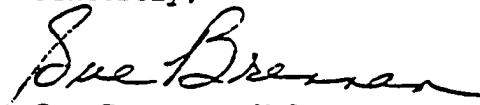
As one of a small group of randomly selected members of Michigan licensed psychologists your completed questionnaire is extremely important for the accuracy of the results. If, for some reason, you are unwilling or unable to respond indicate this on the questionnaire and return it at this time. Another questionnaire and stamped, return envelope are enclosed for your convenience.

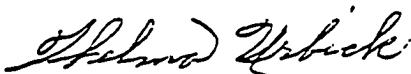
Responses are confidential and unidentified as to name. The code number is used only for follow-up and to determine demographics of those who do not respond, e.g., kind of license, geographic area.

If you would like a copy of the results, enclose your name and address on a slip of paper. (You could use the back of this letter.)

Now, please take a few minutes to return the questionnaire. Any comments will be helpful and appreciated. Thank you.

Sincerely,


Sue Brennan, M.A.



Thelma M. Urbick, Ph.D.
Doctoral Committee Chairperson

APPENDIX G
QUESTIONNAIRE FREQUENCIES AND PERCENTAGES

QUESTIONNAIRE
FREQUENCIES AND PERCENTAGES
 (rounded out)

<u>LICENSE</u>		
Full	87	43%
Limited	111	54%
Unknown	4	2%
<u>AGE</u>		
Range	29 to 77	
Mean	45	n=188
Std. Dev.	10.069	
<u>SEX</u>		
Male	133	67%
Female	67	33%
Unknown	2	
<u>HIGHEST DEGREE COMPLETED</u>		
Master's	84	44%
Ph.D	80	42%
Ed.D	14	7%
Psy.D.	4	2%
Other	10	5%
<u>YEARS OF FULL TIME PRACTICE</u>		
0	39	21%
1-4	26	14%
5-9	43	23%
10-14	39	21%
15-20	26	14%
20-40	20	11%
Unknown	4	2%
<u>YEARS OF PART TIME PRACTICE</u>		
0	98	53%
1-4	31	16%
5-9	25	13%
10-14	14	7%
15-20	8	4%
21-39	7	5%
Unknown	4	2%
<u>PRIMARY PROFESSIONAL OCCUPATION</u>		
Academician	13	6%
Practitioner	163	85%
Other	12	6%
Checked 1 & 2	3	
Unknown	11	2%

THEORETICAL PREFERENCE

Behavioral	17	9%
Psychodynamic (Freudian)	22	12%
Psychodynamic (Other)	25	13%
Humanistic	20	11%
Eclectic	93	49%
Other	13	7%
Unknown	12	

SPIRITUAL ORIENTATION

Jewish	24	13%
Catholic	38	20%
Protestant	70	38%
Nontraditional	16	9%
Agnostic	21	11%
Atheistic	8	4%
Other	9	5%
Unknown	16	

PSYCHOLOGICAL STUDIES INFLUENCED PRESENT SPIRITUAL/RELIGIOUS ORIENTATION

Strongly Disagree	31	16%	
Disagree	53	28%	44% Disagree
Uncertain	18	10%	
Agree	62	33%	
Strongly Agree	23	12%	45% Agree
No Answer	15		

REJECTED CHILDHOOD RELIGIOUS FAITH

Strongly Disagree	47	25%	
Disagree	66	36%	61% Disagree
Uncertain	7	4%	
Agree	43	23%	
Strongly Agree	22	12%	35% Agree
No Answer	17		

HAVE UNRESOLVED SPIRITUAL/RELIGIOUS CONFLICT

Strongly Disagree	47	25%	
Disagree	71	38%	63% Disagree
Uncertain	17	9%	
Agree	50	27%	
Strongly Agree	2	1%	28% Agree
No Answer	17		

OWN SPIRITUAL/PHILOSOPHICAL BELIEFS ARE IMPORTANT

Strongly Disagree	2	1%	
Disagree	7	4%	5% Disagree
Uncertain	4	2%	
Agree	70	38%	
Strongly Agree	103	55%	93% Agree
No Answer	16		

DURING TRAINING AND SUPERVISION RECEIVED HELP ADDRESSING
SPIRITUAL/RELIGIOUS ISSUES IN THERAPY

Strongly Disagree	63	34%	
Disagree	85	46%	80% Disagree
Uncertain	8	4%	
Agree	27	14%	
Strongly Agree	4	2%	16% Agree
No Answer	15		

RELIGIOUS BELIEF DETRACTS FROM INTELLECTUAL DEVELOPMENT

Strongly Disagree	74	40%	
Disagree	72	39%	79% Disagree
Uncertain	17	9%	
Agree	5	9%	
Strongly Agree	17	3%	12% Agree
No Answer	8		

RELIGIOUS BELIEF ENCOURAGES SELF-RESPONSIBILITY

Strongly Disagree	10	5%	
Disagree	42	23%	28% Disagree
Uncertain	36	20%	
Agree	75	41%	
Strongly Agree	22	12%	53% Agree
No Answer	17		

