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LOYOLA UNIVERSITY OF CHICAGO

RELIGIOUS ISSUES IN THERAPY WITH THE OLDER ADULT CLIENT

A THESIS SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL OF LOYOLA UNIVERSITY OF CHICAGO IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS

DEPARTMENT OF COUNSELING AND EDUCATIONAL PSYCHOLOGY

BY

SUSAN J. REARDON

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CHAPTER 1

INTRODUCTION

Two recent foci in psychotherapy research have been religious issues and the older adult client. Although stereotypes have long associated the later years in life with active religious participation, there is little research on how therapists perceive and respond to religious issues with older adult clients (Koenig, 1990).

Modern medical care and advanced technology are allowing more people to live longer each generation. In addition, the largest segment of our current population, the "baby boomers", is fast approaching older adulthood (U.S. Department of Commerce, 1992). With the popularization of psychology in their lifetimes and the commonalty of seeking psychological help, mental health service providers can anticipate working with more and more Americans over the age of sixty-five (Butler & Lewis, 1982). Another trend in our society is the resurgence of organized religion and an awakening of individual spirituality (Ostling, 1992). It is due to this "graying and praying" of America that mental health providers are called to re-assess how their values, experiences and training have prepared them to deal with religious material coming from the older adult client.

Purpose of Study

These two trends in psychotherapy research, religious issues and the older adult client, have little literature joining them. This work will review recent literature in what until now has been three distinct areas of research: religious issues within psychotherapy, religion and aging, and older adults in therapy. The purpose of this study is to examine and to attempt to integrate these three areas so that the impact of religious issues in therapy with older adults can be better understood and utilized by clinicians.

Religion and psychotherapy. Bianchi (1989) in a paper on psychotherapy as religion suggests religion and science have historically distanced themselves as mutually exclusive and competing value systems. He poses that this distancing between the two disciplines can be readily traced back and attributed to Sigmund Freud (Bianchi, 1989; Freud, 1961a). Bergin (1991), in agreement offers that part of the reason this distancing has been perpetuated is the concern among clinicians that religiosity can be associated with a variety of mental disorders. However, some practitioners are looking at this distancing as a manifestation of Freud's personal bias and interpreting it as an artificial division of the human person (Houts & Graham, 1986; Humphries, 1982; Nelson & Wilson, 1984; Ragan, Maloney, & Beit-Hallahmi, 1980). The result of such research is the possibility of an

increasing respect for religious attitudes as a strong cultural influence in society (Koenig, 1990; Miller, 1992).

At their most basic levels, both psychology and religion attempt to provide a sense of order and meaning to human experience and activity. The two disciplines have historically been used in the hope of curing souls, searching for meaning, setting ideals, offering leadership, and proposing change in follower's lives (Bianchi, 1989; Hackett, 1986). In contrast, their essential disparity is in their ways and means of searching for understanding and inciting change. While religions have overtly involved elaborate systems of values and taboos, psychology and psychotherapy have done the same in much more covert systems. Many have suggested that only recently has psychology begun to identify and examine the morals behind its scientific methods and goals (Grosch, 1985; Humphries, 1982; London, 1986). Perry London (1986), a pioneer in such work, suggests that every aspect of psychotherapy assumes some implicit moral doctrine. This is certainly in contrast to Freud's early conceptions of psychology as an exact science of behavior, distinct and far less subjective than religion (Freud, 1961a).

Despite such similarities, practitioners of either philosophy frequently struggle to cross into the other's realm. Alan Bergin (1988) in his paper on the contributions of a spiritual perspective to psychology points out that the

majority of ministers of all faiths are ill prepared in the basics of psychology as are the bulk of psychologists ill prepared in the basics of faith traditions.

Freud himself, although not tolerant towards the integration of religion and psychotherapy, did recognize how important it is for the psychologist to understand the strength of religious ideas (Freud, 1961a). However, Freud's resistance to integration has long overshadowed his recognition of the strength of the religious philosophies of his patients. Consequently, psychology developed with this same resistance toward religion. Only now are mental health practitioners beginning to integrate religious values and considerations with psychotherapy (Humphries, 1982; Quackenbos, Privette & Klentz, 1986). With this integration comes greater opportunity for clinicians to enter the realms of their clients. Understanding of a client's religious background can assist clinicians in making sense of the inner worlds and experiences of their clients (Bearon & Koenig, 1990).

Aging and religion. Think of a religious person. Odds are an image of an old, frail woman will enter into mind (Koenig, 1990). The stereotype has long been strong and persistent in our culture. And perhaps for good reasons. Koenig proposes that the world construct of older persons may often be based on or heavily influenced by religious themes (Koenig, 1990). Demographics support this

suggestion. The Princeton Religion Research Center has consistently found that religious attitudes and behaviors are more prevalent among persons over sixty-five as compared to younger people in our country (Princeton Religion Research Center, 1976, 1982, 1985, 1992). Harrison's research on older women in our society supports this image as a feminine one (Harrison, 1991). According to Harrison, older women are gradually becoming a numerical majority in our country (Harrison, 1991). National surveys have also shown that women have consistently outlived men in this country (U.S. Department of Commerce, 1992). Considering that the above stereotype may indeed be demographically justified, many researchers are beginning to address how important it is for mental health professionals to be able and willing to engage older adults with religious issues in therapy (Koenig, 1990; Markides, Levin, & Ray, 1987).

Aging and psychology. Freud outlined the inelasticity of the mental processes and the ineducability of the older adult patient (Freud, 1961b). Freud even went on to propose that analysis is "doomed" with older adults due to the amount of material to be dealt with and the limited time with which to work with an older adult (Freud, 1961c). Throughout his writing is the implicit assumption that older adults do not have enough time left to live to be worth undertaking a long and laborious analysis (Freud, 1961c, 1961a, 1961b). Although many have indicated that these

ideas are less overt in the training of today's mental health professional, the prejudices persist (Gatz & Pearson, 1988; Hillerbrand & Shaw, 1989; Meeks, 1990; Panek, 1983; Schaie, 1988; Wilcox, 1992). Others have demonstrated that modern developmental theories often neglect or far under represent the later end of the life span (Kalab, 1985; Levenson, 1981, Whitbourne, & Hulicka, 1990). Some have even proposed that one consequence to this situation is that few clinicians have opted to work with an older adult population or are accurately trained to do so (Knight, 1986; Santos & Vanden Bos, 1982)

Importance of this study. Harold Koenig and his research team, in their exploration of religion and older adults, have repeatedly pointed out that little has been written about the importance of addressing religion or its' utility in psychotherapy or supportive counseling of older adults (Koenig, 1990; Koenig, George, & Siegler, 1988; Koenig, Kvale, & Ferrel, 1988; Koenig, Moberg, & Kvale, 1988). In addition, Koenig (1990) has suggested that little is known about how mental health professionals view religion in older adults and how they deal with related issues when they arise in treatment. However, recent surveys have demonstrated that the over sixty-five bracket of our country's population is growing and the prevalence of religious beliefs is also increasing (Gallup & Jones, 1989; Miller, 1992; Princeton Religion Research Center, 1992).

Koenig believes that as more and more Americans are reporting religious affiliations, the older adults seen in therapy settings are more likely to use religious language, present with religious themes and perceive their world through religious frameworks (Koenig, 1990).

Recent research has shown that older adults often rely on religion to cope, to make sense of their own personal sense of change and loss as well as an attempt to make sense of the world as a whole (Bearon & Koenig, 1990; Blazer, 1991; Crane & Kremer, 1987; Ellor, 1990; Koenig, George, & Siegler, 1988; Koenig, Kvale, & Ferrel, 1988; Koenig, Moberg, & Kvale, 1988; Markides, 1983). It is for these reasons, that psychologists are challenged to become attuned to their own responsiveness to religious needs of older adults and educated on therapeutic interventions with this special population.

Background Information: Demographics

Religion in America. American culture has shown an increased interest in religion and recent research indicates psychologists are being called to respond (Miller, 1992; Schumer, 1984; Worthington, 1991). The 1989 Gallup Poll demonstrated that religious attitudes are prevalent within the population. Ninety-four percent of all surveyed adults believe in God or a universal spirit, seventy-six percent reported prayer to be an important part of life, and thirty-three percent reported reading the Bible weekly or more

(Gallup & Jones, 1989). Of adults aged fifty or over, seventy-three percent reported a membership to a church or synagogue, forty-nine percent reported attending religious services in the last seven days, and fifty-eight percent reported watching religious television programming (Gallup & Jones, 1989).

With so many people engaging in religious activities, Robert Theodore, a proponent for the utilization of spiritual values in counseling believes it is probable that most clients seen in counseling have some religious values that influence their behavior (Theodore, 1984). This is in support of Koenig's hypothesis that more and more people will come to counseling presenting with religious frameworks, language, or problems in the near future (Koenig, 1990).

Bergin has used the analogy of "adding a spiritual keystone to the building blocks" already provided by the science of psychotherapy (Bergin, 1988). This analogy seems fitting; it is not a dramatic shift in approach of the human being that is proposed but rather a consideration of an often neglected dimension (Bergin, 1980a, 1980b, 1985, 1988, 1991).

Everett Worthington (1991), in support of Bergin, outlines four reasons that today's psychotherapist will be increasingly called upon to deal with religious issues in psychotherapy. First, in the past two decades religious

people have become more vocal about beliefs and practices (Worthington, 1991). Whether a local news cast or daily paper, the issue of religion and politics is in the forefront. The abortion issue has polarized our country's political system to the extent that the issue has been used as a litmus test for public office; city and town mottos have been modified to eliminate any reference to God, and the rights of church members to refuse modern medical services have all been headline news (Parson & Hill, 1993; Richardson & Dewitt, 1992; Rovner, 1992). Second, the number of religious cults has increased in our country (Worthington, 1991). Recent headlines involving the Waco, Texas cult drew attention to the existence of these groups which had previously been largely unnoticed by the media (Lacayo, 1993). Although Waco is an extreme example, the proliferation of other groups is staggering among American youth (Woodward, 1993). Third, the influx of immigrants into the United States has resulted in importation of significant communities of diverse beliefs (Worthington, 1991). And fourth, with increasing cultural diversity and increasing communication technologies, there is more pressure for people to understand and tolerate alternative philosophies, religions, and beliefs from the East and the West (Worthington, 1991). Overall there seems to be a significant need for religious oriented or at least tolerant therapy to serve a people from such a religiously influenced

society (Quackenbos, Privette & Klentz, 1985; Worthington, 1991).

