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The impact of religious values on the therapeutic process.

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THE IMPACT OF RELIGIOUS VALUES ON THE THERAPEUTIC PROCESS

A Dissertation Presented

by

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In memory of my grandparents...

To my parents...all of them gave me the foundation of my faith. Through their presence in my life I grew up to understand the real meaning of love and learned to see God through the eyes of love.

To my brothers Suso and Eduardo...with them I have shared the blessings of that same love.

To Carola...with her presence she redefined for me the concept and the experience of sisterhood. She finally taught me that love cannot be measured by time.

To my friend Sister Joanne Frey...an inspiration in my life. She has traveled with me in my journey to refine the experience of God within me.

In thanksgiving for all that I have received from God.

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What defines each individual's human nature is his/her ability to express gratitude. For everything that we are we have received from others beginning with life itself.

Many people are woven to the fabric of the thirty six years of my life. It would be almost impossible to name them all here to express my gratitude to them. I hope that if they ever read this they will know who they are. Finishing a doctoral degree is probably not the greatest accomplishment of a lifetime. However, for me eight years ago it was the reason to stay in this country.

Because of the person I am, I cannot avoid looking back and at this special time of my life retrospectively see all those faces and lives that have touched mine in so many ways. I carry them within me and for the blessing of their presence in my life I am eternally grateful. During the last ten years I have walked through a process of personal growth that has taken me to understand and truly accept the importance that religion and my values play in the composition of my being. My personal and professional experiences are probably the reason why I selected the topic of this dissertation.

Encouragement came from different directions and this is the time to acknowledge them.

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I am grateful to all those who participated in the research. Their answers not only made this project a reality but also gave me more light to continue to explore my own spirituality and if possible to help others in their own exploration too. In particular I want to acknowledge Debbie Kaegebein: her patience and support made a difference during the critical times of this process.

Without Eduardo, my brother, and Mariflor, my sister-in-law, I would not be writing this acknowledgment. Both deserve the credit of not only typing my dissertation but theirs too at during the same time. I only hope that life gives me the time to show them the way I know best -by loving them- how much they both have done for me.

At this point in time, I think of my uncle Enrique Morales Paez. He shared many of my spiritual concerns and would have enjoyed this time in my life. His memory is always present.

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I have spent countless hours thinking about Daniel Sanchez Olivieri. He is too young yet to understand the content of this research but I dream of the day when he and I will sit down to talk about it and other things. Dreams come true and I love him dearly.

ABSTRACT

THE IMPACT OF RELIGIOUS VALUES ON THE THERAPEUTIC PROCESS

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The purpose of this dissertation was to determine how therapists of different religious denominations handle the issue of their own values in the psychotherapeutic relationship when presented with hypothetical case vignettes. The major hypothesis of this study was whether therapists that scored high in religiosity on the Religious Attitude Scale would have more difficulty interpreting and handling cases than therapists who scored low. It also investigated whether those therapists that scored high in religiosity would have their values affect their interpretation of the hypothetical cases more than those low in religiosity.

Another hypothesis predicted that women high in religiosity would report experiencing more difficulties interpreting and handling the hypothetical cases than men high in religiosity.

The study was conducted using a "convenience sample" of sixty experienced psychotherapists from two mental health clinics. The participants received two instruments: eight hypothetical case vignettes describing cases with different problems and the Religious Attitude Scale.

The study results did not support any of the hypotheses postulated. Degree of religiosity did not affect participant's interpretation and handling of the hypothetical case vignettes.

These results can be explained in two ways: it seems that therapy training program have been successful in sensitizing their students in not allowing their religious values to interfere with their work. Another possible explanation could be that those programs do not train the students to use their religious values effectively in the therapeutic process.

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CHAPTER I

INTRODUCTION

The tenet that therapists must remain morally neutral and at all times nonjudgemental of the material related to them by their clients seems difficult to maintain.

Since birth all of our experiences are inscribed in our "tabula rasa" -our personality- to develop what becomes each individual's value system. Therefore, it is impossible to be neutral in a process that constantly examines values and moral principles. The fact that the therapist's attitudes and values are communicated to the client in the therapeutic process is becoming clear (Lovinger, 1978; Meadow et al., 1979; Nelson & Wilson, 1984).

The neutral or value-free therapist is a myth. Values reflect the culture, the historical time in which events take place and the differences between individual therapists (Gardfield, 1974).

Edith Weisslopf-Joelson (1980) in her article "Values: The Enfant Terrible of Psychotherapy" explained how difficult it is for therapists to accept the presence of their own value system in the therapeutic process. This resistance has forced therapists to embrace theoretical approaches such as client-centerness that will protect them from recognizing their values. Moreover, language also has changed for protection. But she explained that:

> "The therapist's appearance and clothing as well as the appearance of his/her office communicate values. Even a noncommittal "Mhm" or a Rogerian reflection might, by its timing, suggest to the client what the therapist views as important." (p.462)

Psychotherapy is presented to the world as an objective and scientific endeavor. Thus,

> "Honesty tends to create relaxation and relaxation tends to create sensitivity. Perhaps our newly acquired sensitivity would open our hearts to a faint but insistent message, a message which some perceive as coming from above us. The message tells about ultimate absolute values. The carrier of the message has been given many names. The Hindus call it "Atman", the Taoists call it "Tao", the Jews call it "Ruach Hakoolesh" and the Christians call it "The Holy Spirit." (Weisskopf-Joelson, 1980, p.466)

As documented by the literature, American psychology has infrequently focused its theoretical, research (in particular) and clinical attention on religious/spiritual experience or in a much broader sense on the impact on values in psychotherapy (Strupp, 1980; Chesner & Baumeister, 1985; Lewis & Walsh, 1980; Shafranske & Gorsuch, 1984; Kessel & McBrearty, 1967). One reason cited by these authors to explain the lack on interest in values and spirituality has been the sense of urgency experienced by psychology to dissociate itself from philosophy in order to become an empirical science.

Bergin (1980) has been one of the leaders in promoting the study of values (religious) within psychology and has pointed out an increased movement to expand knowledge in this area. He has explained this development as a consequence of the disillusionment with science as the dominating source of truth, the failure of organized religious systems and non-religious approaches to address the problems within modern life, and the influences of these issues within the personal experience of psychologists.

It is clear to me that in the process of becoming psychologists, spiritual issues are not addressed during the course of training. Therefore, a number of questions can be raised regarding this lack of training: To what extent do psychologists recognize, respect, respond to or influence the spiritual or religious values of their clients?. To what extent does a psychologist´s personal beliefs and personal history, influence clinical work?. To what extent does a psychologist´s theoretical orientation influence clinical work as related to values?. To what extent does a psychologist´s training prepares him/her to be aware of the value orientation of clients?.

Significance for Research

The literature reveals the shared roots of psychology and religion. The ultimate goals for both psychology and religion are the same.

Both seek the well being of the individual and try to facilitate the emotional growth of the person in a mature and adaptive way. Psychology strives to find concrete answers to abstract questions, while religion provides abstract answers to unlimited and indefinable questions (Loschen, 1974) but both provide a base for meaning and purpose in life. It appears to be that every diagnosis relates to an illness which can be split into a scientific diagnosis (psychological) and a spiritual one (religious) (Tournier, 1960).

Over time, the mental health literature has disregarded the importance of religion and spiritual values in people´s lives and when these values had been addressed the tendency has been to consider them pathological. Issues around language and objectivity have prevented researchers from exploring, and by the same token, coming to appreciate the value that religious belief, as a personal value, can play in the emotional growth of an individual. As indicated by Bergin (1983), it is important that all clinical practitioners try to understand the religious world view of their patients and in doing so be also aware of their own

religious values. Spiritual tendencies exist in every human being and therefore must be taken into account within the therapeutic relationship in order to help the patient achieve emotional growth and fulfillment. Research findings on this aspect are not conclusive. However, some results suggest that addressing values of both therapist and client has a positive effect on therapy (Hlasny & McCarrey, 1980; Chesner & Baumeister, 1985).

Throughout the development of the behavioral sciences, biological, psychological and social aspects have been considered to understand the individual (Nelson & Wilson, 1984). However, Christianity indicates that the spiritual dimension is essential to understand human nature in a holistic fashion.

Values play a crucial role in the formation of each individual personality and therefore cannot be ignored in the therapeutic alliance between therapist and client. I believe that values provide human beings with meaning in their lives, a way of coping with problems of morality, and are guidelines to help manage conflicts that arise throughout each individual's life time.

Bergin (1980) emphasizes the role values, in particular religious ones, play in psychotherapy since those values are part of each individual.

On the contrary, Ellis (1980), along the same continuum, expresses his objection about the use of religion to create hope and meaning in people's lives. Fromm (1950) takes an intermediate stand by seeing in religion positive or negative forces depending on the way religion is use by the individual.

Regardless of their conceptualization about religion and the function it plays on the individuals world view, the fascinating aspect is the importance that the different authors have placed upon religion as a fact of life. Thus, accepting the existence of the spiritual dimension of human nature. Besides the specifics and differences of each religious approach, human history shows a constant spiritual search for something beyond human comprehension that is part of each individual. This could be identified as the underlying cause for the rebirth of interest in religious values and acceptance of the impossibility of neutrality in the psychotherapeutic process.

While neutrality evolved as a way to reduce the emotional stress in therapy and to avoid behavior that could damage the therapeutic relationship (Lovinger, 1984), the literature is now showing that neutrality is a fallacy and that therapy can alter values even when the therapist tries to be "neutral" (Bergin, 1980; Lovinger, 1984).

As it will be seen on Chapter II, the research literature is scarce, yet. It is nevertheless, growing in terms of the importance of the therapist acknowledgment of values and its effect on psychotherapy. As stated by Lovinger (1984): "Values can have a strong impact, and their introduction into therapy should further therapy in some reasonably clear way".

Some research studies seem to confirm the hypothesis that there is a correlation between client improvement and similarities between the value system of the therapist and the client. The increasing tendency is to acknowledge values in therapy, to create an awareness of value systems without considering them to be pathological or not acceptable.

Previously stated is the fact of the limited research in this area. In part this can be explained by the threat that psychological explanations of religious experiences represent to religious groups (Paloutzian, 1983). Somehow it has been perceived that a scientific explanation will demean the religious experience. A new path is being opened and the difficulty of defining religious concepts in operational terms is also being overcome. This opens the door to continue to explore the importance of values in psychotherapy and particularly to determine in a more clear fashion how different therapists, identified with a religious denomination, handle the issue of values in the psychotherapeutic relations with their clients.

CHAPTER II

REVIEW OF THE LITERATURE

Conflicts Between Values Underlying the Therapeutic Process and Religious Doctrines

A value is defined as a principle, standard, or quality considered worthwhile or desirable. (The American Heritage Dictionary, 1979). Values play an important role in the personal and emotional growth of each individual. They constitute the foundation of personality and thus of behavior. When an individual experiences confusion about his/her own value system, emotional discomfort takes place and is expressed in different ways.

Within this context religious values can be understood as the expression of man's belief in and reverence for a superhuman power recognized as the creator of the universe. From a psychological point of view, religion appears as:

> "an interlocking set of symbols, explanations, and behaviors to which an individual appeals, for the most part unconsciously, in order to understand oneself ultimately." (Haule, 1983, p.109)

Psychology and religion have a common origin which is the understanding and caring of that inner energy that moves the individual to acquire, through time, a sense of life meaning, identity and destiny. Everyone carries within a

religious dimension even though the person might not be aware of it.

More and more the human race is beginning to move away from materialism to embrace more spiritual ways of approaching life. Psychology and psychologists are questioning the importance of addressing those religious values in therapy (Spero, 1981; Bergin, 1983).

The idea of neutrality in the therapeutic process is being questioned in light of the importance of sharing values with the client as a means of better understanding the emotional development of the person in treatment, as well as the discomfort created by confusion around those same values mentioned earlier (Bergin, 1980; Kitchener, 1980). This sharing can be a creative force for change that tells the clients that their emotional experiences and difficulties are being perceived and received by someone -the therapist- who is sensitive to that set of beliefs.

It seems that even humanistic psychology has a set of values, and therefore does sometimes make judgments (McDonagh, 1982). The fact that the therapist's attitudes and values are communicated to the client in the therapeutic process is becoming clear (Lovinger, 1978; Bergin, 1980; Meadow et al., 1979; Beutler, 1979; Strupp, 1974; Barron, 1978).

It seems that there is a myth around the moral neutrality of the therapist and it appears to be that contrary to what has been sustained earlier in counseling circles, the acknowledgment of such religious values can have a positive effect in the therapeutic process (Pepinsky & Karst, 1964).

A search of the literature in this area found that most of the studies published have been devoted to the theoretical understanding of the issues in the form of position papers. These conceptual papers in conjunction with those empirical studies found will be the focus of this chapter.

Therapists may self-consciously seek to fulfill only one function and interpret the reality of their clients from their own theoretical approach, but as human beings they cannot avoid responding to those situations in a more holistic way therefore, transgressing the narrow bounds of their own expertise.