RELIGIOUS BELIEF IS A WAY OF AVOIDING REALITY

Strongly Disagree	42	23%	
Disagree	73	40%	63% Disagree
Uncertain	28	15%	
Agree	35	19%	
Strongly Agree	5	3%	22% Agree
No Answer	19		

RELIGIOUS BELIEF PREVENTS ATTEMPTS TO MAKE EFFECTIVE
CHANGE

Strongly Disagree	27	15%	
Disagree	65	35%	50% Disagree
Uncertain	22	12%	
Agree	63	34%	
Strongly Agree	7	3%	37% Agree
No Answer	18		

RELIGIOUS BELIEF PROVIDES A MORAL BASE FOR THOSE WHO DO
NOT WANT TO PROVIDE THEIR OWN

Strongly Disagree	11	6%	
Disagree	66	36%	42% Disagree
Uncertain	35	19%	
Agree	63	34%	
Strongly Agree	8	4%	38% Agree
No Answer	19		

RELIGIOUS BELIEF IS A NEUROSIS

Strongly Disagree	85	46%	
Disagree	76	41%	87% Disagree
Uncertain	17	9%	
Agree	4	2%	
Strongly Agree	3	2%	4% Agree
No Answer	17		

RELIGIOUS BELIEF CONTROLS EXPRESSIONS OF DISORDERS

Strongly Disagree	11	6%	
Disagree	46	25%	31% Disagree
Uncertain	50	28%	
Agree	69	38%	
Strongly Agree	6	3%	41% Agree
No Answer	20		

RELIGIOUS BELIEF IS TOO SUBJECTIVE TO BE USEFUL IN THERAPY

Strongly Disagree	36	20%	
Disagree	103	57%	77% Disagree
Uncertain	19	11%	
Agree	19	11%	
Strongly Agree	4	2%	13% Agree
No Answer	21		

RELIGIOUS BELIEF HELPS INTEGRATE PEOPLE WITH SOCIETY

Strongly Disagree	2	1%	
Disagree	17	9%	10% Disagree
Uncertain	30	17%	
Agree	112	61%	
Strongly Agree	20	11%	72% Agree
No Answer	21		

RELIGIOUS ACTIVITY EFFECTIVELY CHANGES ONE'S PERCEPTIONS OF CIRCUMSTANCES

Strongly Disagree	1		
Disagree	13	7%	7% Disagree
Uncertain	38	21%	
Agree	111	63%	
Strongly Agree	18	10%	73% Agree
No Answer	21		

RELIGIOUS BELIEF PROMOTES A SENSE OF HELPLESSNESS

Strongly Disagree	32	18%	
Disagree	100	56%	74% Disagree
Uncertain	25	14%	
Agree	22	12%	
Strongly Agree	1		12% Agree
No Answer	22		

RELIGIOUS BELIEF FOSTERS HIGH SELF-ESTEEM

Strongly Disagree	2	1%	
Disagree	42	23%	24% Disagree
Uncertain	51	28%	
Agree	73	41%	
Strongly Agree	12	7%	48% Agree
No Answer	22		

RELIGIOUS BELIEF IS RELEVANT TO THE THERAPY PROCESS

Strongly Disagree	15	8%	
Disagree	44	24%	32% Disagree
Uncertain	37	20%	
Agree	65	36%	
Strongly Agree	21	12%	48% Agree
No Answer	20		

STRENGTHENING SPIRITUAL EXPRESSIONS IS A LEGITIMATE GOAL FOR THERAPY

Strongly Disagree	19	10%	
Disagree	40	22%	32% Disagree
Uncertain	28	15%	
Agree	80	44%	
Strongly Agree	16	9%	53% Agree
No Answer	19		

IT IS UNETHICAL FOR A THERAPIST TO INTRODUCE RELIGIOUS ISSUES INTO THERAPY

Strongly Disagree	22	12%	
Disagree	76	42%	54% Disagree
Uncertain	35	19%	
Agree	32	18%	
Strongly Agree	17	9%	27% Agree
No Answer	20		

COUNSELING ON RELIGIOUS ISSUES IS WITHIN MY COMPETENCE

Strongly Disagree	20	11%	
Disagree	56	31%	42% Disagree
Uncertain	27	15%	
Agree	61	34%	
Strongly Agree	16	9%	43% Agree
No Answer	22		

REFERRAL IS THE BEST WAY TO HANDLE RELIGIOUS ISSUES

Strongly Disagree	12	7%	
Disagree	69	38%	45% Disagree
Uncertain	44	24%	
Agree	50	28%	
Strongly Agree	7	4%	32% Agree
No Answer	20		

FEW CLIENTS WISH TO DISCUSS THEIR RELIGIOUS BELIEFS

Strongly Disagree	11	6%	
Disagree	107	59%	65% Disagree
Uncertain	21	12%	
Agree	42	23%	
Strongly Agree	1		23% Agree
No Answer	20		

I CONSIDER MYSELF DEEPLY RELIGIOUS

Strongly Disagree	26	14%	
Disagree	68	38%	52% Disagree
Uncertain	18	10%	
Agree	51	28%	
Strongly Agree	18	10%	38% Agree
No Answer	21		

COMMENTS

Yes	66	33%
No	136	67%

REQUEST RESULTS

Yes	43	22%
No	159	77%

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