Aging in America. The largest segment of our current population, the "baby boomers", will be entering their senior years in the upcoming decades (United States Department of Commerce, 1992). This, combined with advances in medical care and an extended life expectancy in our country, all contribute to what we can expect to be the largest group of older adults in our history. The trend has been referred to as "the graying of America" (Butler & Lewis, 1982). It is expected that individuals over age sixty-five will not only be more present in our society, but more active, and more likely to be consumers in the mental health system (Gatz & Pearson, 1988). In addition, the number of Americans over age eighty-five is expected to grow to twenty-four million or ten times the current population in this age group during the next five decades (Harrison, 1991).

Definition of Terms

Spiritual versus religious. A review of the literature on spirituality and religion in psychotherapy produces a sampling of diverse and at times contradictory definitions. Ellor (1990) eloquently comes to the conclusion that the only agreement among authors seems to be the understanding that they will never agree. To break apart definitions of

spirituality from religion begins to simplify the task of understanding what these terms mean.

Spirituality tends to emphasize the process of looking within (McFadden & Gerl, 1990; Shafranske & Gorsuch, 1984). Although not universally agreed upon, spirituality is most generally defined as a search for meaning which is often inner directed to make sense and put perspective upon the outer world (Bergin, 1988; McFadden & Gerl, 1990; Shafranske & Gorsuch, 1984). In contrast, religion is often conceptualized as much more of an external force. In reviewing the literature on religion and psychotherapy words such as ritual, system, organization, structure, and beliefs are frequently seen in reference to religion (Bianchi, 1989; Brown, 1980; Clement & Warren, 1973; Lovinger, 1984).

It is not the purpose of this literature review to separate these two closely related realms, but rather to see how they operate together within an older adult engaged in therapy. Therefore, for the purpose of this paper, religion will be conceptualized as an individual's search for meaning and a sense of community, whether inner or outer directed. A Judeo-Christian framework will be utilized for two reasons. First, it is the religious tradition the bulk of current research focuses upon. Second, eighty-two percent of those Americans surveyed in the Princeton research

identify themselves with a Judeo-Christian tradition (Princeton Religion Research Center, 1992).

Aged, old and elderly. The choice of a word to describe an individual over the age of sixty-five in our country poses a dilemma. In a time of "politically correct adjectives" the choice of such a word can have a powerful affect. For this work, the term "older adult" has been chosen, not so much for its neutrality, but for lack of a respectful and commonly recognized word in our language. Daniel Schmidt and Susan Boland (1986) identify the term "older adult" as a "super-ordinate stereotype or category under which more specific stereotypes are hosted hierarchically". Therefore, in the spirit of using the least offensive and most practical term available in the literature, "older adult" will be used to describe an individual over the age of sixty-five. This is a general prerequisite to the included gerontological studies. When a study utilizes a population more specific than the above, a mention will be made.

Therapy, counseling, therapist and counselor. When an older adult seeks mental health services, depending on the resources available, the service provider may be a Master's-prepared clinician, Bachelor's-prepared counselor, psychiatrist, psychologist, or social worker. The studies used in this literature review survey all of the above. For the sake of fluidity throughout this work the words

therapist, clinician, or mental health provider will be used to identify the service provider. The professional activity of helping will be referred to as therapy or counseling unless there is reference to a particular theory or practice. When a specific study is being addressed the expertise of the clinicians surveyed will be identified.

Therapy: religious or secular? Both Perry London and Alan Tjeltveit in their work on therapy and morals come to the conclusion that all therapists, whether dealing with religious or nonreligious clients, whether themselves orthodox or agnostic, deal with values and morals every time a client walks through the door (London, 1986; Tjeltveit, 1992). However, as O'Malley, Gearhart, and Becker (1984) found in their survey of therapists and clergy on the cooperation between psychology and religion, dealing with values is usually perceived as the realm for the religious counselor and is often less esteemed in so called "secular" practices. Lovinger (1984) and Worthington and Scott (1983) propose that counselors in secular settings frequently opt to avoid issues of a spiritual or religious nature in the Freudian tradition of separating religion and psychology. Those who do attempt to integrate the two then earn the special titles of "religious" or "pastoral counselors" (Lovinger, 1984; Worthington & Scott, 1983). Whether secular or pastoral, this work proposes that all therapists deal with similar material from clients and the

differences come from what is addressed and what is avoided.

Methodology

Library searches for recent journal articles performed for this literature review were primarily done through the Psychlit computer program owned by Loyola University of Chicago libraries. Additional materials found in bound books were identified through use of the LUIS computer system also available at Loyola. Key words used for the searches included "aging, old age, older adult, ageism, senior citizen, later life; religion, religious, spirituality, church, synagogue, prayer; therapy, counseling, mental health, psychology, psychologist, psychiatry, psychiatrist, psychotherapist." A complete search of published works was begun in 1990, the year the author began this project. Initially a ten year span, 1980-1990 was done. As the project continued the years 1991-1993 were added. Works from previous dates were added as all bibliographies and reference lists were reviewed for previous significant research. These were added at the author's discretion. Unpublished works, articles in languages other than English and foreign research were not included.

Format of Thesis

The following chapter will explore the literature on religious issues within psychotherapy. Religion's influence

in the community, upon the therapist, and within therapy will be explored. The barriers to utilizing and addressing religious issues will also be addressed. Finally, the debate over psychotherapy as a value free or value laden practice will be reviewed.

In Chapter 3, the topic of religion and aging will be explored. First, the functions of religion in the life of an older adult will be examined. Following will be an exploration of both the theories of aging and the theories of religiosity that today's clinicians have available to them.

Chapter 4 will look at older adults in therapy. The barriers to treatment for older adults will be examined as will the prevalence of ageism in mental health. Finally some of the religious and spiritual issues that may be raised in therapy with older adults will be examined in the context of how clinicians may interpret and handle these issues.

The final chapter, Chapter 5 will summarize the results of the literature review and make some suggestions for future practice and research in this area.

CHAPTER 2

RELIGIOUS ISSUES WITHIN PSYCHOTHERAPY

Although religion and psychotherapy have historically dealt with similar life questions and issues, their relationship up until now has been at best tentative. However, as the American population experiences a resurgence in religious teachings and traditions, psychotherapy will be challenged to further embrace religion into its realm. Modern and future mental health consumers are more likely to bring religious issues to the consultation room. These issues, whether born out of the client's religious community, the client's own value system, or even the relationship between the clinician's and client's belief systems are more and more likely to turn up in the process of therapy. These various relationships with religion as well as the relationship between values and psychotherapy will be explored.

Religion and Community

An individual's background has long been known to influence thoughts and behaviors. However, for the religiously affiliated client, religious teachings and training can be particularly salient to future interactions with others. Parsons and Wicks (1986) point out that the

religiously affiliated individual is often strongly influenced by those they are brought up with, live with, and associate with. Such experiences have a particularly strong influence on how they perceive others and themselves. Community, for these individuals offers a sense of identity, familiarity, support, reciprocity, and security. Membership has been indicated to influence and even dictate how one interacts with and perceives others within and outside of the community (Parsons & Wicks, 1986).

Identification. Who we are, what others say we should be, and what we ourselves expect are all struggles dealt with in the psychotherapy room. Tjeltveit (1989) proposes that the process of psychotherapy deals with the models, metaphors and images individuals have of themselves. According to Tjeltveit (1989) ignoring these models risks ignoring key aspects to a client's experience and behavior. These models may emerge from an ethnic, familial, or religious tradition. His work indicates that for many, religious teachings offer the most powerful of influences. Religion offers essential descriptive and prescriptive models of human beings which can influence behavior, thoughts, and feelings (Tjeltveit, 1989). Unfortunately, religious traditions and their impact on individuals have not until recently been considered as important as ethnic and familial traditions in the eyes of many psychotherapists.

Social support. Parsons and Wicks (1986) in their work with cognitive pastoral psychology and religiously affiliated lonely persons, stress that belonging and social support are commonly recognized as essential for the emotional and physical health of the general population. They suggest that religion and religious communities have historically provided this sense of belonging and social support. In addition, they pose that it is in these communities where relationships are an essential means for living out religious teachings, that a lack of social support can be devastating to community members (Parsons & Wicks, 1986).

Others have drawn a similar relationship between loneliness and religiosity (Heggen & Long, 1991; Johnson & Mullins, 1989). Religious scriptures emphasize the importance of belonging. When a religious client does not experience a sense of community, that void may be experienced as a personal failure or unworthiness, and can be manifested in a diagnosable illness such as depression (Heggen & Long, 1991; Johnson & Mullins, 1989). Older adults who are experiencing multiple losses may be particularly susceptible to such labeling.

Johnson and Mullins (1989) investigated the hypothesis that high religiosity is related to less loneliness. Their interviews of 131 older adults showed that greater involvement in the social aspects of religion was

significantly related to less loneliness. However, the subjective dimension of religiosity was not related to less loneliness when the social contact variables were controlled (Johnson & Mullins, 1989). Their study suggested that religious activities can be a rich and readily available source of social support for older adults (Johnson & Mullins, 1989).

Social services. In 1962, David Moberg suggested that the church and the social work profession overlap in many of their activities (Moberg, 1962). Kudlac (1991) has a similar perspective; he points out that throughout much of history, religious leaders have been responsible for a community's emotional well being and were essentially the mental health care providers. Only since the late nineteenth century has there been a movement towards separating the psychological and religious dimensions (Kudlac, 1991).

Parsons and Wicks (1986) indicate that there still remains some resistance to this separation by members of religious communities. When in distress, they suggest an individual is most likely to seek assistance from a familiar community member. Often the identified community member is a religious leader. He or she is sought out for advice over a professional clinician who if an outsider, can pose a potential threat to the community and to the belief system (Parsons & Wicks, 1986).

Perhaps, it is for this very reason that so many religious organizations have developed elaborate social service systems to serve their members. Today, although religious leaders are no longer recognized as the primary mental health care providers in modern communities, religious organizations continue to provide the ancient service of mental health care to their followers (Parsons & Wicks, 1986). Catholic Charities, Lutheran Social Services, and the Jewish United Fund are just a few examples. Such organizations are often particularly attentive to their aging members as well as the most accessible to older adults belonging to a religious community.

Religion and the Psychotherapist

While religious communities have been developing social service networks for their own members, Gibson and Herron (1990) point out that some mental health professionals have been distancing themselves from religion. Possibly due to the Scopes trial, religion and science have become mutually exclusive in the minds of many Americans (Tomkins, 1965). One result of this exclusivity is the presupposition that professional mental health care providers are not religious (Gibson & Herron, 1990; Grosch, 1985). Stereotypes hold that to be a psychotherapist and to be a religious person would be contradictory.