> "... for the scientist is also a human being; he functions not only qua scientist but also qua person, and as such he is inevitably forced to think in terms of ends as well as means, values as well as facts."
> (Hoffman, J., 1979)

Thus, the academic and clinical expertise cannot be separated from the human dimension of the therapist.

Moreover, and as indicated by Barron (1978), the selection of a particular theoretical approach depends on the value system and personality of the therapist.

The early conceptualization of psychology as explained by Greben and Lessen (1976) implied that neutrality was important because it would allowed the client to project his/her feelings on to the relatively blank screen of the therapist. Objectivity by the therapist was necessary in order to see clearly what was happening in the client´s world and, moreover, neutrality was considered then as a protective shield for the therapist, for his/her own feelings.

The conceptualization of therapy as not being value free will be useful in helping to achieve a less distorted view of the client´s reality. Objectivity is not an agent of change but the subjective feelings shared by therapist and client in the therapeutic relationship. Recognition of the humanness of the therapist and client is necessary for therapy to happen (Kessel & McBrearty, 1967; Greben & Lessen, 1976).

The inclusion of the "moral aspect" in the therapeutic process must be accomplished. It seems that the acknowledgment and positive critique of it gives room for a more consistent emotional healing (Nelson & Wilson, 1984).

Cognitive and ethical development can cohabit and therefore are part of the comprehensive formulations about human behavior and values that both psychology and religion claim as their aims (Grosh, 1985). As indicated in the literature, countertransference is not one of the most positive aspects of the therapeutic relation. The therapists, in traditional approaches (behaviorism, psychoanalysis) are asked to be objective, detached and emotionally uninvolved with the client, they should be a "tabula rasa" into which clients will project their conflicts, anxieties and emotional needs. By the same token, the therapist should and must avoid a similar behavior (Wapmick, 1985). Kessel and McBrearty (1967) suggested that the psychoanalytic understanding of transference and resistance as an intra-psychic phenomenon derived from the client's unconscious processes can be better understood as the interaction between the personality characteristics of both therapist and client.

The assertion that psychotherapy is a value free, ethically neutral endeavor is no longer true. When two persons agree, within the therapeutic relation, to deal with the problems of life, the traditional approach of the scientific object/subject paradigm does not stand any more and a new environment takes place in which the realities and the worlds of both client and therapist must be present in

an honest and open way for examination, exploration and expansion (Strunk, 1985; Strupp, 1974; Barron, 1978).

It is, therefore, unavoidable the fact that each individual affects each other's belief system in the process and that each person involved in the process cannot deny his/her belief system, thus, be neutral. Even when the therapist tries to be neutral, values continue to be transmitted (Rosenthal, 1955; Greben & Lessen, 1976).

> "The client comes to the therapist for help with a problem, and then the therapist decides if he can help him. If the situation is favorable, that is, if the therapist regards it as a problem which falls within his competence, some agreement or contract is reached in which the client is accepted. It is here that the matter of values is clearly involved".
> (Garfield, 1974, p.202)

Accepting a theoretical approach without considering the individual's value system is a denial of the real self within the individual.

Bergin's Six Theses

Allen Bergin (1980) has become one of the most outspoken scholars in explaining the roles of religious values in psychotherapy. Bergin (1980) proposed six theses that support the myth of neutrality and by the same token the crucial need to address values in psychotherapy.

Allen Bergin's six theses follow:

Thesis 1: Values are an inevitable and pervasive part of psychology. (p.97)

Thesis 2: Not only do theories, techniques and criteria reveal pervasive value judgments, but outcome data comparing the effects of diverse techniques show that nontechnical, value-laden factors pervade professional change processes. (p.97)

Thesis 3: Two broad classes of values are dominant in the mental health professions. Both exclude religious values, and both establish goals for change that frequently clash with theistic systems of belief. (p.98)

Thesis 4: There is a significant contrast between the values of mental health professionals and those of a large proportion of clients. (p.101)

Thesis 5: In light of the foregoing, it would be honest and ethical to acknowledge that we are implementing our own value systems via our professional work and to be more explicit about what we believe while also respecting the value systems of others. (p.101)

Thesis 6: It is our obligation as professionals to translate what we perceive and value intuitively into something that can be openly tested and evaluated. (p.102)

The first thesis supports the idea that religious values are among those values that in a direct or indirect fashion affect psychotherapy.

According to Strupp (1980d) the idea that the therapist´s values should not play a role in psychotherapy is unrealistic and he goes on to indicate that it can even be harmful.

However, Humphries (1982) does not agree with this type of reasoning when he indicates that:

> "there seems to be a lack of awareness that psychotherapists may harm their patients by conveying their own attitudes toward religion as though they were matters of scientific fact. Such behavior invades the sanctuary of the patient´s spiritual life and violates his capacity to make his own autonomous choices". (p. 129)

Bergin´s second thesis stresses the fact that not only theoretical frameworks and techniques but also other factors such as religious ones are crucial elements that lead to therapeutic change. For him change is a function of human interactions in which personal and belief factors are exchanged.

The third thesis states that two systems of values, humanism and clinical pragmatism are presently the two dominant forces in the mental health field. These two approaches exclude religious values.

Bergin proposes that from a theistic point of view some additions can be made to clinical thinking. The following chart shows Bergin's theistic values in comparison to the Clinical and Humanistic ones.

Theistic	Clinical-Humanistic
God is supreme. Humility, acceptance of (divine) authority, and obedience (to the will of God) are virtues.	Humans are supreme. The self is aggrandized. Autonomy and rejection of external authority are virtues.
Personal identity is eternal and derived from the divine. Relationship with God defines self-worth.	Identity is ephemeral and mortal. Relationship with others define self-worth.
Self-control in terms of absolute values. Strict morality. Universal ethics.	Self-expression in terms of relative values.Flexible morality. Situation ethics.
Love, affection, and self-transcendence are primary. Service and self sacrifice are central to personal growth.	Personal needs and self-actualization are primary. Self-satisfaction is central to personal growth.
Committed to marriage, fidelity and loyalty. Emphasis on procreation and family life as integrative factors.	Open marriage or no marriage. Emphasis on self-gratification or recreational sex without term responsibilities.
Personal responsibility for own harmful actions and changes in them. Acceptance of guilt, suffering and contrition as keys to change. Restitution for harmful effects.	Others are responsible for our problems and changes.Minimizing guilt and relieving suffering before experiencing its meaning. Apology for harmful effects.

Forgiveness of others who cause distress (including parents) complete the therapeutic restoration of self.	Acceptance and expression of accusatory feelings are sufficient.

Theistic	Clinical-Humanistic
Knowledge by faith and self-effort. Meaning and purpose derived from spiritual insight. Intellectual knowledge inseparable from the emotional and spiritual. Ecology of knowledge.	Knowledge by self-effort alone. Meaning and purpose derived from reason and intellect. Intellectual knowledge for itself. Isolation of the mind from the rest of life.

These theistic views do not represent any religion in particular but are fundamental to Christianity and probably can be found in other religions as well like Buddhism.

Pragmatism and humanism provide positive guidelines that enhance personal growth. The former gives clear-cut behavioral tools that foster healthy emotional growth, eliminating anxieties, depression and guilt. The latter is more philosophically oriented, touches on issues such as what is good and how life should be lived. However, neither one nor the other focuses on the spiritual aspects of behavior. As Bergin indicates:

> "Pragmatic and humanistic values alone, although they have substantial virtues, are often part of the problem of our deteriorating society."
> (1980, p.99)

And to explain his theistic view he adds:

> "What are the alternative values? The first and most important axiom is that God exists, that human beings are the creations of God, and that these are unseen spiritual processes by which the link between God and humanity is maintained."
> (1980, p.99)

Albert Ellis (1980) has strongly disagreed with Bergin's third thesis. Ellis suggested that the Pragmatic/Humanistic views presented by Bergin are only a partial view that represents the thoughts and humanistic values of those that are also religiously oriented. Ellis (1980) added that there is another side to that way of thinking which is the clinical-humanistic-atheistic approach. The information presented in the table shown next clearly indicates the differences between Bergin and Ellis in their conceptualization of religious values in psychotherapy.

THEISTIC	CLINICAL-HUMANISTIC	CLINICAL-HUMANISTIC-ATHEISTIC
(Bergin,1980)	(Bergin, 1980)	(Ellis, 1980)
God is supreme. Humility, acceptance of (divine) authority, and obidience (to the will of God) are virtues.	Humans are supreme. The self is aggrandized. Autonomy and rejection of external authority are virtues.	No one and nothing is supreme. To aggrandize or rate the self is to be disturbed. A balance between autonomy and

		living cooperatively with others and a balance between rejecting and overconforming to external authority are virtues.
Personal identity is eternal and derived from the divine. Relationship with God defines self-worth.	Identity is ephemeral and mortal. Relationships with others define self-worth.	Personal identity is ephemeral and mortal. Relationships with others often provide increased happiness but never define self-worth. Nothing does. Self-worth, self-esteem, or rating one's "self" globally is a (theological) mistake, leading to disturbance. Self acceptance can be had for the asking, independent of any god or human law.
Self-control in terms of absolute values. Strict morality. Universal ethics.	Self - expression in terms of relative values. Flexible morality. Situation ethics.	Basically the same as clinical-humanistic.

Love, affection, and self-transcendence are primary. Service and self-sacrifice are central to personal growth.	Personal needs and self-actualization are primary. Self-satisfaction is central to personal growth.	Personal desires and self-sought within a social context. Increasing self satisfaction, including social satisfaction and love, is central to personal growth
Committed to marriage, fidelity, and loyalty. Emphasis on procreation and family life as integrative factors.	Open marriage or no marriage. Emphasis on self -gratification or recreational sex without long-term responsibilities.	Choice of no marriage, conventional marriage, or open marriage. Emphasis on sex gratification with mutually chosen partners with or without long-term responsibilities . Family life optional; often desirable but not necessary for health and happiness.
Personal responsibility for own harmful actions and changes in them. Acceptance of guilt, suffering, and contrition as keys to change. Restitution for harmful effects.	Others are responsible for our problems and changes. Minimizing guilt and relieving suffering before experiencing its meaning. Apology for harmful effects.	Personal responsibility for own harmful actions and changes in them. Maximizing responsibility for harmful and inmoral acts and minimizing guilt (self-damnation in addition to denouncing one´s acts). No apology for effects of one´s unethical behavior. Restitution for harmful effects.

Forgiveness of others who cause distress (including parents) completes the therapeutic restoration of self.	Acceptance and expression of accusatory feelings are sufficient.	Forgiveness of others who cause needless distress including parents but no condonation of their acts. Unconditional acceptance or positive regard for all humans at all times, but clear-cut condemnation of their immoral behavior. Acceptance of self helped by unconditional acceptance of others.

(Ellis, 1980, p.636-637).

This latter conceptualization has its origin in the idea that there are no gods or superior beings that can affect human behavior (Ellis, 1980).

Gay Walls (1980) argues with Bergin's third thesis and objects to the inclusion of values in psychotherapy when they are analyzed in reference to divine authority. In doing so, Walls (1980) says: "... we abdicate our responsibility to justify and critically assess our values." (p.641). His suggestion is that all values should undergo rational scrutiny regardless of their theoretical conceptualization.

The different arguments expressed by Bergin, Ellis and Walls represent the tendency most frequently found in any

comparison of value systems which is to present the preferred value system in a positive light rather than a contrasting one (McMinn, 1984). In light of the above, it can be said that the biased interpretations of the literature can mislead the reader to stereotypes that do not represent the diversity of approaches that allow psychotherapy to be perceived in a more holistic manner. The Princeton Religious Center in Princeton, New Jersey conducted a poll (1979) in which eighty percent of Americans stated they believed in Jesus as the divine Son of God. (Christianity Today, Dec. 1979). Religiosity is an element present in almost every human being.

The fourth thesis of Bergin (1980) indicates that the values of the mental health professionals usually differ from those of the clients. Therefore, it appears that a comprehensive statement of treatment goals must include a consideration of the values of both therapist and client (McMinn, 1984). In this thesis Bergin is suggesting, from my point of view, a conciliatory and inclusive approach that will include in the treatment process the client and therapist's value system as a way to understand the client/therapist relationship within a more realistic frame of reference since neutrality is not feasible.

In his fifth thesis, Bergin (1980) states that an acknowledgment on the therapist part that he/she is using

his/her own value system as part of the therapeutic process appears to be mandatory as well as respecting the value system of his/her client. In doing so the therapist can then feel comfortable to offer the client the possibility of a secular and/or spiritual dimension for treatment (Nelson & Wilson, 1984). Clients, then, will be ultimately responsible for the choice of participation after they have been fully informed of the therapist's values (McMinn, 1984).