Personal beliefs. One proposed reason for this rejection of theology by psychologists is put forth by

Jeffries McWhirter. McWhirter (1989) suggests that religious ideology does not progress at the same speed as physical, intellectual, conceptual, and moral development. This disparity in development is hypothesized to place some therapists in an ego-dystonic relationship with their faith sometime while in advanced education or training in psychotherapy. Rather than further development in religious ideology and theology, the result can be a rejection of the religious beliefs which seem intellectually illogical and scientifically unfounded and an embracing of the newly found psychological belief systems (McWhirter, 1989).

Although McWhirter's theory (1989) seemingly explains why clinicians may move away from religion, research has demonstrated that all therapists have not made the clean cut with religious traditions as is often assumed (Houts & Graham, 1986; Ragan, Maloney, & Beit-Hallahmi, 1976; Shafranske & Gorsuch, 1984). Shafranske and Gorsuch (1984) in their survey of California clinical psychologists found the majority of clinicians sampled reported spirituality to be personally relevant in their lives. Their results showed that although psychologists as a group tended to be less religious than the general population, they were not categorically anti-religious or irreligious (Shafranske & Gorsuch, 1984). Rather, their study suggested that psychologists express and experience their religion and

spirituality in a more private and idiosyncratic way. They also found that the extent to which a clinician experiences religion as personally relevant directly affects their perceptions of the relevance of those same issues in therapy (Shafranske & Gorsuch, 1984). Their findings support the work of an earlier study done by Ragan, Maloney, and Beit-Hallahmi (1976).

A later study completed by Shafranske and Maloney (1990) supported these conclusions. When surveying a random sample of American Psychological Association Division 12 clinical psychologists, the authors found that ninety-seven percent of the subjects reported being raised in a particular religion. In addition, seventy-one percent reported current affiliation with an organized religion and forty-one percent reported regular participation (Shafranske & Maloney, 1990). Although this does reflect a twenty-six percent decrease when compared to adult affiliation of the general population, the numbers are not significantly different from those of other scientific professionals (Houts & Graham, 1986).

In contrast to Shafranske and Maloney's findings, William Gibson and William Herron (1990) found that while a majority of the therapists they sampled held religious beliefs and had religious affiliations, a minority were active in their religious practices. Interestingly, their results also suggest that religious and nonreligious

therapists do not differ in their perception of the therapy process (Gibson & Herron, 1990). However similar their perceptions may be, concern still lies in how clinicians' religious beliefs influence their practice of psychotherapy.

Shafranske and Maloney (1990) in a survey of four-hundred American Psychological Association psychologists found that although psychologists may possess opinions regarding their clients religiousness or share in their belief orientation, they tend not to participate or actively seek to influence their client's lives in this regard. In other words, psychologists are leaving their religious beliefs, affiliated or not, at the door of the therapy room. Others support Shafranske and Maloney's findings (Gibson & Herron, 1990; Strupp, 1980; Worthington, 1988).

Lovinger (1984), in contrast, proposes that religious therapists just like religious clients see their world, and therefore their clients, through a cognitive and affective understanding developed within their religious community. Whichever theory is subscribed to, training in dealing with religious issues of one's own and of one's client is, according to Lovinger (1984), essential to psychotherapists of all orientations.

Humphries (1982) in a discussion of how neglect of religious issues can potentially result in abuse of clients, points out that there is no truly "neutral" position when it comes to religion in therapy. According to Humphries

(1982), even to be agnostic is to hold a religious position. Nonreligious therapists have their own problems and challenges which need attention and understanding in therapy. Lovinger (1984) divides this group into three: the nonaffiliated, the anti-affiliated and the formerly affiliated. The nonaffiliated, according to Lovinger, are more apt to carry an attitude of indifference towards religion and view it as another cultural influence in a therapy setting. Presley (1992) describes this behavior as avoidance. In contrast, Lovinger views the anti-affiliated as more likely to view religion as destructive or confining and see therapy's role as challenging religious views. Albert Ellis and his Rational Emotive Therapy are often exemplified as advocates of this point of view (Ellis, 1980). Presley (1992) describes this behavior as eradication. The last of Lovinger's groups, the formerly affiliated would most likely fit McWhirter's proposal of choosing to leave a belief system less developed than their cognitive system, and thus distance themselves from any religious material in a therapy session (McWhirter, 1989; Lovinger, 1984).

Presley (1992) points out that the greatest challenge for all three of these groups, those who wish to avoid, eradicate, or integrate religion and therapy, is to take the ethical responsibility of respecting the faith systems of clients. Although each of these approaches, when

practiced within the professional code of ethics is acceptable to Presley, each assumes there is some level of understanding of the client's religiosity upon his or her behavior by the therapist (Presley, 1992). The catch twenty-two of this situation is that not all secular counselors will be qualified to evaluate and understand a religious client's value system and the full implications of that system. For instance, if a clinician has a personally hostile view of a particular set of religious beliefs, or simply a lack of basic knowledge of a religious system that a client adheres to, it may be in the best interest of the client to simply refer to another practitioner. However, the reality is that there are currently very few clinicians trained in this area to accept these referrals (Greenberg & Witzum, 1991). Ideally, every clinician's training would prepare him or her to assess and deal with these situations, but the field of psychology has yet to meet the ideal.

Professional training. Several studies show that today's practitioner has little or no training in dealing with spiritual or religious issues in therapy (Cunningham, 1983; Houts & Graham, 1986; Sansone, Khatain, & Rodenhauser, 1990; Shafranske & Gorsuch, 1984). Ironically, sixty percent of American Psychological Association psychologists surveyed by Shafranske and Maloney reported that client's often expressed their personal experiences in religious language (Shafranske & Maloney, 1990).

Houts and Graham's (1986) study of the impact of client and therapist religious values on clinical judgements demonstrated that given clinicians' lack of education and clinical training related to these issues, the clinicians' interventions were based on their subjective, personal experiences. Kivley's research (1986) takes this concern one step further in pointing out that a clinician's self perceived competence in handling religious issues in therapy is significantly related to the clinician's religious intensity, not to professional training in handling such issues. Of concern is the fact that Shafranske (1990) found that the majority of surveyed practitioners viewed religion and spiritual issues as relevant in their practice and to varying degrees even utilized interventions of a religious nature with limited if any religious training. Others have come to similar conclusions (Cunningham, 1983; Houts & Graham, 1986; Shafranske & Gorsuch, 1984; Sansone, Khatain, & Rodenhauser, 1990).

Bergin and Payne (1991), in an essay on a proposed agenda for a spiritual strategy in personality and psychotherapy argue that today's practitioners who are addressing religious issues in the therapy room are often operating out of their own personal experiences and beliefs rather than training and professional codes. What this situation risks is a lack of professional competence on behalf of the clinician and the clinician's personal beliefs

guiding therapy sessions with religious clients (Bergin & Payne, 1991).

Bernard Spilka (1986) in response to this situation proposes that what is needed is an "accepting and supporting therapist who knows how religious and psychological difficulties may be related". Greenberg and Witzum (1991) in addressing the problems of treating a religious client in psychotherapy come to a similar conclusion. They propose that today's therapist needs a basic knowledge of the religious doctrines and rituals in order to fully understand or address religious material in therapy (Greenberg & Witzum, 1991). However, both Bowman (1989) and Lovinger (1984) indicate that current graduate programs rarely include this material in training programs.

Theoretical schools. Modern schools of psychology still hold onto their historical roots tenaciously. Each of these schools has a different relationship with and perception of religious beliefs' impact upon mental health. Often this relationship is a result of the founder's personal experience. This is noted most clearly with Freud's anti-religious stance in his analytical psychiatry (Freud, 1961a).

However, today's trend is to move away from particular theories of practice. Lazarus and Beutler's (1993) exploration of technical eclecticism indicates more and more clinicians are opting for an eclectic stance that allows the

use of many schools' techniques to best meet the needs of individual clients. Such an expansion can allow for a greater possibility of inclusion of religion into therapy sessions (Spilka, 1986). Perhaps this is why Shafranske and Maloney (1990) found seventy-four percent of their sampled psychologists to disagree with the statement "religious or spiritual issues are outside of the scope of psychology". Of the schools surveyed by Shafranske and Gorsuch (1984), Jungians were found to have the most compatible of relations with religious clients, and behaviorists, not surprisingly, the most tenuous of relationships.

A relative of behaviorism, rational emotive therapy (RET), and its founder, Albert Ellis, have taken the brunt of criticism for unfavorable relations with religion. Numerous articles have been written for and against the use of RET with religious clients (Bergin, 1980b; Ellis, 1980, 1992; Lawrence, 1987; Propst, Ostrom, Watkins, Dean, & Mashburn, 1992). The debate centers on Ellis, who as a known atheist, has advocated that RET is useful with anyone including a religious client. Ellis has argued that he does not find religion in its usual definition to be irrational, but that he finds devout religiosity to be emotionally harmful (Ellis, 1992). Ellis also argues, as do his supporters that despite his personal beliefs the theory and framework of RET can be quite useful with a religious client population (Ellis, 1980, 1992; Lawrence, 1987).

At the other end of the spectrum, Jungian psychology, existential psychology, and object relations theory, attempt to integrate the two philosophies of psychology and religion (Spero, 1990). However, even in the attempt towards synthesis there remains a tension with the roots of psychology. Moshe Spero (1990) identifies this tension as a single basic assumption within all psychological theories. The assumption is that all religious experiences come from interpersonal relations (Spero, 1990). Such an assumption rules out the possibility of addressing a unique human-God relationship independent of human perception and language. Spero proposes that the result is a significant impairment in the ability of today's theories to form an accurate and comprehensive view of human-divine relations (Spero, 1990). Spero (1990) in an attempt to resolve this tension proposes a model for parallel interpersonal and human-divine relations. The goal of such a model is to allow clinicians to simultaneously track the multiple layers of meaning inherent in religious material from a client and at the same time comfortably discuss God within therapy (Spero, 1990).

Although some counselors may not subscribe to beliefs of formal religions, they know that such beliefs often guide the lives of their clients and that to help they must understand their clients. Spero's model is just one way therapists may strive to do this (Spero, 1990). Other therapists may opt to not deal with religious issues in

therapy or with self identified religious clients, and refer them elsewhere. Whether striving for appropriate referral or effective treatment of religious clients, therapists benefit from a general understanding of various religions and the value systems of religious people.

Religion and Psychotherapy

Understanding religion in therapy. Bergin and Payne (1991) advocate that a spiritual approach to therapy, as all therapeutic approaches, implies hypotheses and techniques of change. The challenge comes in defining exactly what these hypotheses and techniques are, how they should be used, and by whom.