The therapists' views of human nature, their specific training and value system will be reflected in the therapy that clients receive. The understanding of all these aspects will lead to a holistic conceptualization of the therapeutic process (Nelson & Wilson, 1984). Avoidance of these elements in the therapeutic process implies a denial of an integral point of the individual's self. As Bergin (1980) emphasizes:

> "If we are unable to face our own values openly, it means we are unable to face ourselves, which violates a primary principle of professional conduct in our field. Since we expect our clients to examine their perceptions and value constructs, we ought to do likewise. The result will be improved capacity to understand and help people". (p. 102)

The last thesis opens the door to the experimental testing of the individual's value system. Bergin (1980) explains the need to transform those values into testable hypotheses. To this effect, he presents nine testable

hypotheses shown in the next page. Even though Ellis (1980) agrees with five of Bergin's hypotheses he presents four different ones with an emphasis in a more humanistic-atheistic approach. It appears from the content of these hypotheses that the Humanistic-Atheistic approach emphasizes that the person must search for a meaning of life that is not related to a superior being. Ellis centers his thoughts in the individual's potentiality to find the answer to achieve the goal of being a full human being. It is my understanding that Bergin's hypotheses laid the ground for a locus of control that is in the individual but grown out of man's intrinsic religious values and relationship with God.

Theistic hypothesis (Bergin, 1980, pp.102-3)	Humanistic-atheistic hypothesis (Ellis, 1980, p.638)
Religious communities that provide the combination of a viable belief structure and a network of loving, emotional support should manifest lower rates of emotional and social pathology and physical disease.	Atheistic communities that provide a balanced, undogmatic belief structure and a cooperative, forgiving community without any absolutistic commandments will manifest lower rates of emotional and social pathology and physical disease.

Those who endorse high standards of impulse control (or strict moral standards) have lower than average rates of alcoholism, addiction, divorce, emotional instability, and associated interpersonal difficulties.	Basically the same.
Disturbances in clinical cases will diminish as these individuals are encouraged to adopt forgiving attitudes toward parents and others who may have had a part in the development of their symptoms.	Basically the same.
Infidelity or disloyalty to any interpersonal commitment, especially marriage, leads to harmful consequences both interpersonally and intrapsychically.	Unequivocal and eternal fidelity or loyalty to any interpersonal commitment, especially marriage, leads to harmful consequences both interpersonal and intrapsychically.
Teaching clients love, commitment, service, and sacrifice for others will help heal interpersonal difficulties and reduce intrapsychic distress.	Teaching clients forgiveness and selective love, commitment, service, and sacrifice for others will help heal interpersonal difficulties and reduce intrapsychic distress. Teaching them unselective, universal, and unequivocal love, commitment, service, and sacrifice for others will help sabotage interpersonal relations and increase intrapsychic distress.

Improving male commitment, caring and responsibility in families will reduce marital and familiar conflict and associated psychological disorders.	Basically the same.
A good marriage and family life constitute a psychologically and socially benevolent state. As the percentage of persons on a community who live in such circumstances increases, social pathologies will decrease and vice versa.	Basically the same.
Properly understood, personal suffering can increase one's compassion and potential for helping others.	Personal suffering consisting of appropriate feelings like sorrow, regret, frustration, and annoyance at one's own or another's undesirable behavior will often increase one's compassion and potential for helping others. Personal suffering consisting of inappropriate feelings like panic, horror, depression, and hostility will usually decrease one's compassion and potential for helping others.
The kinds of values described herein have social consequences. There is a social ecology, and the viability of this social ecology varies as a function of personal conviction, morality, and the quality of the social support network in which we exist.	Basically the same.

In light of the above it is then clear that the values of the therapist affect both the goals and the process of psychotherapy (Bergin, 1980; Nelson & Wilson, 1984; McMinn, 1984; Grosch, 1985; Strunk, 1985). This leads to the concept of convergence developed by Pepinsky and Karst (1964) as a process by which "a measurable shift in client behavior towards that of the therapist" takes place in psychotherapy. This idea was previously supported by Rosenthal (1955) who found in his research that the therapeutic relationship between client and therapist moves the client into a process of introjecting moral values more similar or consistent with that of the therapist.

Open discussion in the early stages of therapy about the values (including religious ones) that might affect the therapeutic relationship appears to be mandatory in particular when there is a significant discrepancy between the values of both therapist and client. In this regard, the literature tends to imply that a " common world view " between client and therapist can be a tool to facilitate communication, empathy and acceptance of the client by the therapist (Strunk, 1979; Gass, 1984).

The recognition that every person carries within him/herself past relations to the world, emotional predispositions and expectations about the future is called proception (Buchler, 1955). The acknowledgment of every

individual's proceptions can be a critical element in understanding life and thus has an impact in the understanding and acceptance of others. In other words, personality plays an important role in the formation of the client-therapist relationship. Personality, a product of those proceptions, in turn defines the value system by which we guide our lives. Therapists have been trained to be silent about their personal values in order to avoid contaminating the therapeutic alliance. In Strupp (1980) words:

> "... it is impossible for a therapist to interact with another human being for a period of time without the other person becoming aware of the therapist's values on a number of subjects, no matter how strenuously the therapist may try to present a "neutral" facade. A totally neutral or opaque therapist may be deleterious because what the patient urgently needs is a relationship with a real human being rather than an impersonal analytic technician."
> (p. 396)

The whole idea of value matching has been theoretically analyzed and recommendations have been suggested (McMinn, 1984; Nelson & Wilson, 1984) in which the overall statement is that addressing of religious values and values in general should take place only after the therapist has been able to evaluate the client's level of spiritual and psychological maturity. Nevertheless, values should be discussed in the early stages of therapy, in particular when

there is a discrepancy of value systems between client and therapist. It will be up to the client to decide his/her participation in the process once values have been disclosed. Openness and respect are the underlying principles to follow.

Neither therapist nor client should feel forced to discuss these areas but as stated by Peteet (1981), therapists miss the opportunity to help their clients integrate religious and emotional personality dimensions when religious values and values in general are not part of the psychotherapy.

In short, the therapist must recognize and accept the need of the religious client to cognitively understand his/her own religious value system. The intellectualization of religious beliefs, its cognitive analysis, is as important and mandatory for the religious client as is the experiencing and understanding of feelings (Strunk, 1979). The therapist should not avoid addressing this crucial dimension of human nature and must not see that need as pathological.

What can be identified as a pathological, dysfunctional religious belief?. What can be defined as a mature religious belief system?.

Strunk (1965) explains that a mature belief system exists when the person's behavior demonstrates the fostering of social concern and involvement in his/her environment. The person with a mature set of beliefs maintains contact with others and the society at large as opposed to a withdrawal attitude. Intellectual and spiritual awareness is a solid component of the belief system, and the individual also experiences a personal conviction of the existence of a transcendental power greater than him/herself. As indicated by Spero (1985), a mature experience of God is a complex and endless process.

Therefore, religious beliefs and values in general cannot be reduced to psychosocial terms but rather comprise the patient's world view that ultimately will determine the presence or absence of psychopathology.

Religion can exacerbate but also control mental illness depending upon how it is used. " Extreme or unusual attitudes of all kinds produce deviant and damaging behavior of all kinds " (London, 1976). Therefore, if religious beliefs need to be challenged to correct maladaptive behavior, the therapist should do so but, not always religious beliefs are the base of disruptive behavior. In this regard, Ness and Wintrob (1980) reported that people who engage on more religious activities reported less symptoms of emotional stress.

Allport and Ross (1967) defined religiousness in terms of intrinsic (good) and extrinsic (bad) religiosity. The extrinsically religious individual seeks religion to obtain security and status. The intrinsically oriented one, internalizes his/her beliefs and lives by those beliefs regardless of external consequences.

In other words, the intrinsically religious individual will confront his/her value system against those of the larger system (society, peer pressure, etc.) and will struggle to maintain the integrity of his/her own values regardless of the outcome. This type of individual represents a positive kind of motivation in which religion serves as the central point around which life is organized. On the contrary, the extrinsically oriented individual carries a negative motivation in which religiosity is conducive to selfish goals (Watson, Hood, Morris & Hall, 1985).

Ellis (1980) sustains the idea that religiosity causes emotional disturbances and thus all absolutistic, dogmatic religion increases psychopathology. Hence, the solution is "to be quite unreligious and have no degree of dogmatic faith that is unfounded or unfoundable in fact".

As mentioned earlier the introjection of religion in psychotherapy must occur after the therapist has had the opportunity to assess the level of spirituality and

psychological maturity of the client. In this regard, it is suggested that discussions of religion are inappropriate with psychotic and delusional patients since their disturbance lies in their reality testing. Thus, religion and God can be included in their delusional perceptions of the world and disrupt their thought processes (Nelson & Wilson, 1984).

In light of the above it can be said that the religious beliefs that are a part of the whole essence of the personality and increase the personal and spiritual growth of the individual providing a meaningful world view can be identified as non pathological but mature. When religion is used to acquire security or protection from facing the internal unbalance of emotional life, it can be called pathological.

A re-birth in the importance of values and religion in the context of psychotherapy is taking place. Consequently, its role in personality theories and psychotherapy is being reconsidered (Bergin, 1980). According to him, religious values can and must appear in the therapeutic process not to contaminate it but to better understand the cognitive and emotional development of every human being. The purpose of psychotherapy is to produce change, hence, not only behavior modification is important but also the internal (spiritual/emotional) processes must be taken into account.

> "For too long we have been wedded to the empirical and rational alone, but both cultural and intellectual trends have given rise to a rebirth of spiritual, intuitive, and inductive modes because of the value vacuum left by standard approaches." (Bergin, 1980).

The idea of refusing to address values within the therapeutic realm has proven to be wrong and even behaviorists are seeking for a way to explore the whole idea of values and their role in the lives of individuals and in the therapeutic process (Kitchener, 1980). Bergin (1980) suggested that the therapist's openness in sharing religious values is not only ethically mandatory, but is also likely to facilitate the therapeutic process. According to him, a clear value system of theistic religion would serve as a solid frame of reference for the therapeutic relationship. Behaviorism has seen values as facts, nevertheless this conceptualization is changing. Facts and values are not the same and therefore must be accepted as two interwoven dimensions that contribute to the formation of the personality structure of each human being.

Research Studies

The review of the literature provided sixteen research studies. These studies are presented on the table after the general comments. One reason to explain the paucity of studies could be the difficulties encountered

operationalizing religious terms. Even though theoretical constructs can be developed, religion belongs more to the philosophical world than to the scientific world. Religious people have a different orientation to knowledge and its development than scientists.

The following research studies address the issue of values in psychotherapy. However, each study focused on a different aspect of it. The majority of them explore values in relation to the client. Very few studies centered the research looking at values from the therapist point of view. Therefore, the following research studies are assemble using as criterion a similar focus of research.

Research of Belief Systems and Values

To acknowledge the importance of the individual's world view, Paloutzian, Jackson, and Crandall, (1978), studied the relevance of the conversion experience, belief systems and personal and ethical attitudes. The goal of the study was to determine the relation between type of religious belief systems, type of conversion experience (sudden, gradual or unconscious) and four attitudinal variables: purpose in life, social interest, religious orientation and dogmatism.

Two different groups of subjects participated in the study. The first group studied comprised eighty four college

students; the second group one hundred and seventy seven adults of varying ages. The instruments used were the Purpose Life Test, the Intrinsic-Extrinsic Religious Orientation Scale, the Social Interest Scale and the Short Dogmatic Scale. The results suggested that in both groups the Christian religious patients scored higher on purpose of life, social interests and dogmatism. Non-Christians were found to be less certain about what they believed to be true, therefore were more open to different points of view.

This research indicates that the religious dimension plays a crucial role in coloring the world view of the person. In other words, the actual meaning of life will vary according to the so called proception or world view.

The acknowledgment of the importance that each individual world view has, raises the question of the appropriateness of equating the values of the therapist with that of the client to achieve a good outcome in therapy. It would appear reasonable to predict that positive outcomes would be achieved where the therapist and client have common religious values. The research done by Carlton Gass (1984) on values and psychotherapy supports Paloutzian et al. (1978) in that religious clients have a distinctive set of beliefs and values. Not only those values and beliefs determine the client´s world view but according to Gass

(1984) have an impact on how the client understands the process of psychotherapy. The sample for this study was comprised of one hundred orthodox Christians and one hundred and four non-Christians who answered a value survey constructed by the researcher. The purpose of the survey was to measure beliefs and values related to psychotherapy and mental health. The survey was constructed including items of religious nature. The questions of the survey revolved around seven different factors: 1) Orthodox-Christian Values, 2) Importance of Parental Influence, 3) Professional Services, 4) Counseling Knowledge, 5) Conformity: Social-Practical, 6) Self-Reliance, and 7) Non-Professional Aid.

Results confirmed the hypothesis that the selection of a therapist that shares the same value system than that of the orthodox Christians is of vital importance since a different value orientation on the part of the therapist appears to be, according to Gass (1984), the reason why the client's religious values are inappropriately addressed. As expected, the Non-Christians did not placed much importance on the religious belief of the therapists.

The survey indicated that orthodox Christians feel more comfortable with religious rather than secular mental health services. However the difference in terms of percentages between orthodox Christians and Non-Christians for this result is small (5%). In other words, the Orthodox

Christians showed a preference for the inclusion of prayer and biblical material as a helpful technique to understanding problems of emotional nature within the psychotherapy process and expressed the importance of God as a crucial life influence therefore, the need to address this element in psychotherapy. The other aspects contained in the survey did not showed great significant differences between Orthodox-Christians and Non-Christians.

These results can be an indication of the increasing need for therapists to enhance their own sensitivity and awareness of the beliefs and values of their clients. This could be done by becoming more aware of their own value system and personal beliefs and how those also impact the psychotherapeutic process. The acknowledgment of the values of both therapist and client could enhance the positive outcome of psychotherapy. Secular psychotherapeutic approaches ignore the beliefs and practices of clients as well as those of the therapist.

Research on Religious Values and Therapist Perception

Haugen and Edwards (1976) studied religious values and their effect on the perception of a therapist in a psychotherapeutic context. The subjects for this research study were seventy one male and female undergraduates. The methodology included five measurements in the form of

questionnaires. The first was the K Scale of the Minnesota Multiphasic Personality Inventory to determine defensiveness. The second, a modified Religious Fundamentalism Scale used to determine the subjects' religious beliefs. The third, the Tape Rating Scale that measured the subject's attraction toward the taped therapist and each subject's receptivity to the taped therapist's influence. Fourth, the Persuasibility Questionnaire to measure the subject's agreement with the taped therapist's rating. The fifth questionnaire was the Willingness to Meet Scale that basically indicated the willingness of the subjects to meet with the taped therapist to discuss student problems.

The purpose of this research was to determine whether the identification or acknowledgment of the therapist's value orientation and interpersonal style would have an effect on the client's perception of the relationship. Secondly, they tried to determine if knowing about the religious value orientation of the therapist would be an element to be weighed higher than the interpersonal style of the therapist. Results suggest that there is no greater tendency among the participants to choose therapists of their own religion or a different religious value system among religious clients. The subjects that identified themselves as been Christians did not rate the taped

therapist as been more Christian than those that identified themselves as Non-Christian. In other words, the hypothesis that Christian subjects would be more attracted, receptive, persuaded, and willing to meet a taped therapist labeled Christian than one labeled Non-Christian was not confirmed.

Research on Value Similarity and Its Effect in Psychotherapy

Some researchers have addressed the issue of neutrality in terms of the effects of therapist and counselor value similarities on the psychotherapeutic process. Mendelsohn and Geller (1963) studied the effects of therapist and client similarity on the outcome of therapy. The purpose was to determine if therapist-client similarity or dissimilarity is relevant to the outcome of therapy. The sample for the client group included seventy two subjects, forty one females and thirty one males. Ten counselors were part of the research. Subjects responded to the Myers-Briggs Type Indicator which is an instrument based on four dimensions: Judgment-Perception, Thinking-Feeling, Sensation-Intuition and Extroversion-Introversion. The results on this instrument were correlated with the number of therapy session that the clients attended.

The results indicated that overall, the greater the therapist-client difference score for each dimension, the fewer the number of sessions attended. It was clear that the

similarity between therapist and client increased the possibility of a long term relationship. The negative correlation between therapist/client scores and number of sessions is explained by the authors in that an essential component of therapy is the client's feelings that he can communicate with his/her therapist, that he/she understands and is also understood.

Mendelsohn (1966) did a replication of the previous research and found similar results. This time the sample included two hundred and one clients, one hundred and eleven males and ninety females. The therapists group was comprised of eleven counselors, six of them females. All responded to the same instrument: the Myers-Briggs Type Indicator. This replication study showed that duration of counseling as measured by number of sessions attended, was not associated with client personality, therapist personality or sex matching between counselor and client. Thus, this study demonstrated that therapist-client matching of values is a more important determinant of outcome than these other variables. The author also points out that the similarity between client and therapist enables them to work together with greater efficiency and directness. Nevertheless too much similarity suggested Mendelsohn can become an obstacle in the development of an effective balance of empathy and objectivity. Also can lead the therapist to explore personal

and conflictual material too early in the therapy that would make the client uncomfortable. Therefore there has to be a balance in the similarity shared.

Another research focusing on similarity of values was done by Lewis and Walsh (1980). The purpose of the study was to determine the nature of the client's reactions to an explicit value communication as opposed to an implicit therapist value communication, and to examine the effects of client-therapist value similarity on client's perceptions of and confidence in the therapist. The subjects were one hundred and twenty female undergraduates that listened to a fifteen-minute tape of a therapy session in which the therapist was either explicit or implicit about her values and expressed either a pro or con attitude toward marital sex. Besides the tape, subjects were also asked to complete the Ohio State University Attitude Survey to determine their position regarding premarital sex.

The results of this study are consistent with those of Haugen and Edwards (1976) that perceived that similarity of values tends to increase the perception of the therapist as trustworthy and helpful. The results also indicated that even though there was no significant difference between the way in which explicit and implicit therapists are perceived, clients were more willing to see a therapist that shared their same values than one that had dissimilar ones.

The results of Lewis and Walsh research suggest that therapists are left with the option of overtly communicating their values or allowing them to operate in an implicit way recognizing that in either way, the motion of a value-free therapy is only a myth.

Along the same lines of research, Lewis, Davis and Lesmeisler (1983) studied the impact of pre-therapy information regarding therapist's values and therapy orientation on the clients' (a) judgments of similarity to the therapist's values, (b) trust in the therapists' ability to be helpful, and (c) willingness to see the therapist. The sample was comprised of thirty six female undergraduates that had expressed profeminist attitudes. To determine the degree of this profeminist orientation, subjects completed a short version of the Attitudes Towards Women Scale. Three different groups were formed and each one received one of the three different types of therapy advertisements containing three differing amounts of pretherapy information regarding the therapist's values: explicit feminist, traditional and feminist label.

Contrary to other research, the results of this one indicates that the clients (self identified feminists) did not see themselves as similar to the explicit feminist therapist, nor did the clients found her to be as potentially helpful as either a traditional or a feminist label therapist.

Even though these results may contradict previous ones about the issue of similarity and sharing of values, the results can be explained in light of the newness of the controversial questioning of the idea of neutrality in psychotherapy. Clients still believe and think in terms of therapist value neutrality and it will take a process of re-education and acknowledgment of the idea of a value-free psychotherapy as a myth to obtain more consistent results. The findings of this research are congruent with Mendelsohn (1966) and Lewis and Walsh (1980) research studies in that the sharing of values in particular on the side of the therapist has to be appropriately communicated in terms of timing, amount and content in order to avoid any obstacle that would impede the successful outcome of the therapy. The idea of balance value sharing underscore once more the neutrality myth.

In 1985, Lewis and Lewis replicated the study of Lewis and Walsh (1980) with some changes. The sample this time was of ninety six women that were asked to complete the Student Attitude Survey to determine their attitudes toward dating, marriage, drugs and premarital sex. As in the Lewis and Walsh research, subjects listened to a modified version of the tape used that contained explicit or implicit therapist's values.

The Counselor Rating Form was used by clients to rate the tapes in terms of the therapist expertise, attractiveness and trustworthiness.

The results suggested again that explicit pretherapy value information increased clients' ability to correctly identify a therapist's values. Thus, increasing the client's ability to recognize the therapist's influence attempts.

One of the major limitations of this particular research is that similarity of values was assessed using only one specific value position instead of the therapist's more global value system (Christian).

Research on The Impact of Self Disclosure

The degree of self disclosure of the therapist and its effect on the clients' self disclosure was researched by Delerga, Lovell and Chaikin (1976). The purpose was to determine how client's expectancies about a therapist's role behavior may influence the client's reactions to a high or low disclosing therapist. The sample included seventy one college females.

Excerpts of a therapy interview was given to the subjects to evaluate in terms of therapist disclosure (low and high intimacy) and expectancy about the appropriateness of personal therapist disclosure (appropriate, inappropriate).

Results indicated that if the therapists believe that self disclosure on their part is appropriate for effective psychotherapy, they must indicate so as part of their professional role. The contrary may be counterproductive when the client is not expecting high therapist disclosure and therefore provoking client withdrawal as apposed to increase disclosure.

Research on Value Similarity and Perception of The Therapist

The purpose of Hlasny and McCarrey research (1980) was to determine the effect that similarity of values and warmth has on clients trust and if those aspects affect the perception of therapists as effective professionals. The sample included eighty male undergraduates. The instrument used was the Rokeach Value Survey (Form D). A week later, forty subjects were asked to place themselves in the position of seeking a psychotherapist to help them with some personal problems. Therefore, the subjects were given a value profile of a therapist 66% similar to their own obtained a week earlier. The other forty subjects were asked the same and received a profile 33% similar to their own.

Hlasny and McCarrey (1980) research results suggest that client's and therapist's similarity of values has positive effects on client's trust of the therapist, therefore decreasing the client's sense of risk or vulnerability in the therapeutic session and increasing the

trust for the therapist of similar values. Similarity in values also led to the judgment that the therapist is an expert, reliable and with good intentions. These characteristics facilitate more the positive outcome of therapy.

Research on Therapist and Client Religious Values

The research so far presented here in terms of the self disclosure or value similarity has focused on one specific value or attitude. In an effort to be more generic as suggested by Lewis and Lewis (1985), the effect of therapist's disclosure of religious values on client's self disclosure was researched by Chesner and Baumeister (1985).

The purpose of the study was to determine if therapist disclosure of religious values would have an effect on the intimacy of client disclosure and hence affect the course and outcome of therapy. The sample included seventy eight male undergraduates (forty eight Christian and thirty Jewish). The instrument used to determine intimacy of disclosure was the Jourard Self-Disclosure Scale. Subjects were afterwards assigned to three therapy-like situations in which the subjects were expected to discuss personal issues. In the first group condition the therapist wore a crucifix. In the second group the therapist wore a black yarmulke. In the third group the therapist had no religious insignia.

The results indicated that a positive correlation exists between subject's religiosity and intimacy of disclosure when therapist and client share the same religion. The intimacy of client disclosure was inhibited when the therapist and the client had a different religious faith. However, these results give little support to Bergin's (1980) idea that therapist disclosure of religious values increases the positive outcome of the therapeutic process in that in any condition the clients (subjects) increased the intimacy of their disclosures when the therapist disclosed his/hers religious values.

Another research study that touches on client and therapist religious values was conducted by Houts and Graham (1986). The purpose of the study was to determine if the clinical judgment of religious and nonreligious therapists was affected by the identification of the client's religious value system. The sample for this study was comprised of subjects that answered an abbreviated form of the King and Hunt Religious Attitudes Scale that measured Creedal Assent, Devotionalism, Orientation to Growth and Striving and Salience-Cognition. Also the Clinical Judgment Scale and the Health Sickness Rating Scale were used. Clinician subjects were randomly assigned to view one of three videotapes of an intake interview between a male client and a male therapist. The scripts of the videotapes contained identical wording

except for those portions in which the degree of traditional Christian values was manipulated between non-religious, moderately religious and religious.

Subjects watched the interview for the first few minutes and were told to view the client clinically in order to make some judgments about him. Initial clinical impressions were assessed with the Clinical Judgment Scale. Therapists' perception of client psychopathology was determined with the Health Sickness Rating Scale. Subjects also completed a manipulation check rating of the religious values of the client on a scale ranging from non religious to extremely religious (5-point bipolar scale).

The results indicate that nonreligious therapists do not perceive religious clients as more disturbed. Religious and non religious therapists saw more psychopathology in clients that had doubts about their religious beliefs than those who did not expressed doubts.

Research on Therapist Values and Treatment Goals

The role that therapist's values play in the selection of treatment goals when the client has a similar or different set of values than those of the therapist was studied by Worthington and Scott (1983). The sample included eighty one subjects divided into four groups and two different settings: two professionals and two students

groups assigned either to a secular or a Christian setting. Each group was presented with a set of facts about a fictitious client. Four possible perceptions of the client about these facts followed. These perceptions indicated a particular position towards religion. Each participant was given a questionnaire that measured their attitudes towards that fictitious client and their potential goals for counseling such client.

Even though the expression of religiosity was not perceived as pathological, this study clearly suggested that religious therapists would set more goals targeted to spiritual concerns than nonreligious therapists. There were also indicators that nonreligious therapists might not like religious clients as much as non-religious ones.

Research on The Effects of Value Communication

To examine the idea that the therapist communicates his/her values throughout the therapeutic process some research studies have been conducted. David Rosenthal (1955) was the first one to examine the effects of value communications in psychotherapy. His sample included twelve patients and the instruments used before and after psychotherapy were the Moral Values Q-Sample (sixty statements based on three major areas of behavior, sex, aggression and authority); the Frank's Symptom-Disability

Check List; the Allport-Vernon-Lindzey Scale of Values and the Butler-Haigh Self Concept items. The therapists were given two of these tests. The results showed that the patients that improved in their treatment tended to change their values in the direction of the therapist. The opposite effect took place for the unimproved patients.

However, it should be noticed that out of the twelve patients included in this research, only two were rated as improved therefore these results are very tentative.

Another research that investigates the issue of value communication is the one done by P. Pentony (1966). The purpose of the study was to answer the question of whether client values change over the course of therapy to resemble those of the therapist. The sample comprised sixty four subjects including staff, students and clients of a Counseling Center with a client centered orientation. Pentony assessed values with a seventy item questionnaire based on the Kluckhohn classification of value orientations. The results showed that therapeutic outcome was that the client expressed values corresponding more closely to the values of the therapist than was the case prior to therapy. Pentony (1966) suggested as an explanation for these results that therapists communicate their values to their clients and that the clients adopted aspects of the therapist's values. The other alternative explanation may be that as a

result of therapy, the client develops a more mature approach to living and therefore tries to incorporate within him/herself values of client-centered therapists.