Pattison (1969) identifies four patterns of dealing with religious involvement in psychotherapy: psychological means to psychological goals, psychological means to spiritual goals, spiritual means to psychological goals, and spiritual means to spiritual goals. He divides practitioners into specialists and dualists. Specialists focus entirely on either the psychological or the spiritual, while the dualist attempts integration (Pattison, 1969).

Theodore (1984) proposes a tripartite model for understanding the characteristics of human behavior which would be the targets of such techniques. He describes three equal and overlapping realms of the physical, psychological, and spiritual. He describes the level of functioning in each area to be capable of changing with age,

experience, or educational perspective. The result is a system in which any one of the three realms may dominate at different times of life (Theodore, 1984).

Presley (1992) in a more recent article, identifies three therapist approaches to religion: avoidance, eradication, and integration. This approach is more dependent on the therapists training and personal preference for dealing with religious issues in therapy. Although each model proposes specific means to understanding religious issues in therapy, none offers explicit techniques toward the integration of religion and therapy.

Integrating religion and therapy. The use of religion, spirituality, and religious issues obviously is not called for in the case of every client. Miller (1992) in a paper on the integration of religion and therapy concludes it is normally in the clinician's best interest to remain open to the integration and use of religion within the course of therapy. Both religion and psychology can offer tools for the therapist's use.

Cunningham (1983) in a paper on spirituality and psychotherapy suggests that one step towards integrating religion and therapy is making the therapy process sensitive to a client's religious upbringing and beliefs. Such an approach invites religious attitudes and feelings to be shared and used in the therapy process. Bergin and Payne (1991) expand on this proposal by setting an agenda for a

spiritual strategy in psychotherapy. They point out that the usefulness of integration is determined by several factors. The religiosity of the client, desire by the client to discuss religious issues, the comfort level of the therapist, skill of the therapist, and the call for use of such issues in a particular course of therapy determine the usefulness of integration. In other words, a careful assessment by the therapist of the client, the client's religious history, and his or her issues needs to take place before religion is used in the therapy process (Bergin & Payne, 1991).

Even when amenable to the idea of integration, therapists are understandably cautious about entering into the domain of a client's religion. Lovinger (1984) points out that religion is not a standard part of graduate training programs and clinicians are often neither prepared nor experienced in integration of these two realms. Ironically, even though academia does not unite these realms, many authors agree that reality does (Bergin & Payne, 1991; Cunningham, 1983; Koenig, 1990; Lovinger, 1984; Miller, 1992).

The effort to implement spiritual values in therapy is a goal for which some therapists have been striving for quite a while. In 1975, over twelve percent of registered American Psychological Association members reported providing services to religious institutions and their

followers (American Psychological Association, 1975). Beit-Hallahmi (1975) in an early article on orthodox religious clients emphasizes that therapists must understand the function of religion in defining a client's identity, existence, and close relationships. Pattison (1969) in an even earlier article hypothesizes that the therapeutic relationship has the power to influence the client's relationship with God. His rationale is that psychotherapy can contribute to emotional experiences which influence spiritual experiences and eventually clarify relationship distortions with God, and in turn with others (Pattison, 1969).

Worthington (1989) in a more recent article, identifies and summarizes five reasons for today's counseling psychologists to give attention to religious faith in understanding clients. First, there is a high percentage of the United States population which identifies itself as religious. Second, many people who are undergoing emotional crises spontaneously consider religion in their deliberations about their dilemmas. Third, many clients are reluctant to bring up their religious considerations in secular therapy. Fourth, therapists, in general, are not as religiously oriented as their clients. Fifth, as a result of being less religiously oriented as their clients, therapists are usually not as informed about religion as would be maximally beneficial to their clients (Worthington,

1989). Worthington concludes that therapists can benefit in assessment and counseling by understanding the religious development of many of their religious clients (Worthington, 1989).

As beneficial as integration may be for the religious client, Bergin and Payne (1991) and Kudlac (1991) caution that this effort needs to be considered within a context. Kudlac (1991) divides this context into practical and theoretical levels. On a practical level, clients often verbalize concerns about the meaning of their lives and actions within religious frameworks (Kudlac, 1991). Here, integration can be as simple as a willingness to include religious issues in the conversation and an understanding of the importance and implications of this inclusion (Kudlac, 1991). According to Bergin and Payne (1991), it is on the practical level that most clinicians have been working with spiritual issues. However, they believe that only with specialized training and an awareness of religious issues can a spiritual approach be embraced on a theoretical level (Bergin & Payne, 1991). They suggest that to have a spiritual approach to psychology on a theoretical level has profound implications for personality theory (Bergin & Payne, 1991). For Bergin and Payne (1991), to accept a spiritual framework is to accept the existence of spirit within individuals. The acceptance of a spiritual dimension implies an understanding that the essential

identity of a person is eternal, has a spiritual aspect, and can respond to the spirit of God through prayer (Bergin & Payne, 1991). Thus the therapy process is opened up to influences beyond the human and to an eternal frame of reference.

Even when a therapist is open to this integration, difficulties can arise. Lovinger (1984) posits that if a therapist is inexperienced in dealing with religious issues, is ignorant of the clients' religious tradition, or has unexamined countertransference regarding religion the integration may not be successful. Bowman (1989) adds that therapists can become anxious when dealing with religious material because religion deals with some of the most difficult questions faced by humanity. The result if not recognized by the clinician, can be a countertransference reaction that impedes effective treatment for the religious client (Bowman, 1989).

Benefits of religion in therapy. Several authors have advocated the benefits of including religion in the therapy process (Ellor, 1990; Lovinger, 1984; McWhirter, 1989; Shafranske & Maloney, 1990). To respect and welcome religiosity into the therapy room, is according to Lovinger (1984), to respect and welcome a most private and valued part of a religious client's identity. McWhirter (1989) advocates that with an openness to religion, a therapist can gain a whole new perspective and understanding of the

religious client, his or her identity, and presenting complaint. Ellor (1990) proposes that the therapist can also gain the opportunity to use the already existing coping mechanisms within religion and religious symbols to meet therapy goals.

Shafranske and Maloney (1990) in a random sample survey of four-hundred American Psychological Association Division 12 clinical psychologists found a number of reasons to include religious issues in the course of therapy. Fifty-three percent of the surveyed psychologists rated having religious beliefs as desirable for people (Shafranske & Maloney, 1990). Sixty-four percent of those surveyed reported that the religious backgrounds of clients influenced the course and outcome of therapy. Eighty-seven percent believed it was appropriate to know the religious background of a client. And, fifty-nine percent supported use of religious language, metaphors, and concepts in psychotherapy (Shafranske & Maloney, 1990). Their findings suggest that the surveyed psychologists appreciated the religious and spiritual dimensions of their client's experiences (Shafranske & Maloney, 1990). However, even though the surveyed clinicians recognized the utility and power of religion in the course of therapy, few were trained in assessment techniques of religiosity, special problems of religious clients and interventions (Shafranske & Maloney, 1990).

Assessing religiosity. Bernard Spilka (1986), in a paper on the question of including religious issues in therapy, suggests religion has been associated with mental disorders in at least five different ways: as an expression of abnormality, as a socializing and suppressing force, as a haven, as a therapy, and as a hazard (Spilka, 1986). And yet, according to Spilka, few clinicians stop to evaluate how a particular client's religiosity may relate to his or her mental health. Considering religion's tenuous history and relationship with therapy, it is understandable that the process of assessing religion is not always valued by clinicians. Both Worthington and Koenig propose that in order to understand religious clients, an assessment needs to take place to assist therapists in understanding how religion may relate to psychological problems (Koenig, Moberg & Kvale, 1988; Worthington, 1986). Unless a clinician overtly or tacitly comments about spiritual and religious interests, clients may avoid mentioning them.

Kelly (1990), in a paper on counselor responsiveness to client religiousness, poses that in order for therapists to increase their responsiveness to client religiousness, therapists need an understanding of the degree and quality of a client's religiousness, and its connections with presenting problems. He advocates all practitioners include religion and religiosity in the intake interview (Kelly, 1990). According to Kelly, simply getting a

religious history as part of an intake interview can open the possibility of integration and discussion. Kelly suggests it is common for therapists to either fail to ask questions about religion during initial evaluations or limit their questions to asking clients what faith they come from. He points out that this material is essentially worthless since even clients in a single denomination may have beliefs that vary greatly (Kelly, 1990). Others have supported Kelly in advocating for a more detailed religious history, in order to assist the clinician in determining how a client really functions religiously (Bowman, 1989; Miller, 1992).

Wadsworth and Checketts (1980) describe assessment and diagnosis in psychology as being more an art than an objective procedure. According to Wadsworth and Checketts (1990), the labeling of a behavior as abnormal involves making value judgements of the individual. It is therefore not surprising that the question of bias by a religious clinician or upon a religious client has been addressed (Lewis & Lewis, 1980; Wadsworth & Checketts, 1980).

Lewis and Lewis's (1985) study examines the effects of patient and therapist religious affiliation on therapists' diagnostic and prognostic impressions. Seventy-seven licensed Iowa psychologists responded to an audio-taped interview of a depressed client either with strong religious content or no religious content. Their results yielded no

differences in therapist's attraction to or diagnosis of the religious or nonreligious client (Lewis & Lewis, 1985). This is in support of a study by Wadsworth and Checketts (1980) which found psycho-diagnostics are not biased by clinicians' or clients' religious beliefs.

According to Worthington (1986), it is especially important for counselors of religious clients to assess the religious commitment of their clients. Worthington recognizes the strength and depth of a religious commitment as an important mediating variable in understanding how similar a client's behavior might be to behavior of other religious clients. In order to define normal or deviant, a norm must be found and understood. Lovinger (1990) outlines several approaches to understanding religion in an individual's life. The first sees religion as largely or wholly in terms of pathology (classic psychoanalysis). The second treats religion as wholly sacred and not open to significant scrutiny (the approach of many modern clinicians). The third makes it the centerpiece of the treatment process (pastoral psychology). The fourth regards religion in the life of the person as affected by the course of individual development, cultural and political influences cognitive and emotional imperatives, and human creativity (Lovinger, 1990). This last most comprehensive approach, is the ideal for Lovinger and offers the greatest potential for

understanding of the religious client in the therapeutic relationship (Lovinger, 1984, 1990).