A study by Welkowitz, Ortmeyer and Cohen (1967) suggests that changes in value during therapy are a function of the patient's internalization of the therapist's values rather than a function of increased mental health. The purpose of the study was twofold: first to determine if therapists and their own patients have more similar value systems than random pairs of therapist-not own-patients and secondly if there is a correlation between similarity of patient-therapist value and therapists'subjective evaluations of the patient's mental health status: patients rated as improved by their therapist are expected to have greater similarity than patients rated as not improved.

The sample comprised thirty eight therapists and forty four patients of a training institute from a university counseling center. Two instruments were used to assess values of therapists and patients: the Ways To Live Scale and the Strong Vocational Interest Blank. In addition ratings by the therapists of extent of patient improvement were obtained. The results indicated that therapists and their own patients had more similar values than randomly paired therapist-client combinations and that clients rated as improved by their therapists shared more similar values

to those of their therapists than clients rated least improved.

Not all the studies in this review are similar in that some focus on the therapist and others on the clients. Therefore, the outcome is different and no definite results are obtained as to the value of having a match between the belief system of the therapist and of the client. However, the results indicate that religiosity for the Christians is important to determine purpose in life and thus, important enough to be taken into account in psychotherapy as indicated in the Paloutzian, Jackson and Crandall (1978) study. This study used more sophisticated measurement instruments which increased the value of its findings.

Summary and Critique of Research Studies

The literature emphasizes the importance of and the need for research on values and psychotherapy. A great amount of theoretical literature is available but the call for research has been ignored not only because of the lack of instruments and confusion about the meaning of values but also because of the resistance on the part of the therapists to admit that their values play a role in therapeutic process (Lewis & Walsh, 1980; Chesner & Baumeister, 1985; Kessel & McBrearty, 1967).

The general impression is that research in the area of values and psychotherapy is of two types: one aspect centers on investigations dealing with the therapist's communication of his/her own values to the client and how that affects the outcome of the process. The other type of research focuses on the therapist/client value similarity and its effect on outcome. There are, of course, variations on these two central themes (Kessel & McBrearty, 1967).

However and as pointed out by Ehrlich and Wiener (1961):

> "The intrinsic difficulties in assessing values and trying to relate them to specific behavioral manifestations or inferring them from certain behavioral acts, are, of course, multiplied when values are investigated in therapeutic setting. Here, we run into such specific additional problems as sampling patient and therapist population and behavior, controlling for possible contamination of the studied phenomenon resulting from its being under observation and many other complications connected with extended observation of voluntary relations, the duration and termination of which cannot be reliably anticipated. Nonavailability of appropriate instruments, the technical difficulties inherent in the conditions under which they would have to be employed, the confusion about the meaning of change in values, the loss of cases during the period of study and above all, the frequent reluctance on the part of the therapist to admit that his values enter into the therapeutic relations, have tended to discourage empirical work in the area." (p.365)

Overall one of the limitations common to almost all the studies found is the fact that they only focus on one single aspect of values instead of making the assessment generic. For instance, some of the research studies looked only into attitudes regarding premarital sex. Others only included one gender in the sample. The majority of the studies used college students, females and whites for the sample. The number of participants also varied. Of sixteen studies only three had a sample over two hundred subjects. Nine research studies had a sample between sixty four and ninety six participants and three studies ranged between twelve and thirty six subjects per sample. Moreover, few studies used analogies as opposed to real life subjects. Along the same lines, the lack of more sophisticated instruments is another limitation. Also the fact that there is not one instrument that was used consistently. These elements become obstacles for the generalization of the findings. None of these research studies paid attention to elements such as gender and ethnicity, variables that can affect the outcome of the research. In general the literature does not appear to pay attention to the issue of ethnicity around religious values. The computer search did not show any ethnic group studies; all related to main stream groups.

Criticisms of Specific Studies

Paloutzian, Jackson and Crandall's (1978) study used more sophisticated measurement instruments which increased the value of its findings. Among the research studies discussed in this chapter, their research has the largest sample with participants being from both sexes. These elements plus the fact that the age of the subjects was also controlled makes this research more valuable from a methodological point of view.

The research done by Gass (1984) uses an author-develop survey. This element could be considered as one that decreases the empirical value of the research. Even though the results tended to favor the idea that similar values between therapist and client increases the outcome of psychotherapy, the difference between the sample groups was not significant enough to generalize these results.

Haugen and Edwards (1976) used more standardized instruments in their research increasing the probability for more accurate results. Even though their results showed no difference for the clients in terms of a high or low tendency to choose therapists of the same religious values than those of the client, their results regarding perception of value similarity as a factor in considering the therapist as trustworthy was confirmed by Lewis and Walsh in 1980. One aspect that could explain why the hypothesis on selection of

therapists of the same value system was not confirmed could be the fact that the research sample was not taken from a psychiatric population. As explained by the authors, the subjects selected were defined as not having psychological problems and the dimensions of Christian and warmth could be more important to a psychiatric population.

Both research studies done by Mendelsohn (1963 and 1966) posses good methodological qualities. A standardized instrument was used for both and for the replication of the study the sample was increased to facilitate more the generalization of results. The fact that the same results were obtained in the replication study gives more value to them. The replication results give more ground to the idea that the matching of client-therapist values is of more importance to therapy than sex matching or the personalities of either or both therapist and client.

Lewis and Walsh (1980) used a combination of a standardized instrument and taped interviews. The results of this research back-up, as mentioned earlier, the results of Haugen and Edwards (1976). Another critique to this study is that only females participated. It would seem to me that issues of gender play a role in how we perceive people and the importance that similarity of values have for either therapist and client depend on sex differences.

The research done by Lewis, David and Lesmeisler (1983) and Lewis and Lewis (1980) on the impact of pre-

therapy information on value similarity, perception of therapist and outcome of therapy raises important questions about the degree of therapist self disclosure and issues of control during therapy.

Excessive pre-therapy information seems to have a negative effect according to results on these research. However, balance sharing of values on the part of both therapist and client during the therapeutic process seems to have a positive outcome and gives the client a sense of more control over the process than if the therapist tries to cover his values and beliefs. As argued by Rawlings and Carter (1977) the traditional unilateral therapist control limits client freedom of choice and denies clients the status of responsible adults through the therapeutic process. The similarity of values also seems to produce successful outcomes since the client appears to experience more acceptance and understanding. Nevertheless, the research indicates that the sharing of value similarities has to be appropriately communicated to the client to avoid withdrawal or early termination.

Another piece of critique is the issue of gender mentioned earlier that repeats itself in these two studies: only females comprised the sample. Standardized instruments were not used in either of the two studies.

Issues of value communication in the therapeutic process were looked into by Derlega, Lovell and Chaikin (1976). The results somehow support the findings of Lewis, David and Leismeisler (1983) in terms of the appropriate time and degree of self disclosure and its relation to outcome in therapy.

The findings of Haugen and Edwards (1976) and Lewis and Walsh (1980) were confirmed by Hlasny and McCarrey (1980) regarding value similarity, perception of the therapist and psychotherapeutic outcome. A combination of some standardized and some non-standardized instruments, was used to increase the value of the research in comparison to others that used less valid instruments. It should be noted too that results were obtained using a simulation design. Nevertheless, they still represent a potentially significant contribution to the literature.

Chesner and Baumeister (1985) addressed the issue of the disclosure of religious values. From a methodological point of view this research appears to be more sophisticated in the use of a standardized instrument. However, the results are not conclusive since not clear determination was made about the real impact of the therapist religious values' disclosure on the outcome of therapy. The subjects that participated were not persons who expected to be in therapy. Thus, it is possible that troubled clients would have responded differently.

Houts and Graham (1986) and Worthington and Scott (1983) centered their research on the therapist. We could infer from their results that the issue is not really the matching of belief systems between client and therapist but more so the awareness and acknowledgment of each other belief systems.

Houts and Graham's (1986) research appears to have more empirical value than Worthington and Scott's (1983) because of their use of standardized, valid and reliable instruments to assess the variables under investigation. The Worthington and Scott (1983) study has some limitations: therapists responded to written questions rather than to live clients. This eliminated the personal interaction between therapist and counselor that occurs in setting the treatment goals. On the other hand the findings do not causally relate values, goal selection and therapy outcome. Also in terms of the sample the level of training, theoretical orientation and professional background (pastoral counseling, social work, psychology, psychiatry was not determine. Therefore is hard to make valid generalizations from this study.

Rosenthal's (1955) study on the effects of value communication in psychotherapy, even though it has a small sample, provides reliable findings from an empirical point of view. The sample included equal numbers of female and

male participants and the instruments used are more reliable measurement devices. Rosenthal's (1955) research is very valuable because it started to look into the effects of therapist values' communications and how those values can be transferred to the client in subtle ways, even when trying to avoid doing so.

Pentony's (1966) research supports the original findings of Rosenthal (1955) as well as the study done by Welkowitz, Cohen and Ortmeyer (1967). The study by Pentony (1966) and by Welkowitz et al. (1967) are methodologically more sound than the original work of Rosenthal (1955) and they utilized a much larger sample than the earlier studies. Thus, there is increased evidence that there is a convergence of values between therapist and client during therapy and that the client's internalization of the therapist's values has a facilitating effect on outcome.

The analysis of these research studies thus not show that similarities or differences have a definite influence in the therapeutic relationship. However, it appears that the sharing of similar values can create a more positive outcome. In other words, if therapist and client have the same religious orientation values one can assume that the establishment of a therapeutic relationship would be facilitated. Still the therapist does not have to share the client's value system, though the basic standard would be at

least to be aware and accept the client's religious orientation without considering it to be pathological or unacceptable.

CHAPTER III

METHODOLOGY

The purpose of this chapter is to present the methodological aspects of the present study: hypotheses, sample, instrumentation, design and statistical analysis, and procedure. It also includes a discussion of the limitations of the research.

Hypotheses

Hypothesis I.- Therapists who are high in religiosity as measured by the Religious Attitude Scale will report their values affect their interpretation and handling of the client vignettes more often than therapists who are low in religiosity.

Hypothesis II.- Therapists who are high in religiosity as measured by the Religiosity Attitude Scale will describe the problem of the client in a different way than those therapists who are not high in religiosity.

Hypothesis III.- Therapists who are high in religiosity as measured by the Religious Attitude Scale will report greater difficulty in "seeing" the hypothetical clients in the vignettes due to a conflict between their values and those of the client, than those therapists who are low in religiosity.

Hypothesis IV.- Therapists who are high in religiosity as measured by the Religious Attitude Scale will respond to the clients' problems as posed on the case vignettes using a more spiritual approach than those therapists who are not high in religiosity.

Hypothesis V.- Women who are high in religiosity as measured by the Religious Attitude Scale will report experiencing more difficulties in the interpretation and handling of the client vignettes presented to them than men who are high on religiosity.

Sample

The population for the study included sixty experienced psychotherapists from two mental health clinics in the metropolitan Boston area, sixteen of whom were males and forty four females. Sixty percent of the subjects were clinicians who held Masters degrees and forty percent were at doctoral or licensure level. One clinic was an outpatient mental health facility that serves children and families. The other site was an independent counseling agency that provides psychotherapy and pastoral counseling to individuals, couples and families. The researcher works for both institutions.

The sixty subjects received two instruments: the case vignettes and the Religious Attitude Scale (see Appendixes A

and B). All participants were instructed to read and fill out each instrument and return them to the researcher.

Instrumentation

All instrumentation used in this study is contained in Appendixes A and B. The first instrument is comprised of eight vignettes. These vignettes were developed by the researcher using hypothetical cases. They differ from each other in content. Ethical dilemmas centering around the themes of abortion (case three and five), sexual relations (case one and six), sexual abuse (case two), birth control (case four), suicide (case seven) and unethical behavior (case eight) were used to develop the cases. Participants were asked the same five questions for each of the eight case vignettes:

- What is the problem?
- What would you say to this client?
- How much do you think your values would affect your interpretation and handling of this case?
- How difficult would it be for you to see this person as a client due to conflict between your values and his/her values?
- If somewhat difficult or very difficult, why is it a problem?

Two pilot studies were conducted to develop the final format of the case vignettes. Eleven vignettes were developed for the first pilot study. Three therapists from the agency in which the investigator works were selected to critique the initial eleven case vignettes. They were asked to read each vignette to determine clarity of language and appropriateness of length and content. After incorporating the suggested corrections the eleven vignettes were tested by administering them to a group of twenty two graduate students registered in a counseling psychology class at Northeastern University. The purpose of the second testing was to determine if the vignettes really portrayed the proposed problem suggested by the author in each of the case vignettes. Judges were instructed by the author to read and answer each of the case vignette questions. On that basis, it was previously decided that vignettes which elicited answers that were irrelevant because respondents did not identify the proposed theme of the vignettes would be eliminated for the final version. After each of the twenty two participants answered all five questions for each of the eleven vignettes, three case vignettes were eliminated.