Special problems. Greenberg (1991) outlines four problems a clinician faces in the treatment of religious clients. The first is the resistance to the process of assessment by clients. Greenberg indicates that religion and religious beliefs are held as extremely private and guarded by some religious clients. This is in agreement with Beit-Hallahmi's (1975) suggestion that a religious client may initially be hesitant in discussing religious issues with a secular therapist. Lovinger (1984) suggests that verbalizing a respect for a client's beliefs and a personal lack of interest in challenging them may allay anxiety on the client's behalf (Lovinger, 1984). Another problem is the countertransference experienced by the therapist treating religious clients (Greenberg, 1991). Greenberg proposes that a therapist's reaction to a religious client can vary from envy to repulsion depending on the therapist's own religious stance. Others have indicated that an unawareness of these personal reactions can impair the therapist's effectiveness (Payne, Bergin, Bielema, & Jenkins, 1990). Finally, Greenberg (1991) points out the concerns of distinguishing religious belief from delusional belief and obsessive-compulsive rituals. (Greenberg, 1991). Without a thorough understanding of the belief and value systems of several religious communities,

this distinction may not be possible for a clinician. Greenberg (1991) stresses the importance for the clinician to have some information and understanding on normative behavior within various religious communities. Doctrine, ritual, and social organization separate communities of religious from the mainstream. Greenberg (1991) attests that without a respect for and some basic knowledge of these communities, treatment of the strictly religious is difficult if not impossible for clinicians.

In addition the religious client is susceptible to other problems. One is the common attitude among religious clients that "if I am sufficiently religious, then therapy won't be necessary" (Lovinger, 1984). This attitude is similar to the belief that all illness is a result of sinfulness. Gorsuch and Smith (1983) pose that the more religious an individual is, the more likely he or she is to attribute responsibility to God for occurrences. In addition, Gorsuch and Smith (1983) suggest religious individuals attribute even more responsibility to God for extreme occurrences such as severe illness or emotional distress. They suggest that the religious client who has become distraught enough to seek professional help is probably doing so while feeling religiously inadequate (Gorsuch & Smith, 1983). Gorsuch and Smith (1991) suggest the result can be a spiritual crisis along side and because of the psychological distress that led to seeking help.

Another area of difficulty may come from the way in which the client relates to God and to others. Pattison (1969) theorizes that if a client has disturbed experiences in the areas of faith, trust and hope in relation to God, the individual can hardly be expected to experience healthy faith, trust, and hope in human relationships and more specifically in therapy (Pattison, 1969).

Resistance is a challenge to therapy with any client. Peteet (1981) has proposed three types of resistance to treatment which may present as religious concerns. He refers to the first as group pressure (Peteet, 1981). For example the Christian Scientist experiences tremendous opposition and discouragement from using any form of medical treatment. However, other religious communities, particularly orthodox and fundamental communities, regard psychological treatment with mistrust (Peteet, 1981). Second, is an idiosyncratic religious belief which presents as resistance to treatment. When a psychological problem is denied or minimized as a spiritual problem, this is usually what is occurring. And third, is the concern about the role of the therapist as a moral agent. Here, a client may verbalize fear that the clinician is trying to "brainwash" or devalue the religious community (Peteet, 1981). For each of these situations, Peteet suggests discussing the process with the client to gain trust and prevent avoidance of the

issues which could lead to even more damage to the clients (Peteet, 1981).

Countertransference is another therapy issue with all clients, but can be particularly salient with religious clients. Bowman (1989) posits that the most destructive effect of any countertransference occurs when zealous therapists use their therapy process as a setting for converting a client to their own religious positions. For Bowman (1989), it is important to recall that all therapists are ethically and morally bound to not impose their personal beliefs upon clients (American Psychological Association, 1990; Nelson & Wilson, 1984).

Positive countertransference of religiously identified clients can be equally problematic. Jenson and Bergin (1988) suggest that the more religious the therapist is, the greater the likelihood that he or she will regard religious values as important to psychotherapy and mental health. Bowman (1989) warns that these therapists may become so interested in the theological content of the client's beliefs that they fail to conduct therapy. According to Bowman (1989), religiously identified therapists may also make the mistake of using their own religious terminology in discussions of religious material, forgetting that these terms may not have the same connotation for the client. Miller (1982) suggests that when aware of one's own biases toward religion and mental health, the therapist can better

serve the client, and these biases are less likely to limit the therapeutic process.

Interventions. Every therapist, in all likelihood, eventually encounters issues regarding client religious values and experiences. Aust's (1990) research indicates that therapists have been able to use client religiosity to promote growth during the therapeutic process. There are probably as many suggestions for and approaches to dealing with religious issues in therapy as there are therapists. However, a few acknowledged experts in the field have proposed specific recommendations.

Bergin and Payne (1991) suggest that there are essentially two categories of counseling techniques used in dealing with religious or spiritual issues. First, those grounded in traditional psychological theories from professional secular sources, which are then adapted to religious content. Second, those originating specifically from within spiritual or religious frameworks, which are used therapeutically in coping with both standard symptoms and religious issues (Bergin & Payne, 1991). Although the second category would seem to lend more room for integration of therapy and religion, Bergin and Payne (1991) indicate it is actually the first category which is most often used by secular therapists.

Houts and Graham's (1986) research suggests that client religious and spiritual issues are regarded in one of two

ways by therapists. They are generally regarded as either not relevant or viewed as relevant as understood within the personal framework of the therapist (Houts & Graham, 1986). In both instances, Houts and Graham (1986) found that the therapeutic perspective is based on the therapist's value system rather than the clinical orientation of the therapist. Goldsmith and Hansen (1991) propose that religious clients express their value conflicts in somewhat different ways than nonreligious clients and that such value conflicts, especially religious ones are fertile ground for therapeutic interventions (Goldsmith & Hansen, 1991).

Payne, Bergin, Bielema, and Jenkins (1990) suggest that a client's religious values and issues should be explored as early as intake. At this point, the relationship, if any, between the client's presenting complaints and religious issues can be identified. They suggest attempting to communicate the therapist's own religious values in a clear way during the beginning phase of treatment to those whose treatment may be affected by such. And finally, they suggest it is always the client's choice to continue or discontinue openly discussing religious issues (Payne, et al., 1990).

Many others are in agreement. Meyer (1988) suggests psychologists should clarify their own biases and identify possible conflicts between their own and their client's religious values. Humphries (1982) proposes that therapists

be open and candid in discussing their own religious viewpoints followed by urging clients to reach their own conclusions. Lovinger (1984) has found it helpful to explicitly state his own personal religious stance when inquired by a client and to then elaborate that he has no interest in having others see things his own way. Worthington (1989) suggests religious issues can be an important aspect of clinical assessment in the determination of a diagnosis and an etiology. His work indicates that an understanding of a client's religious status, level of religious maturity, and position in the life cycle can be invaluable in making an accurate and useful clinical assessment (Worthington, 1989). Spilka (1986) proposes that where spiritual content performs constructive roles, it should be supported; where it is dysfunctional it should be addressed. Beit-Hallahmi (1975) suggests that the issue of the religious gap in the therapist client relationship is best handled openly and directly, facilitating a smoother working alliance between the therapist and the client. However, in heed of the above suggestion, he points out that the therapist's self disclosure regarding religious beliefs can have considerable impact upon the therapeutic relationship and if religious backgrounds are different, challenge the client's basic definition of existence (Beit-Hallahmi, 1975). Thus, although many advocate an open stance, possible consequences should be anticipated in

dealing with religious issues as with any other value laden issue in therapy.

Values and Psychotherapy

Though many clinicians do not subscribe to beliefs of formal religions, surveys have demonstrated such beliefs often guide the lives of their clients (Princeton Religion Research Center, 1975, 1982, 1985, 1992). Worthington (1988) asserts that appropriate referral or effective treatment of religious clients requires at least a general understanding of the value systems of religious people. He insists that therapeutic values are inherent in any theory of counseling because all theories take as their primary goal helping clients change for the better. Worthington (1988) points out that in working with a religious client, change either explicitly or implicitly encourages, discourages, ignores, or de-emphasizes religion. If a therapist holds values that embrace religion yet employs a theory that does not acknowledge religious beliefs, he postulates that a client may sense conflicting cues from the therapist and from the theory of therapy (Worthington, 1988). For example, those who adhere strictly to psychoanalytic theory or RET may find themselves at odds with their values when called on to support a client's religious beliefs as it is in the best interest of the client. Lovinger (1984) sums up this situation by concluding values pervade psychotherapy on several levels:

the technical construction of the theory, the person of the therapist, the person of the client, and the relationships among them.

Goldsmith and Hansen (1991) offer a valuable metaphor for conceptualizing the relationship between values and therapy. This metaphor is intended to assist clinicians in assessing the content and importance of a client's values, a client's ambivalence or conflict with significant others, and the degree of emotional distress associated with adhering to or rejecting these values. They describe a castle and the island on which it stands as representing a region of central values (Goldsmith and Hansen, 1991). The surrounding swamp represents less centrally held, less coherent values held by clients. These include conflicted values arising from internal ambivalence or perceived differences from others. These are unstable and may shift. On the other side of the swamp lies a hostile territory of values that are firmly rejected by the individual. Goldsmith and Hansen (1991) propose that it is in the swamp, rather than on the island that a therapist targets effective interventions intended to clarify and possibly change a client's values.

Worthington (1991) uses a more concrete means to determine the use of values in therapy. According to Worthington an inner boundary determining the role of religious values in therapy is dependent on the relationship

between client and therapist. Only when the relationship is solid enough to deal with the intimate level of religious beliefs are they brought out and examined. Worthington (1991) also points out that the setting and events of the therapy are likely to affect whether religious values are dealt with in the therapy session (Worthington, 1991). For example, if an individual seeks out a Christian counselor, religious values will most likely be dealt with more explicitly and comfortably than if the individual had sought out a counselor from a city mental health clinic.

Can therapy be value free? Beutler (1979) calls therapy a persuasive endeavor that influences changes in clients' behaviors, even religious behavior. Bergin (1988) proposes that all people use values to evaluate their world and guide their behavior. Worthington (1988) claims it is almost axiomatic that values play a prominent role in the ways that people construe their world. Tjeltveit (1992) suggests that change is the ultimate goal of most therapies. Goldsmith and Hansen (1992) hypothesize that change in a person's most central values are likely to be accompanied by radical shifts in behavior, relationships and self perception. Such strong statements in the recent research call attention to the possibility that therapy, particularly therapy dealing with religious issues, may not be able to be value free.