The second instrument used was the Religious Attitude Scale developed by Poppleton and Pilkington (1963). The scale appears to be an adequate measure of religiosity. To calculate the reliability of the scale, Poppleton and Pilkington divided it into three subtests of seven item

each. Scores were calculated for all subjects in each of the three subtests. Intercorrelations between these parts were calculated and corrected for length. The value obtained was 0.97, a very high measure of reliability. In terms of validity the scores obtained on the scale corresponded in a consistent way with other indices of religious behavior and belief. A pilot survey was done with two groups: a pro-religious and an anti-religious one. A T-test between the mean scores of these two groups showed them to be significantly different at $p < 0.01$. Because of the bimodal nature of the distribution, non-parametric statistics were used, median scores for a pro-religious (group A) and anti-religious group (group B) were worked out. Group A had a median score of 116, and group B a median score of 60. There was no overlap at all between the scores of these two groups. This preliminary version of the scale showed evidence of validity. It may be concluded from the above discussion that the scale shows promise in appropriately discriminating between groups high in religiosity and those who are not. Therefore, it was used in the present study to identify those individuals on the sample who are highly religious and those who are not so religious in their view of life.

Design and Statistical Analysis

This study was an ex-post facto research study using individuals of high and low religiosity to determine whether they differ in how they react to case vignettes of hypothetical clients. There was no experimental manipulation of the independent or dependent variable.

There were five hypothesis. Three were appropriately analyzed using Chi Square Contingency Analysis and the other two with analysis of variance.

Hypotheses II, IV and V were analyzed using Chi Square Contingency Analysis (see table III.1). This analysis was used to determine the significance of the relationship between religiosity and respondents' descriptions of problems posed by the vignettes (hypothesis II), their responses to client problems described in the vignettes (hypothesis IV), and whether or not they expressed difficulty in handling the vignettes clients problems (hypothesis V). To do this, the sample was divided into subgroups (high and low) according to degree of religiosity as measured by the Religious Attitude Scale. Participants definitions of the problem (question one) and what participants said they would do in response to the hypothetical clients' problems (question two) were analyzed to determine content categories (hypotheses II and IV). The respondents' spiritual approach (hypothesis IV) referred to

the respondents' focus on the religious connotations of the problem presented in the hypothetical case vignettes. The spiritual approach was also measured by content analysis of the responses given by the respondents to the problems posed in each of the eight case vignettes.

Table III.1 .- Analysis of Hypotheses

Independent Variables	Dependent Variables
Level of Religiosity	Interpretation of Vignettes
HIGH LOW	Categories will depend on content analysis

Hypotheses I and III were analyzed using factorial analysis of variance. The independent variable was the degree of religiosity (high, middle and low) and the dependent variables were the degree of difficulty handling the case and the degree of effect on the value system of the therapist. Both dependent variables were continuous. Participants responses to Q1 (What is the problem?) and Q2 (What would you say to this client?) were analyzed by the author using content analysis. For question one, five categories were identified for each case vignette (see Table III.2).

Table III.2 .- Categories for Question One for Each Case Vignette (Question One: What Is The problem?)

Case	Category	Case	Category
1	Low self-esteem Co-dependency Sexual abuse Conflict with values Identity Issues	5	Dependency Abortion Anger and depression Low self-esteem Grief and loss
2	Disengaged mother Enmeshed relationship Denial of sexual abuse Role confusion Poor parenting skills	6	Poor parenting skills Sexual overstimulation Poor interpersonal relations Inappropriate sexual behavior Insecurity
3	Low self-esteem Conflict with values Self-destructive tendencies Guilt Anxiety	7	Grief Guilt Emotional neglect Denial Loss
4	Issues of control and power Insecurity Poor judgment Conflict with values Inability to make decisions	8	Conflict with values Fear Insecurity Ethics Guilt

For question two, four categories were determined (see Table III.3). Analysis of the presence of the categories in each case vignette were conducted. The degree of religiosity was disguised to avoid contamination.

Table III.3 .- Categories for Questions Two for Each Case Vignette (Question Two: What Would You Say to This Client?)

Case	Category	Case	Category
1	Talk about feelings of insecurity Talk about relationships with parents and others Talk about perception of self Talk about needs and feelings	5	Talk about self image Talk about values Talk about depression and anger Unconditional acceptance of client
2	Talk about about trust Clarify concern of sexual abuse Building empathic relationship Working on parenting skills	6	Talk about parenting skills Talk about sexual behavior Talk about feelings of insecurity Work on relationships
3	Talk about feelings and relationships Unconditional acceptance of client Address conflict with values Address guilt feelings	7	Explore feelings Talk about grief and loss Talk about suicide Unconditional acceptance of the client
4	Address issues of poor judgment Talk about control and power Talk about values and feelings Recommend couple therapy	8	Evaluate alternatives Provide emotional support Talk about feelings Assessment of personal values

CHAPTER IV

RESULTS

This chapter contains the descriptive statistics followed by a discussion of the results of the analysis of each hypotheses. Finally, some additional analyses are included.

Descriptive Statistics

The total sample of the study included sixty experienced psychotherapists most of them Masters degree level, of these sixteen were males and forty four females. They ranged in age from 23 to 64. The group's mean age was 40.96. Twenty identified themselves as Catholics, twenty one as Protestants, three were Jewish and three Buddhists. Thirteen subjects reported not belonging to any religious denomination.

Tables IV.1, IV.2 and IV.3 include the descriptive statistics for the total sample including level of religiosity, values in relation to how each participant interpreted each case vignette and degree of difficulty expressed by participants in relation to conflicts between their values and those of the hypothetical client.

The sample from which the Religious Attitude Scale was standardized showed a religiosity mean of 88 while the sample for this study had a religiosity mean score of

Table IV.1 .- Descriptive Statistics of Total Sample with Respect to Level of Religiosity

Variable	Mean	Std. Dev.	Std. error	Max.	Min.	Range
Religiosity Scale Scores	63.80	17.96	2.32	98	25	73

Table IV.2 .- Values in Relation to How Each Participant Interpreted Each Case Vignette

Case	Mean	Std. Dev.	Std. Error	Max Score	Min Score	Range
Case 1	1.96	0.88	0.11	4	1	3
Case 2	2.20	0.95	0.12	4	1	3
Case 3	2.03	0.97	0.12	4	1	3
Case 4	2.08	0.96	0.12	4	1	3
Case 5	1.88	0.88	0.11	4	1	3
Case 6	1.93	0.82	0.10	4	1	3
Case 7	2.08	0.82	0.10	4	1	3
Case 8	1.86	0.96	0.12	4	1	3

n= 60 subjects evaluated the cases

Table IV.3 .- Degree of Difficulty Expressed by Participants in Relation to Conflict Between Their Values and Those of The Hypothetical Client

Case	Mean	Std. Dev.	Std. Error	Max Score	Min Score	Range
Case 1	1.13	0.34	0.04	2	1	1
Case 2	1.21	0.45	0.05	3	1	2
Case 3	1.23	0.56	0.07	4	1	3
Case 4	1.33	0.62	0.08	4	1	3
Case 5	1.20	0.54	0.07	4	1	3
Case 6	1.23	0.42	0.05	2	1	1
Case 7	1.51	0.70	0.09	4	1	3
Case 8	1.28	0.61	0.07	4	1	3

n = 60 subjects evaluated the cases

X = 63.80 (see Table IV.1). The difference between the means of the two samples was 23.20 suggesting that the sample for this study can be considered to be "less religious" than Poppleton and Pilkington's 1963 sample. The standardization sample was from England and not from the United States.

Questions three and four asked: "How much do you think your values would affect your interpretation and handling of this case?" and "How difficult would it be for you to see this person as a client due to conflict between your values and his/her values?". The data presented on Table IV.2 and

IV.3 summarizes the subjects' responses to these two questions in relation to each of the eight case vignettes. As can be seen on the tables there was not a great deal of variance among respondents.

Hypothesis I

Hypothesis I stated that therapists who are high in religiosity as measured by the Religious Attitude Scale will report their values affected their interpretation and handling of the client vignettes more than therapists who are low in religiosity.

Hypothesis I was tested with a series of eight one-way analysis of variance using as the independent variable, the degree of religiosity, and as the dependent variable the degree to which the values affected the interpretation and handling each of the eight cases (Q3: How much do you think your values would affect your interpretation and handling of this case?)

Table IV.4 includes the means for the low, middle and high religious groups with respect to the eight cases and the ANOVA results.

Results on the eight one-way Anovas indicated no statistically significant difference between degree of religiosity and reported degree of difficulty in handling the cases posed by the eight case vignettes.

Table IV.4 .- Means and ANOVAs for Low, Middle and High Religiosity Groups and Degree of Difficulty Handling Clients

Q	X Low	X Medium	X High	ANOVA Results
Case 1	1.76	2.05	2.10	F(2.57)=0.88, p=0.42, n.s.
Case 2	2.14	2.26	2.20	F(2.57)=0.08, p=0.92, n.s.
Case 3	1.85	1.84	2.40	F(2.57)=2.22, p=0.11, n.s.
Case 4	2.00	2.21	2.05	F(2.57)=0.25, p=0.77, n.s.
Case 5	1.61	2.00	2.05	F(2.57)=1.48, p=0.23, n.s.
Case 6	1.66	1.94	2.20	F(2.57)=2.26, p=0.11, n.s.
Case 7	2.04	2.00	2.20	F(2.57)=0.31, p=0.73, n.s.
Case 8	1.85	1.84	1.90	F(2.57)=0.02, p=0.98, n.s.

n = 60

Thus, therapists with high degrees of religiosity did not experience greater difficulties handling and interpreting the cases than those who were less religious. Hypothesis I was not supported by the data.

Hypothesis II

Hypothesis II stated that therapists who are high in religiosity as measured by the Religiosity Attitude Scale will describe the problems of the hypothetical clients in a different way than those therapists who are not high in religiosity.

Hypothesis II was tested using Chi Square Contingency Analysis to determine the relationship between religiosity (high, low) and subjects' descriptions of the presenting problem in each of the eight vignettes. Case Three and Five dealt with abortion; Case One and Six, with sexual relation; Case Two, with sexual abuse; Case Four, with issues of birth control; Case Seven, with suicide and case eight with unethical behavior. The results (see Table IV.5) indicated that there were no statistically significant relationships between the two variables for each of the eight cases. Therapists with different degrees of religiosity did not differ in how they described the hypothetical clients' problems. Hypothesis II was not supported by the data.

Hypothesis III

Hypothesis III stated that therapists who are high in religiosity as measured by the Religiosity Attitude Scale will report greater difficulties seeing the hypothetical clients described in each of the eight vignettes due to a conflict between their values and those of the clients than therapists who are low in religiosity.

Hypothesis III was tested with a series of eight one-way analysis of variance using the subjects degree of religiosity (low, middle and high) as the independent variable, and the degree of conflict between the therapist

Table IV.5 .- Responses to Question One For Each of The Eight Vignettes

Case	Q1 Responses	Chi Square values
1	1. Low self-esteem 2. Co-dependency 3. Conflict with values 4. Identity issues 5. Promiscuity 6. Intimacy, trust	X^2=4.22, d.f.=5, n.s.
2	1. Disengaged mother 2. Enmeshed relationships 3. Denial of sexual abuse 4. Role confusion 5. Poor parenting skills	X^2=5.42, d.f.=4, n.s.
3	1. Low self-esteem 2. Conflict with values 3. Self destructive tendencies 4. Guilt and anxiety	X^2=4.20, d.f.=3, n.s.
4	1. Issues of control and power 2. Insecurity 3. Poor judgment 4. Conflict with values	X^2=0.95, d.f.=3, n.s.
5	1. Dependency 2. Abortion 3. Anger and depression 4. Low self-esteem 5. Grief and loss	X^2=3.16, d.f.=4, n.s.
6	1. Poor parenting skills 2. Sexual overstimulation 3. Poor interpersonal relations 4. Inappropriate sexual behavior	X^2=1.09, d.f.=3, n.s.
7	1. Grief and guilt 2. Denial 3. Emotional neglect 4. Other	X^2=1.20, d.f.=3, n.s.
8	1. Conflict with values 2. Fear 3. Insecurity 4. Other	X^2=5.47, d.f.=4, n.s.

n = 60

values and the client values as indicated by subjects' responses to question four (Q4): How difficult would it be for you to see this person as a client due to conflict between your values and his/her values?

Results indicated no significant statistical relationship between degrees of religiosity and difficulties in seeing the hypothetical client due to perceived value conflict (see Table IV.6). Statistical significance was established only for participants' responses to Case Seven. Case Seven dealt with the issues of suicide and parental emotional neglect. In this instance those who rated low in religiosity reported greater difficulty in handling the hypothetical case than those who rated high. This was contrary to what was predicted. With respect to the vignette dealing with unethical behavior (Case Eight) the relationships between religiosity and degree of conflict "approached" statistical significance. Those who were classified as being less religious expressed greater conflict. With respect to the other six cases there were no statistically significant differences between degree of religiosity and expressed conflict. Thus, highly religious therapists did not report greater difficulty "seeing" hypothetical clients whose values differed from theirs than did less religious therapists. Hypothesis III was confirmed only for one of the cases.

Table IV.6 .- Means and ANOVAs for The Low, Middle and High Religiosity Groups and Degree of Conflict Reported

Q4	X Low	X Medium	X High	ANOVA Results
Case 1	1.43	1.21	1.05	F(2.57)=1.08, p=0.34, n.s.
Case 2	1.38	1.15	1.10	F(2.57)=2.29, p=0.11, n.s.
Case 3	1.19	1.21	1.30	F(2.57)=0.21, p=0.81, n.s.
Case 4	1.33	1.42	1.25	F(2.57)=0.35, p=0.70, n.s.
Case 5	1.09	1.26	1.25	F(2.57)=0.59, p=0.55, n.s.
Case 6	1.28	1.21	1.20	F(2.57)=0.24, p=0.78, n.s.
Case 7	1.81	1.42	1.30	F(2.57)=3.19, p=0.04, s.
Case 8	1.52	1.21	1.10	F(2.57)=2.80, p=0.06, n.s.

n = 60

Hypothesis IV

Hypothesis IV stated that therapists who are high in religiosity as measured by the Religious Attitude Scale will use a more spiritual approach with their clients than those therapists who are not high in religiosity. The term spiritual approach was defined as the therapist focusing on the religious nature of the problem depicted in the vignette, i.e., seeing abortion as a sin as opposed to focusing on a non religious topic, i.e., feelings of insecurity. Content analysis was used to determine whether

or not participant responses to each of the case vignettes were characterized by a religious approach. This content analysis did not yield any responses which focused on spiritual issues. Thus, the hypothesis was rejected. However, analysis of differences between the two groups with regard to the non spiritual themes used was conducted using Chi Square Contingency Analysis (see Table IV.7). The results of this analysis indicated no statistically significant relationships. Highly religious therapists did not differ in the non spiritual content of their responses from less religious therapists. Thus, hypothesis IV was not supported by the data.

Hypothesis V

Hypothesis V stated that women who are high in religiosity as measured by the Religious Attitude Scale will report experiencing more difficulties in the interpretation and handling of the case vignettes than men who are high in religiosity.

Hypothesis V was tested using Chi Square Contingency Analysis to determine the relationship between gender and the degree of difficulty reported in the interpretation and handling of the cases within the high religiosity group for each of the eight cases. The results indicated that there was only one statistically significant relationship between gender and degree of difficulty reported in the

Table IV.7 .- Chi Square Results Between Degree of Religiosity of Therapists and Content of The Responses

Case	Would Talk to Client About	Chi Square Results
1	1. Feelings of insecurity 2. Relationship with parents 3. Perception of self 4. Needs and feelings	X^2=5.17, d.f.=3, n.s.
2	1. Feelings 2. Concerned about sexual abuse 3. Building empathic relation with daughter 4. Work on parenting skills	X^2=5.62, d.f.=4, n.s.
3	1. Feelings and relationships 2. Unconditional acceptance of client 3. Conflict with values 4. Guilt	X^2=4.19, d.f.=4, n.s.
4	1. Poor judgment 2. Control and power 3. Values and feelings 4. Need for couple therapy	X^2=3.11, d.f.=4, n.s.
5	1. Self image 2. Values 3. Depression and anger 4. Unconditional acceptance of client 5. Feelings	X^2=4.63, d.f.=3, n.s.
6	1. Parenting skills 2. Sexual behavior 3. Relationships	X^2=3.31, d.f.=3, n.s.
7	1. Feelings 2. Grief and loss 3. Suicide 4. Unconditional acceptance of parents	X^2=5.93, d.f.=3, n.s.
8	1. Alternatives 2. Providing emotional support 3. Feelings 4. Personal values	X^2=4.62, d.f.=4, n.s.

n = 60

interpretation and handling of Case Three within the high religiosity group (X^2 = 4.34, d.f.=1, $p < 0.05$) (see Table IV.8). Case Three described a woman wanting to have an abortion because she does not know which of her two sexual partners is the father of the child. Analysis of data indicated that 100% of the males (n=10) that scored high in religiosity had difficulties in the interpretation and handling of the case. Females (n=20) who scored high in religiosity were about evenly divided between having some difficulty and having no difficulty. The important element here is that every male had difficulty in the interpretation and handling of Case Three.

With respect to the other seven cases there were no statistically significant relationships between gender and reported degree of difficulty in the interpretation and handling of the case vignettes within the group high in religiosity. Thus, highly religious female therapists did no differ significantly from highly religious male therapists with respect to reported difficulties in the interpretation and handling of the case vignettes other than for Case Three. Hypothesis V was, therefore, not supported by the data.

Table IV.8 .- Degree of Difficulty in Handling Hypothetical Cases Among Highly Religious Males and Females

Case 1	X^2=0.04, d.f.=1, n.s.
Case 2	X^2=0.93, d.f.=1, n.s.
Case 3	X^2=4.34, d.f.=1, s.
Case 4	X^2=0.63, d.f.=1, n.s.
Case 5	X^2=0.93, d.f.=1, n.s.
Case 6	X^2=0.38, d.f.=1, n.s.
Case 7	X^2=0.18, d.f.=1, n.s.
Case 8	X^2=0.53, d.f.=1, n.s.

n = 60

Additional Data Analyses

A series of four simple regression analyses were conducted to determine if the independent variables of age, sex, level of activities in the church and religious denomination were statistically significant predictors of the subjects' level of religiosity.

The results indicated that the variable of activity in the church and the variable of religious denomination were statistically significant predictors of religiosity scores.

People who were active in the church tended to be more religious [F(1.58)=25.65, p < 0.001]. The degree of religiosity mean for those subjects not active in the church was 53.93; for those who were active the mean score was 73.66.

The degree of religiosity according to religious preference are described on Table IV.9. Of the subjects who had no religious affiliations (n=13) ninety two percent scored low in religiosity. Results indicated that seventy per cent of those who identify themselves as Catholic (n=20) scored high in religiosity. Within the Protestant group (n=21) eighty one percent scored high in religiosity. Sixty seven percent of the subjects who were identified as Jewish (n=3) scored low in religiosity. The Buddhist group (n=3) scored 100% high in religiosity.

The results reported will be discussed in the following chapter.

Table IV.9 .- Degree of Religiosity by Denomination

Religiosity Raw Scores		Denominations									
		None		Catholic		Protestant		Jewish		Buddhist	
		No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
High	98	1	8	14	70	17	81	1	33	3	100
Low	25	12	92	6	30	4	19	2	67	0	0

n=60

CHAPTER V

DISCUSSION

The purpose of this study was to explore the importance of religious values in psychotherapy and in particular to determine how different therapists, identified as having different degrees of religiosity, handle the issue of values in hypothetical psychotherapeutic situations. It is becoming more and more acceptable within the psychological field that the psychotherapeutic process is not value free, is not neutral. Both therapist and client bring into the process all of what they are, including their own value system. A qualitative analysis of the subjects' responses indicated that the participating therapists' values are recognized and present in the way they responded to the case vignettes. However, the overall result of this study did not support the hypotheses. The results of this investigation will be summarized and discussed in the next section.

Summary of Results

An ex post facto, quasi-experimental design was used in this study. The participants for the study constituted a "convenience sample" of sixty experienced psychotherapists from two mental health clinics in the metropolitan Boston area. The instrumentation consisted of eight case vignettes

to which subjects were asked to respond and the Poppleton and Pilkington Religious Attitude Scale that participants were instructed to fill out.

Hypothesis I

This hypothesis predicted that therapists who were high in religiosity would report more difficulties with their values in their interpretation and handling of the client's problems discussed in the vignettes than therapists who were low in religiosity. It was found, using analysis of variance, that there were no significant differences between respondents' level of religiosity and value dilemmas in interpreting and handling the eight case vignettes. Thus, this hypothesis was not supported by the data.

Research design factors might have contributed to the absence of support for this hypothesis. The stydy used a "convenience sample" in which all participants were experienced psychotherapists who supposedly are trained to be aware of any intrusion of their own value system in the therapeutic relation. Another factor probably contributing to the lack of significance is the fact that the case vignettes were developed for this study and never tested other than for clarity and content in the pilot study. It is possible that the questions asked did not pick up the differences among therapists in terms of their difficulties

handling the cases in relation to their value system. The vignettes and the questions may have made the religious nature of the investigation too obvious. The size of the sample should also be considered as another explanation for the lack of significance. The sample of this study was small. If differences do indeed exist, a larger random sample would have produced significant results. More importantly, this study did not look into the whole value system of the participants but restricted itself to their degree of religiosity, and how it affected the interpretation and handling of the problems presented in the hypothetical case vignettes.

As mentioned before, the participating clinicians are experienced psychotherapists who have received traditional academic training. They are, therefore, forewarned against the use of their own values when treating clients. The notion that the therapist's attitudes and values are communicated anyway to the client in the therapeutic process, even though it is lately becoming clear, is not yet widely accepted (Lovinger, R., 1978; Bergin, A., 1980; Meadow, M. et al., 1979). Psychology and psychologists are becoming aware of the importance of addressing religious values in therapy (Spero, 1981; Bergin, A., 1983) but they are proceeding with caution since the traditional conceptualization of psychology implies that neutrality is

crucial to allow the client to project his/her feelings onto the blank screen of the therapist (Greben and Lessen, 1976).

Hypothesis II

This hypothesis predicted that therapists who were high in religiosity would describe the client's problems described in the vignettes in a different way than those low in religiosity. It was found, using Chi Square Analysis, that the different degrees of religiosity among the participants had no effect on how they described the problems highlighted in the vignettes. Thus, the hypothesis was not supported by the data.

The failure to established a statistical significant relationship between the variables under investigation can be explained in part by the lack of sophistication of the instrument utilized to identify differences among therapists. Another factor was, perhaps the care therapists take to avoid using their own religiosity as a therapeutic tool. Therefore, it could be said that although therapists also have a world view colored by their own religiosity, professional therapists keep that view in its proper perspective. The results of the statistical analysis conducted to test hypothesis II lend support to Houts and Graham's (1986) conclusions that religious and non religious therapists are capable of identifying psychopathology regardless of their own religiosity.

Hypothesis III

This hypothesis predicted that therapists who were high in religiosity would report greater difficulty seeing a client due to a conflict between their values and those of the client than those therapists who were low in religiosity. Analysis of variance indicated that there was a statistically significant difference between degree of religiosity and participants' responses to Case Vignette Seven. This case vignette described an adolescent suicide as a consequence of parental emotional neglect. Responses to the other seven case vignettes did not vary in a statistically significant way when subjects' responses were analyzed according to degree of religiosity. Thus, the hypothesis was not supported by the data.

Analysis of data indicated that participants considered that their values did not affect their interpretation of the cases described in the vignettes. It is possible that these therapists seem to be aware of the differences in value systems but are still able to see the person as a client regardless of those differences. It is important to underline, once more, that the majority of the research studies so far available in the literature have focused more on the client's values. This can be pointed out as another example of how "protective" clinicians have been of their own integrity as therapists.

Subject's responses to Case Vignette Seven partially supported hypothesis III. Thus, participants experienced some degree of difficulty with their own values and those of the hypothetical clients.

Hypothesis IV

This hypothesis predicted that therapists who were high in religiosity would use a more spiritual approach in responding to the eight case vignettes than those not high in religiosity. Chi Square Analysis of participants' responses indicated that there were no statistically significant relationships between these two variables. Thus, the hypothesis was not supported by the data.

Analysis of the data showed that there was no evidence of a focus on the religious connotations of the problem on the part of those who rated high on religiosity. In fact, the content of the responses was similar for both groups.

The results obtained in the analysis of this hypothesis are contrary to the conclusions of Worthington and Scott (1983) who indicated that religious therapists set treatment goals targeted to spiritual concerns more than therapists low in religiosity.

The research of Houts and Graham (1986) focused on the influence of traditional spiritual values of therapists and

clients on judgment of prognosis, psychopathology and locus of client problems. Religious and non religious therapists found more psychopathology in clients that had doubts about their own religiosity than those who did not have doubts. Once again this research is more centered on the client but is consistent with the results of hypothesis IV: the approach used by the therapist is not based on the therapist degree of religiosity but on the ego dystonic presentation of the client at the time of treatment.

Hypothesis V

This hypothesis predicted that women who were high in religiosity would experience more difficulties in their interpretation and handling of the clients' problems than men who were high in religiosity. It was found, using Chi Square Contingency Analysis, that there was no statistically significant relationship between gender and difficulty in interpreting and handling the eight case vignettes, except for Case Vignette Three. Thus, the hypothesis was not supported by the data.

For Case Three, one hundred percent (100%) of the highly religious males had difficulty in the interpretation and handling of the case. The statistical significance of the relationship between male/female religiosity and the degree of difficulty in interpreting and handling the issue

raised by Case Three does not confirm hypothesis V. Therefore this poses a possible research question in terms of religious males interpretation and handling of cases when facing issues such as abortion and dual sexual partnership on the part of others.

None of the research studies identified in the literature search dealt with specific issues of gender. Therefore, no direct comparison can be made with the results of this study.

Descriptive data analyses showed that overall the participants in this study reported high degree of religiosity. However, despite their own religious values they did not experience problems in how they interpreted and handled hypothetical clients' problems nor on how they approached the psychotherapeutic process. As stated, clinicians continue to be trained under the assumption that psychotherapy must be value free.