Bergin (1980a) proposes six essential theses to understanding and examining the effects of values in therapy. His first and most basic states: "values are an inevitable and pervasive part of therapy" (Bergin, 1980a). Bergin is in agreement with London (1986) who suggests that every aspect of psychotherapy presupposes some implicit moral doctrine. Bergin believes it is inevitable for every therapist to be a moral agent and a value free approach is impossible (Bergin, 1980a). London's (1986) work indicates that moral problems affect how therapists see their client's needs, set goals for treatment, and work in sessions. Tjeltveit's work (1992) indicates that as long as values are involved in therapy as Bergin suggests, therapists function as applied ethicists.

Thesis two: "not only do theories, techniques, and criteria reveal pervasive value judgements, but outcome data comparing the effects of diverse techniques show that nontechnical, value laden factors pervade professional change processes" (Bergin, 1980a). Bergin points to research illustrating few differences across techniques, suggesting that nontechnical variables account for much of the change that occurs in therapy (Bergin, 1980a; Bergin & Lambert, 1978). In addition Humphries (1982) points to a lack of awareness among clinicians that psychotherapists may harm their clients by conveying their own attitudes toward religion.

Thesis three: "two broad classes of values are dominant in the mental health field" (Bergin, 1980a). Bergin (1980a) identifies these two value systems as clinical pragmatism and humanistic idealism. Clinical pragmatism is drawn from a medical model and shares a rigidity with that model. Humanistic idealism is espoused by those with an interest in philosophy and tends to offer a greater flexibility. According to Bergin (1980a), both exclude religious values and both establish goals for change that frequently clash with theistic systems of belief.

Thesis four: "there is a significant contrast between the values of mental health professionals and those of a large proportion of their clients" (Bergin, 1980a). Bergin cites Ragan, Maloney, and Beit-Hallahmi's study which found that only fifty percent of surveyed psychologists reported a belief in God compared to ninety percent of the general population (Ragan, et al., 1980).

Thesis five: "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" (Bergin, 1980a). Many other later clinicians and writers make the same suggestion (Humphries, 1982; Lovinger, 1990; McMinn, 1984; Meyer, 1988; Payne, 1990).

Thesis six: "it is our obligation as professionals to translate what we perceive and value intuitively into something that can be openly tested and evaluated" (Bergin, 1980a). Worthington (1988) suggests that whether a therapist leans toward more or less integration of religion and therapy, values are present in the therapy room and do have a wide range of effects on client's lives. Worthington in support of Bergin argues that if therapists are not aware of the potential impact they may have on a client's religious values or if their therapeutic values are certain to be at odds with the client's values, they should consider referring the client elsewhere (Bergin, 1980a; Worthington, 1988).

The role of professional ethics. Psychotherapists and clinicians from all disciplines have worked to develop an understanding and support of cultural diversity with respect to race, gender, and ethnicity (American Psychological Association, 1990). However, according to some authors, tolerance and empathy as a profession has not yet adequately reached the religious client (Bergin, 1991; Miller, 1992). Worthington (1989) suggests that religious identity is as strong an influence on clients as either racial or cultural identity. He points out that in many instances ethnic and religious identity are intertwined. Yet according to Wadsworth and Checketts (1980) clinicians rarely consider religion among the socio-cultural variables that influence

clinical practice. In addition, they express concern that if the definition of normal is derived from society and the process of diagnosis is subjective, minority groups, overtly religious clients included, are most at risk for misdiagnosis (Wadsworth & Checketts, 1980).

Professional ethics provide a framework for therapy that allows for differences in counseling approaches and clients. However, Presley (1992) points out that this framework does not estimate all ethical dilemmas. The ethical principles of psychologists amended June 2, 1989 illustrate just this point. Although reference is given to the "differences among people, such as those that may be associated with age, sex, socio-economic, and ethnic backgrounds", there is no mention of the religious client (American Psychological Association, 1990). Meyer (1988) indicates that the religious client is a minority member with special needs and differences which have until recently been ignored by professional psychology. Wadsworth and Checketts (1980) suggest the result of this situation could be an ignorance of special needs for religious clients, an underservice to this population, and a misunderstanding of the functions of religion.

Today, as therapists are seeing more religious clients and more research is being done to understand the integration between the two disciplines, a proposal towards a neutral stance is emerging. Bowman (1980) foresees this

neutral, but respectful approach to religious material in psychotherapy dealing with religious questions as one would deal with any other topic in therapy. For Bowman (1980), a neutral approach to religion does not imply an unwillingness to challenge illogical beliefs or unrealistic assumptions. Rather, like Nelson and Wilson (1984), he visualizes the goal to be examining belief systems with clients and helping them identify those beliefs that make a favorable difference in their lives against those that are destructive (Bowman, 1980). Their goal is to begin to help clients restructure their belief systems so as to end the pain that arises out of acting on destructive beliefs (Nelson & Wilson, 1984). Kudlac (1991) advocates that ideally this neutral approach will allow clients to educate their therapists and avoid misunderstanding between therapist and client.

In the end, therapists are on their own. Bergin (1988) argues that an important contribution of a spiritual approach to therapy is that it anchors values in universal terms. He suggests that therapists who are often unaware of their particular moral frames of reference are called upon to examine them and especially how they impact upon clients (Bergin (1988). For Bergin, values must be dealt with more systematically and effectively if therapeutic change is to be lasting (Bergin & Payne, 1991).

Religious practices, values and beliefs are an important part of many clients' lives, identities and value systems. Nelson and Wilson (1984) point out that value systems and personal beliefs are a matter of individual choice, and therapists are bound ethically and morally not to impose personal beliefs on their clients. All therapists must deal with the question of values - not only their clients', but their own. First and foremost, according to Nelson and Wilson (1984), clinicians are called on to have an awareness of their own beliefs and biases.

Bergin (1985) suggests that value decisions affect both specific aims of treatment such as symptom removal, and general aims such as lifestyle changes. For Bergin (1988), it is a delicate matter to preserve client autonomy while simultaneously managing the inevitable values issues that arise during treatment. And today, without the ethical guidelines and the strength of a long research history, clinicians are called to do just this on their own every time a client brings religious belief into the therapy room.

CHAPTER 3

RELIGION AND AGING

The usefulness and inevitability of religion in the psychotherapy process has been explored and researched by many (Aust, 1990; Bergin & Payne, 1991; Lovinger, 1984; Presley, 1992; Theodore, 1984). However, the relationship between aging and religion has been studied sparsely (Blazer, 1991; Ellor, 1990). Some have indicated that religion often has different functions and meanings to different cohorts of older adults (Erikson, Erikson, & Kivnick, 1986). Others have suggested that for today's older adults, religious groups come third after families and the federal government as major sources of instrumental support (Blazer, 1991; Payne, 1988). In addition non-organizational religious participation is mentioned as continuing to meet many of today's older adult's spiritual and emotional needs (Blazer, 1991; Erikson et al., 1986; Koenig, George, & Siegler, 1988).

However, research has indicated that this does not necessarily mean all older adults become more religious with age (Hunsberger, 1985; Johnson & Mullins, 1989; Markides, Levin & Ray, 1987). Koenig, Kvale, and Ferrel (1988) point out that the older adult years have long been stereotyped as

years filled with religious reflection, meaning or preoccupation. Current research still splits on this issue encouraging the perpetuation of stereotypes. Following is a summary of the research addressing these stereotypes and the relationship between aging and religion.

Functions of Religion

Most people organize their thinking and actions around some point of philosophy or experience (Ellor, 1990). Ellor (1990) advocates religion can provide such an integrating force in an individual's life. For today's cohort of older adults religious teachings or beliefs have been surveyed as playing a large role in the spirituality and life philosophy of individuals (Gallup & Jones, 1989).

Spiritual needs of older adults. Blazer (1991) advocates that listening to older adults talk about what they wish to talk about can provide spiritual insights into the process of aging (Blazer, 1991). Ellor (1990) identifies two major issues in life's circumstances which stand out when listening to the spiritual needs of older adults. The first is that aging is a time of multiple losses, and the second is the inevitability of death (Ellor, 1990). According to Ellor these topics help organize and illustrate the religious beliefs and spiritual needs of older adults (Ellor, 1990).

Ellor (1990) recommends using the concept of wholistic theology in working with older adults. Wholistic theology

suggests that all people are whole persons consisting of a physical, social, emotional, cognitive, and spiritual self. Viewing older adult clients from this perspective reveals the significance of religious beliefs and practices that may otherwise go unnoticed. Older adults, according to Ellor's research, find religion and their involvement in religious communities to be significant elements in their lives (Ellor, 1990).

Lovinger (1984) suggests both belief and religion provide reassurance about those matters which are important to individuals, but uncertain. Older adults face many such issues with changes in physical, vocational, and social functioning. Belief, and organized belief systems in the shape of religions, assist in providing a sense of meaning or structure in the face of the unknown. Lovinger (1984) promotes that having a sense of meaning can reduce worry and stress and assists individuals in facing death (Lovinger, 1984).

As older adults face their own physical decline, they face much uncertainty. Johnson and Mullin (1989) describe the later years as a time of anticipated deprivation. In their study of loneliness and religiosity among older adults, they found that as the anticipated deprivation of life approaches, the importance of a belief in life after death increases. This is one way in which individuals'

religious belief systems can assist coping and give meaning in the later years of life (Johnson & Mullins, 1989)

Gladdings, Lewis, and Adkins (1984), in measuring intensity and scope of religiosity found that those who perceived themselves as religious viewed their lives as more meaningful. They also found that individuals who perceive themselves as religious also experience themselves as having a high internal locus of control and purpose in life (Gladdings, Lewis & Adkins, 1984). Other investigations of the relationship between religiosity and life satisfaction have found similar results (Blazer & Palmore, 1976; Hunsberger, 1985; Koenig, 1990; Koenig, Kvale, & Ferrel, 1988; Koenig, Moberg, & Kvale, 1988). Over and over research has shown that religious beliefs offer older adults positive mental health attributes which if recognized can be tapped into and used in the therapy process of religiously affiliated older adults.

Dan Blazer (1991) in a paper on spirituality and aging outlines six dimensions of spiritual well being for the older adult. Self-determined wisdom establishes a stable person-environment fit for the older adult. As an individual ages, he or she accepts the limits with which one can influence the environment. Such wisdom, gained by experience allows an individual to accept and respect the balance of loss and ability imposed by nature (Blazer, 1991). Self-transcendence permits the aging individual to

cross a boundary beyond the self. Growing older is accompanied by changes in physical well being, mental acuity, and the pattern of social interactions. Transcendence allows the aging individual to let go of physical distractions and live more fully in the present (Blazer, 1991). Meaning is an individual search for answers to life's unanswered questions. Meaning is often sought out through a framework of religious beliefs or a life review process (Blazer, 1991). Accepting the totality of life is a similar task to Erikson's last psychosocial stage of development: integrity versus despair (Erikson, Erikson, & Kivnick 1986). Accepting one's life and eliminating the "ifs" from the past is a spiritual process which allows one to accept and integrate the total experience of life (Blazer, 1991). A revival of spirituality occurs as older adults relax defenses and find a new energy to face the realities of life, in particular, the inevitability of death (Blazer, 1991). Finally, exit and existence is an inevitable and real stage of older adulthood. Despite a shift to a more positive view of the aging process, a final disengagement and death are the result of the aging process and a final dimension of spirituality (Blazer, 1991).

Each of these dimensions in addition to providing a sense of purpose and meaning for older adults, also lays down the groundwork for a coping system for older adults.

Coping. Hall (1985a) proposes that an older person needs a strong sense of self concept and a positive world view in order to transcend and survive negative cultural stereotypes. Religion and belief can strengthen these self concepts and enhance coping skills (Hall, 1985a).

Many have indicated that critical to understanding the role of religion in the lives of older adults is an understanding that religion offers a significant means of coping for many (Ellor, 1990; Brown, 1980; Koenig, Moberg, & Kvale, 1988). Koenig, Moberg, and Kvale (1988) point out that the endurance and persistence of religion throughout history suggests that religious attitudes and behaviors serve important functions. The practitioner who ignores or misunderstands religious symbols in the life of a client will, according to Ellor (1990), lose the opportunity to use these coping mechanisms to benefit the client. Koenig (1990) adds that addressing religious issues in a sensitive and respectful manner may help the therapist to enter into a deeper therapeutic relationship with the religious older adult client and facilitate engagement on the same level at which the client is struggling.

Koenig, Moberg, and Kvale (1988) suggest that for older adults with few personal resources and little capacity to manipulate their environment, intrapsychic behaviors that help to alleviate distress and facilitate coping can have particular impact. Survey data have shown that many older

adults turn to scripture to make sense of difficult times or use prayer as a way to reach out to a power greater than themselves (Gallup & Jones, 1989). Research has also shown that private devotional activities have been found to be particularly meaningful for older adults in poor health (Koenig, Moberg, & Kvale, 1988). Despite the method or the belief system, believing seems to have the power to reduce anxiety, give a sense of meaning, and increase coping skills (Koenig, Moberg & Kvale, 1988).

Koenig, Kvale, and Ferrel (1988) found strong correlations among morale, subjective coping, and religious measures in a study of 836 older adults. They surveyed adults seen by physicians in a geriatric assessment clinic obtaining information on socio-demographic data, health variables, and religious beliefs. They found that respondents seventy-five years or older who were actively involved in religious behaviors were significantly more likely than the less religious to achieve high morale scores (Koenig, Kvale, & Ferrel, 1988). There was also a tendency for respondents with lower health scores to score higher on intrinsic religiosity. The private devotional aspects of religion were particularly important for older adults in poor health (Koenig, Kvale, & Ferrel, 1988).

In another study led by Koenig (Koenig, Moberg, & Kvale, 1988), responses to open ended coping questions by older adults were predominantly religious in nature. This

team interviewed one-hundred individuals between the ages of 55 and 80 with semi-structured interviews asking about the worst and best events in their whole lives, last ten years, and present. For the bad times, respondents were then asked how they had managed, coped, or kept themselves at an even keel. Religious coping was the most frequent method of coping mentioned. Almost one half (45%) of the sample mentioned a religious behavior for dealing with one of the three events. Religious attitudes such as faith in God, strength derived from God, and private prayer comprised nearly three-fourths of the religious coping behaviors noted. The results of this study are similar to the only other study to look at open ended coping questions of older adults (Rosen, 1982).

The prevalence and perceived effectiveness of religious coping behaviors among older persons point to a readily available mental health resource for many clients (Koenig, Kvale & Ferrel, 1988). There has been some strong evidence of the important part played by religion in the lives of many older adults (Reid, Gilmore, Andrews, & Caird, 1978). Nationally when feeling discouraged or depressed, forty-eight percent of the American adult population frequently or occasionally pray, meditate, or read the Bible (Gallup & Jones, 1989). In their survey of older adults, Manfredi and Pickett (1987) found that prayer is the most common way of coping among adults aged sixty-five to seventy-nine. Rosen

(1982) when interviewing impoverished rural elderly found that forty percent of respondents spontaneously reported religion as a coping mechanism to interviewers. Analyses of the data indicated that the more frequently the elderly respondents spontaneously reported using religion to cope, the more they were apt to report greater satisfaction with what they had done in their lives and greater current life satisfaction (Rosen, 1982).

Support. Religious affiliation has both social and emotional benefits for the older adult (Johnson & Mullins, 1989). As outlined above, religion provides meaning, a system of values, and beliefs, and tradition for older adult believers (Ellor, 1990; Erikson, et al., 1986; Johnson & Mullins, 1989; Koenig, Kvale, & Ferrel, 1988). Research has also demonstrated that attendance at religious services or participation in religious activities provides opportunities for older persons to be involved in social interaction with others (Johnson & Mullins, 1989; Ellor, 1990).

Johnson and Mullins (1989) investigate another popular stereotype of older adulthood: that most older adults suffer from chronic loneliness. Although surveys have shown that most older adults do not experience such loneliness, the stereotypes persist (Harris & Associates, 1974, 1981). Johnson and Mullins (1989) found older adults report much more life satisfaction in their social lives than is

commonly believed. Religious activities and social involvement in religious communities were found to contribute to this satisfaction. Johnson and Mullins (1989) found that greater involvement in the social aspects of religion were significantly related to less loneliness even when the various social relationship variables were controlled. In addition, subjective religiosity was also related to less loneliness (Johnson & Mullins, 1989). In Koenig, Moberg, and Kvale's (1988) geriatric clinic survey, fifty-two percent of the older adults interviewed claimed that four to five of their five closest friends were members of their church congregation. This underscores the powerful source of social support that religious communities provide older adults (Johnson & Mullins, 1989; Koenig, Moberg & Kvale, 1988).

Meaning. Freud believed religion to be humanity's creation to give purpose and a sense of control over the "untamable nature of the elements" (Freud, 1961a). Modern psychologists focus not as much upon religion as a means of control, but as a means to meaning (Brown, 1980; Ellor, 1990; Johnson & Mullins, 1989; Koenig, 1990; Manfredi & Pickett, 1987; Rosen, 1982; Spilka, 1986). Brown (1980) describes the thrust of religion to be to help people move beyond themselves, to experience transcendence, to know who they are, where they come from, and where they are going.

Older adults experience significant change within our society. Both Ellor (1990) and Peterson (1985) note that older adults cope with deterioration of physical functions and loss of life roles and friends as part of the aging process. Brown (1980) also suggests that to find meaning to such transition can assist coping skills and reduce anxiety. According to Brown (1980), religion can give meaning in a unique and supportive way because religion involves the mind, body, and spirit. Researchers have found that religious beliefs and activities offer older adult followers a sense of meaning, control, and esteem (Spilka, 1986; Lovinger, 1990).

Jung (1966) referred to religion as "the school for forty year olds". For Jung, it was only through religion that older people were able to prepare for the second half of life, for old age, death, and for eternity (Jung, 1966). Today's research supports this idea that older adults affiliated with a religion are better prepared for advanced years due to their ability to find and focus on a source of meaning (Brown, 1980; Ellor, 1990; Manfredi & Pickett, 1987).

Ellor (1990) in his examination of the role of religion in the lives of older adults and their families suggests that for some "religion can become the fabric that holds the life of an individual together". Religious symbols are described as providing a rich source of comfort and

familiarity to older adults facing new situations and new life roles in their aging process (Ellor, 1990). Religious traditions and teachings can give philosophical answers to difficult questions regarding losses and death (Ellor, 1990). Religious faith can offer older adults a sense of purpose and a special role in the religious community or smaller community of family (Ellor, 1990). Overall, religious traditions have been described by several authors as providing courage, meaning and purpose to older adults and enhancing personal coping skills in advanced years (Brown, 1980; Ellor, 1990; Manfredi & Pickett, 1987).

Stability and continuity. According to Payne (1988), religious participation does not simply cease with advancing years and physical limitations. There is no retirement age for religious community membership. As work roles change, and memberships to other social organizations are dropped, the one membership most frequently retained is to the church or synagogue (Payne, 1988).

When declines in organized religious participation do occur due to inaccessibility or immobility, research has indicated they are often compensated for by increases in non-organizational participation (Ainlay & Smith, 1984; Mindel & Vaughan, 1978). In interviewing and studying the lives of twenty-nine octogenarians, Erik Erikson, his wife Joan Erikson, along with Helen Kivnick (1986) found religious involvement to be a great source of continuity in

the lives of their subjects. Those they interviewed shared a feeling of faith; their religious beliefs became something they could count on to find safety in unsafe situations (Erikson, et al., 1986). They found that religious faith helped build stable, integrated personalities that can withstand the pressures that contribute to maladjustment (Erikson, et al., 1986).

Health. Even Freud drew a relationship between religious beliefs and protection against "the risk of certain neurotic illness" (Freud, 1961a). To Freud, the acceptance of a religion or a "universal neurosis" protected one from constructing a personal and often even more devastating neurosis (Freud, 1961a). Today, religion is better understood as a means of continuity, purpose, meaning, and acceptance which protect some from illness (Koenig, Moberg, & Kvale, 1988).

The spiritual dimension does not exist in isolation from the emotions or the body, but provides an integrative force among the three (Ellison, 1983). Limited evidence supports a role for religion as a buffer against psychiatric illness in later life (Koenig, Moberg, & Kvale, 1988). Bergin, Masters, and Richards (1987) even found data to support that significant religious involvement can be a positive correlate to normal functioning and emotional health. McIntosh and Spilka (1990) suggest that a belief in

an influential God may even promote health and the perception of physical well being for the older adult.

A sense of meaning and purpose in life helps to answer, or to tolerate a lack of answers to some of the deep and painful questions that often accompany illness or change (Peterson, 1985). Koenig, Moberg, and Kvale (1988) found the private, devotional and ideological aspects of religion to be particularly salient for elders in poor health. Findings from Bearon and Koenig's (1990) interviews of forty community dwelling older adults show that religious beliefs are intertwined with older adults beliefs about their health and physical symptoms. Their study suggests many older adults see health and illness as being at least partly attributable to God and to some extent open to God's intervention (Bearon & Koenig, 1990).