Limitations

The results of the study are valid only for this sample and should not be generalized to other populations. As noted earlier, the sample was small and therefore the results could have been different with a larger more representative sample. This study dealt with different religious denominations and there are different values

associated with each of those orientations. Therefore, another limitation of this research could be that high religiosity may have different meanings among the different religious denominations, i.e., christians place great importance in positive or negative behaviors and their relation to salvation. The Jewish tradition emphasizes responsibility and self-discipline regardless of salvation. It also needs to be pointed out that this study and its results pertain only to the opinion of participants when they responded to hypothetical case vignettes. The results obtained are not, and do not intend to exemplify how these therapists react or respond to actual situations. This could be the focus for future research. In addition, more sophisticated instruments need to be developed to measure religiosity and its impact on the therapeutic process.

Implications

The findings of this study have implications for research and training.

It is important to be aware of the role that the therapist's value system plays in the psychotherapeutic relation. Even though the results of this study tend to indicate that participants do not have difficulties with their value system around the problems posed by the hypothetical case vignettes, it would be important that

therapists in general be more willing to explore that aspect of their practice.

Also more attention should be given in practice to explore the client's spiritual values in order to be able to understand in more depth their personality. In doing so, the therapist will also be placed in the situation of exploring his/her own values and to what degree they have an impact on the therapeutic relationship. Therapists need to free themselves up more from their academic training to be able to open up to the possibility of a psychotherapeutic process in which their own values are present and need to be taken into account.

Research

The following studies are recommended for further research:

- A prospective longitudinal study of future therapists should be done before they start their academic training to see if there is a gradual change in awareness of their religious values as a they become therapists.

- Research should be conducted on the degree of religiosity of the trainers and their influence on their students. This will help determine the degree of influence that formal training has on the way therapists in formation approach the therapeutic relationship with their clients.

- For the purpose of this study a Religious Attitude Scale was used to determine degree of religiosity. For future research measures that are less obvious should be used so that the participants will be able to express their thoughts more openly and disclose more of their opinions.

Training

From the training point of view the following recommendations are suggested:

- Students who want a more spiritual approach in their training should attend programs that teach such approach.

- Clinical and counseling programs should be open to teach spiritual approaches that would allow students to include these techniques and approaches when doing psychotherapy if they so wish.

Conclusions

The impact that religiosity, as measured by the Religious Attitude Scale, has had on the way respondents reacted to eight case vignettes designed to elicit value laden responses was not evident in this study. Respondents high in religiosity as well as those low in religiosity responded to case vignettes using a non spiritual approach and relying on their academic/theoretical way of interpreting psychotherapy.

This is only a preliminary finding in an area that hardly has been explored. The study has limitations in relation to the sample and instruments. Since it cannot be denied that values are an integral part of each human being, more research needs to be done that will clarify the presence of these values in the relationship between therapist and client.

APPENDIX A: HYPOTHETICAL CASE VIGNETTES

The following papers contain case examples.

Please respond the questions regarding each of the following case examples to the best of your abilities.

Be sure to answer all the questions.

Thanks you for your cooperation.

CASE 1

Ms. Jones has a Bachelors degree and is presently seeking a job. She reports being involved with two sexual partners at this time and "casually" seeing three other men. She states that her two primary relationships are fairly sexually satisfying, but that she finds that she does a lot of the"taking care of" with them and that no one really takes care of her. She lies to each of these men about her sexual behavior regarding other men. She is concerned that she may be perceived as a prostitute. This person comes to you -the therapist- seeking counseling.

Questions:

1.- What is the problem?

_____
_____
_____

2.- What would you say to this client?

_____
_____
_____

3.- How much do you think your values would affect your interpretation and handling of this case?

_____Very much _____Much _____Some _____Not at all

4.- How difficult would it be for you to see this person as a client due to conflict between your values and his/her values?

_____Not difficult _____Somewhat difficult

_____Difficult ----Very difficult

5.- If somewhat difficult, difficult or very difficult why is it a problem?

_____
_____
_____

CASE 2

A 25 year old single mother who has an eight year old daughter is referred to you for treatment. Reportedly, the mother's boyfriend has sexually abused the daughter.

The therapist requests that mother and child be seen together. In the course of the sessions mother and daughter exhibit a "peer like" relationship. Mother reports that she was not aware of the sexual abuse by her boyfriend. The daughter is sexually acting out with other children at school.

Questions:

1.- What is the problem?

_____

_____

_____

2.- What would you say to this client?

_____

_____

_____

3.- How much do you think your values would affect your interpretation and handling of this case?

____Very much _____Much _____Some _____Not at all

4.- How difficult would it be for you to see this person as a client due to conflict between your values and his/her values?

____Not difficult _____Somewhat difficult _____Difficult

____Very difficult

5.- If somewhat difficult, difficult or very difficult why is it a problem?

_____

_____

_____

CASE 3

A college student seeks therapy after having an abortion upon discovery that her boyfriend has decided to marry another woman.

While in therapy she starts seeing another man whom eventually she marries. However, her former boyfriend continues seeing her and she is sexually active with him. She becomes pregnant and stops seeking treatment for fear of confrontation with her therapist regarding her behavior with these two men. After having the baby she returns to treatment since she feels confused about her relationship with the two men and feels increasingly anxious because she is unsure who is the baby's father.

Questions:

1.- What is the problem?

_____

_____

_____

2.- What would you say to this client?

_____

_____

_____

3.- How much do you think your values would affect your interpretation and handling of this case?

____Very much _____Much _____Some _____Not at all

4.- How difficult would it be for you to see this person as a client due to conflict between your values and his/her values?

____Not difficult _____Somewhat difficult _____Difficult

____Very difficult

5.- If somewhat difficult, difficult or very difficult why is it a problem?

_____

_____

_____

CASE 4

Kate and John are getting married. John belongs to a very conservative religious group. He does not believe in birth control and definitely will not use it and will not allow his wife-to be to practice it.

Kate, who is from the same religious background, disagrees. They have discussed the issue over and over and John's position is unchangeable. John has made it clear to Kate that she cannot use birth control. Kate wants to marry him because she feels he is the perfect man for her. However, she has decided to take the pill but not tell him about it. To feel more secure about her decision she seeks your professional advice.

Questions:

1.- What is the problem?

_____

_____

_____

2.- What would you say to this client?

_____

_____

_____

3.- How much do you think your values would affect your interpretation and handling of this case?

____Very much _____Much _____Some _____Not at all

4.- How difficult would it be for you to see this person as a client due to conflict between your values and his/her values?

____Not difficult _____Somewhat difficult _____Difficult

____Very difficult

5.- If somewhat difficult, difficult or very difficult why is it a problem?

_____

_____

_____

CASE 5

Mary is a 25 year old divorced single parent of two boys. Presently she is not working, and her financial situation is poor. Last summer she decided to go and visit her parents who live in another state. There she found the boyfriend of her adolescent years and discovered that she was madly in love with him. Reportedly, finding Peter (boyfriend) was the best that could happen to her. She became pregnant and told Peter. He did not wanted her to have the baby and told her he would be unwilling to help take care of an infant.

She is determined to have an abortion but feels very sad about it. Nothing is going to change her mind. She knows it is the best solution considering her situation but she feels depressed and angry. She is referred to you for counseling.

Questions:

1.- What is the problem?

_____

_____

_____

2.- What would you say to this client?

_____

_____

_____

3.- How much do you think your values would affect your interpretation and handling of this case?

____Very much _____Much _____Some _____Not at all

4.- How difficult would it be for you to see this person as a client due to conflict between your values and his/her values?

____Not difficult _____Somewhat difficult _____Difficult

____Very difficult

5.- If somewhat difficult, difficult or very difficult why is it a problem?

_____

_____

CASE 6

Susan is a 27 year old divorced mother of a five year old boy. She is sexually involved with two different men.

Johnny's teacher has perceived very unusual behavior in the child's play. His games and interaction with other children are very sexually oriented and he looks anxious and agitated.

A complaint is filed through the D.S.S. and the investigation results indicate that the child was never sexually abused. The results also showed that the child was always at home when mother and partners engaged in sexual intercourse and viewed them having sexual relations. Mother is referred to you for treatment.

Questions:

1.- What is the problem?

_____

_____

_____

2.- What would you say to this client?

_____

_____

_____

3.- How much do you think your values would affect your interpretation and handling of this case?

____Very much _____Much _____Some _____Not at all

4.- How difficult would it be for you to see this person as a client due to conflict between your values and his/her values?

____Not difficult _____Somewhat difficult _____Difficult

____Very difficult

5.- If somewhat difficult, difficult or very difficult why is it a problem?

_____

_____

_____

CASE 7

A fifteen year old adolescent boy kills himself. Results of the investigation reveal that the parents' emotional neglect of this child since infancy was a major factor in his decision to commit suicide. The parents are referred to you for treatment.

Questions:

1.- What is the problem?

_____

_____

_____

2.- What would you say to this client?

_____

_____

_____

3.- How much do you think your values would affect your interpretation and handling of this case?

_____Very much _____Much _____Some _____Not at all

4.- How difficult would it be for you to see this person as a client due to conflict between your values and his/her values?

_____Not difficult _____Somewhat difficult _____Difficult

_____Very difficult

5.- If somewhat difficult, difficult or very difficult why is it a problem?

_____

_____

_____

CASE 8

Joe a biologist that works on in vitro fertilization becomes aware that some co-workers are mishandling patient's sperm. The sperm are being improperly matched. Joe's job would be in danger if he reports the incident. At the point of having a "nervous breakdown" he seeks your professional help.

Questions:

1.- What is the problem?

_____

_____

_____

2.- What would you say to this client?

_____

_____

_____

3.- How much do you think your values would affect your interpretation and handling of this case?

_____Very much _____Much _____Some _____Not at all

4.- How difficult would it be for you to see this person as a client due to conflict between your values and his/her values?

_____Not difficult _____Somewhat difficult _____Difficult

_____Very difficult

5.- If somewhat difficult, difficult or very difficult why is it a problem?

_____

_____

_____

APPENDIX B: RELIGIOUS ATTITUDE SCALE

FORM C

Below are 21 statements which concern religious beliefs. Please indicate the extent to which you agree or disagree with them. Underneath each statement you will find five alternative answers. Place a cross (x) beside the statement which best represents your opinion. For example:

More time in broadcasting should be allotted to agnostic speakers.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

Please do not leave out any statements even if you find it difficult to make up your mind.

We should be grateful if you would also fill in answers to the questions on the final sheet.

All the information given will be treated as strictly confidential. Thank you for your co-operation.

1. To lead a good life it is necessary to have some religious belief.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

2. Jesus Christ was an important and interesting historical figure, but in no way divine.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

3. I genuinely do not know whether or not God exists.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

4. People without religious beliefs can lead just as moral and useful lives as people with religious beliefs.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

5. Religious faith is merely another name for belief which is contrary to reason.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

6. The existence of disease, famine and strife in the world makes one doubt some religious doctrines.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

7. The miracles recorded in the Bible really happened.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

8. It makes no difference to me whether religious beliefs are true or false.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

9. Christ atoned for our sins by His sacrifice on the cross.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

10. The truth of the Bible diminishes with the advance of science.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

11. Without belief in God life is meaningless.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

12. The more scientific discoveries are made the more the

glory of God is revealed.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

13. Religious education is essential to preserve the morals of our society.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

14. The proof that Christ was the Son of God lies in the record of the Gospels.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

15. The best explanation of miracles is as an exaggeration of ordinary events into myths and legends.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

16. International peace depends on the world-wide adoption of religion.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

17. If you lead a good and decent life it is not necessary to go to church.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

18. Parents have a duty to teach elementary Christian truths to their children.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

19. There is no survival of any kind after death.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

20. The psychiatrist rather than the theologian can best explain the phenomena of religious experience.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

21. On the whole, religious beliefs make for better and happier living.

___Strongly Agree ___Agree ___Uncertain ___Disagree

___Strongly Disagree

SURVEY QUESTIONNAIRE

Would you please answer the following additional questions?

1. Age (in years) _____

2. Sex: Female or Male (underline one)

3. Would you describe yourself as an active member of a church?

Yes or No (underline one)

4. If "Yes" to question (3) to which denomination do you belong?

_____

5. If "No" to question (3), in which denomination were you brought up (if any)?

_____

6. How many times did you attend church during the month of December? _____

7. Are you a member of any religious group? (e.g. Methodist Society, Paulist Center, etc.).

Yes or No (underline one)

8. Do you say private prayers?

Yes or No (underline one)

9. If so, do you say them:

a. At least once daily? Yes No

b. At least once weekly? Yes No

c. Less frequently? Yes No

(please underline appropriately)

10. Do you consider yourself to be a holder of some form of religious belief?

Yes No (underline one)

11. If "No" to the previous question, which of the following categories best describes your beliefs?

a. Agnostic Yes No (underline one)

b. Atheist Yes No (underline one)

c. Other (please describe as briefly as you can)

_____

12. Please add here any other information or comments you consider useful or relevant to the survey.

_____

_____

_____

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