Because of the major impact of coping on health, Koenig, Moberg, and Kvale (1988) propose that a vital task of health care workers is to assist older adults in dealing with stressful life changes resulting from physical illness and other causes. Older adults, according to their study, will often use coping strategies that have worked effectively for them in the past. Clinicians can thus guide their clients by first inquiring about the strategies they employ to cope and then support and affirm the healthy behaviors while discouraging the self destructive behaviors (Koenig, George, & Siegler, 1988).

If religion is a healthy source spiritually, mentally, and emotionally for clients, Miller (1992) indicates that clinicians are professionally obligated to encourage the client to engage in those behaviors that are promoting health.

Theories of Aging

Sociologists and psychologists have developed various theories to explain the process of aging and its affects on an individual sociologically and psychologically. Previous to these theories aging was viewed as a purely biological process and often as an illness. These theories are different because they were developed in studying a healthy aging population (Butler & Lewis, 1982). Modern theories of aging have been partly responsible for a change in thinking about older adults by modern clinicians. Each theory offers a different perspective to the relationship between religion and aging.

Disengagement theory. The disengagement theory is an early theory of aging developed in the 1950's by research done at the University of Chicago (Cummings & Henry, 1961). The theory is based on the fact that death is inevitable. The theory poses that older people and society mutually withdraw, or disengage from each other in preparation for this inevitability. Deprivations and losses of old age are viewed as ways of divesting oneself of the false securities of life. By letting go, one is freed to live more fully in

the present and to hope more expectantly in the future. It is also postulated that this withdrawal is psychologically healthy for older adults (Cummings & Henry, 1961). This theory values religion in later life as a tool to enhance withdrawal from society and facilitate a focus on an after life. In disengagement theory, religion is a means to a more introspective place in preparation for death. Viewing the aging process from this perspective, one would expect that religiosity increases with aging as a means of disengagement from society (Havighurst, Neugarten, & Tobin, 1968; Schaie, 1988; Worthington, 1989).

The activity theory. Later research based on the idea that older adults are active when given opportunity, a positive environment, and cohort aged peers, established the activity theory (Schaie & Marquette, 1971). The activity theory proposes that older adults should remain as active as possible. It stresses that in order to maintain a positive sense of self, older adults must substitute new roles for those lost in old age and continue as many of the roles of mid life as possible. Substitutes for activities surrendered due to age and life style should be sought out and established to maintain psychological health. For instance, the retiree should seek out a interest or activity to occupy time and continue relationships, rather than attempting to disengage (Schaie & Marquette, 1971).

Within this theory religion and religious belief are examined for their values as activities. Palmore (1980) suggests that religious behavior as an activity is much more important to the well being of an older adult than beliefs and faith. Both cross sectional and longitudinal studies have demonstrated that organizational religious activities such as church attendance and participation in other group religious activity remain high until old age (Koenig, 1990). Correlations have been found between religious activity and happiness, feelings of usefulness and personal adjustment (Palmore, 1980). Overall, according to this theory the value of retaining a connection to religion is the availability of religious activity through worship, ritual, and socialization (Butler, 1976; Palmore, 1988; Young & Dowling, 1987).

Ego development theory. According to Erikson's theory of ego development, all people pass through a series of stages in which an essential conflict must be resolved in order for healthy adjustment to occur (Erikson, et al., 1986). The final stage which is approached in older adulthood is a conflict between integrity and despair. Unsuccessful resolution of this stage results in despair, successful resolution in integrity. Feelings of despair are shown by those who can see no meaning in life, who are not able to come to terms with the realities of the past, who want a second chance to live, who are bitter, and who have

not come to terms with the inevitability of death (Erikson, et al., 1986). Those without a personal philosophy of life or religious belief system in which to make sense of life are vulnerable to these feelings. In contrast, integrity indicates acceptance of the life cycle, acceptance of the past, and acceptance of the self (Erikson, et al., 1986). Often religious beliefs and activities can promote these feelings. Religious involvement not only offers a sense of meaning, but a sense of integrity (Erikson, et al., 1986).

Theories of Religiosity

By understanding a client's religious framework, a therapist can understand the impact religious beliefs have on an individual's mental health. However, measuring religiousness is a difficult task. Bassinger (1990) indicates that analogical nature of religious language and the private nature of religious experiences make it difficult for a researcher to know exactly what has been measured. Theories of religious development have primarily been derived from other theories of human development. Worthington (1989) writes that although there is significant empirical evidence for the developmental theories, when they are applied to religious development there is little empirical evidence to support them. However, according to Worthington (1989), these theories still do retain some validity in explaining the development of religion. Here, three theories of religious development will be briefly

presented in relation to the stereotype that as one ages one becomes increasingly religious.

Cohort theory. Stereotypes that as individuals age they become more religious may be based in part on the observation that today's older adults tend to be more religious than today's youth (McKenzie, 1980; Koenig, 1990). However, McKenzie (1980) argues that the older generation did not become more religious with time. Today's cohort of older adults were more religious in their youth, had more religious training while growing up, and have followed a religious belief system from their youth (McKenzie, 1980).

In a study of twenty-nine octogenarians, Erikson, Erikson, and Kivnick (1986) found that their subjects turned to religion to distill from the past that which they found essential for the future. They noted that religion was used as a force around which life's decisions were made and actions taken throughout all of life's stages (Erikson, et al., 1986). Subjects used lifelong religious beliefs and faith as a kind of compass to guide them through loss and transition. Strong religious beliefs had been instilled in their subjects at a young age and remained with them through their life course as a steady sense of identity, support and meaning (Erikson, et al., 1986).

Shand (1990) in following a group of Amherst college graduates for a period of forty years found a similar pattern. In regard to religious beliefs and behaviors, the

results of the 1984 survey showed a considerable degree of correspondence to the results of the 1942 survey (Shand, 1990). Religious beliefs and behaviors remained stable to this group over time.

The results of both Shand (1990) and Erikson (1986) support Goldsmith and Hansen's (1991) work. Goldsmith and Hansen (1991) proposed that religious upbringing significantly forms the personalities, belief structures, and decision making even of those who consciously disaffiliate from religion. These religious beliefs, no matter how active or dormant remain available for resurgence, well guarded and protected from attack or persuasion from others (Goldsmith & Hansen, 1991).

Events that occur in a specific time period often have been found to affect religious patterns and practices of all age groups (Payne, 1988). Therefore, each age group, or cohort, has its own socialization to religion. According to Payne (1988), those in the cohorts over age sixty-five in 1988 were members of child and youth church organizations between 1900 and 1940 during the peak of religious membership and participation. Following this historical pattern, although recent cohorts of older adults have surveyed as more religious than younger cohorts, their comparatively higher religiosity is more a function of history than of aging (Princeton, 1982, 1985).

<u>Developmental theory.</u> The final crisis of adulthood is thought to be integrity versus despair (Erikson, et al., 1986). Religious maturity is possible as an individual gains psychological maturity (Erikson, 1959; 1982). Both Hall (1985b) and Worthington (1989) suggest that the limitations of age force in individuals a realization that he or she is more than what he or she has done. Such a process places weight on a developmental theory of religion. As we develop psychologically and cognitively, we gain the insights and capabilities to develop religiously. According to developmental theory, only with age and experience, can religious maturity be reached (Erikson, 1959).

Jung (1966) supported such a developmental theory. He claimed that among all his patients in the second half of life, all had problems centered on finding a religious outlook (Jung, 1966). He wrote: "all great religions hold the promise of a life beyond; it makes it possible for a mortal man to live the second half of life with as much perseverance and aim as the first" (Jung, 1966).

Markides, Kevin, and Ray's (1987) research contradicts Jung's research. They interviewed two hundred and thirty Mexican Americans and Anglos aged sixty or over in a twelve year period, three times at four year intervals. Their study showed little evidence that older people increasingly turn to religion as they age and approach death (Markides, et al, 1987). Rather, what they did show was that unless

dropouts from longitudinal studies were considered in the final data of longitudinal studies, the false impression that religiosity increases with old age can be drawn.

Individual theory. Susan Kwilecki developed a theory of religious development which she calls a "scientific approach" in reaction to the more common developmental theories (Kwilecki, 1988). The theory is based on the premise that the process of religious change in any life is slow and complex, influenced by an unlimited number of variables which makes each person's process unique. She argues that the developmental theories place everyone, regardless of culture or personality, on a single evolutionary path. Her goal is to develop a pluralistic approach, recognizing many forms of religion (Kwilecki, 1988).

Kwilecki (1988) sets out to remedy the prescriptive tone of religious development theories and to integrate the force of culture in shaping individual religion. She proposes an examination of religion on three levels in order to fully understand religious development. She suggests first identifying in a client a cross-cultural form of developed religion, then explaining this in terms of specific cultural and personal factors (Kwilecki, 1988). Such a theory allows a clinician to understand a religious client's development and religiosity as a result of a personal history rather than on a prescriptive and morally

evaluative spectrum. This understanding can be particularly important in working with an older adult. The focus of treatment and the management of religious issues can orbit the client's personal history and culture rather than lead to a prescriptive and evaluative labeling process.

In summary there are several theories of aging and of religiosity available to today's clinicians. Which theories are chosen and adhered to has tremendous impact on how an older adult client presenting with religious issues will be perceived and treated. Today's clinicians are encouraged to become more aware of the theories to which they adhere. Only with increasing awareness of the impact of such theories will older adult clients with religious issues be treated respectfully and have their therapeutic needs met.

CHAPTER 4

OLDER ADULTS IN THERAPY

In their study of ageism in psychology textbooks, Whitbourne and Hulicka (1990) conclude that older adults, as a special needs population, have not been a focus of clinician training. Some have suggested this is part of the reason that so few clinicians have historically opted to work with a geriatric population (Knight, 1986; Santos & Vanden Bos, 1982). Monk and Kaye's (1982) research into student gerontological knowledge indicates that even when an attempt to integrate aging issues in curricula is made, the spiritual aspects of aging are still often ignored. Religious issues and spirituality have not until recently been commonly recognized concerns of aging in academia. Consequently, many clinicians who do opt to treat older adult clients are at risk for being ill prepared to address or avoidant of such issues. This chapter will look at barriers to treatment for older adult clients as well as the prevalence of ageism in the mental health system. Finally, some of the religious issues that may be raised in therapy with older adults will be examined in the context of how clinicians may interpret and handle these issues.

Barriers to Treatment

Koenig (1990) reports that there is a great deal of potential for emotional distress in older adulthood. In fact, Brink (1991) even suggests later life may be considered a time of significant risk for psychopathology. Roybal (1988) reports that as many as seven million older adults in the United States are estimated to be in need of professional mental health services; yet estimates that very few of these people are receiving any treatment. According to his data, older adults who make up almost 12% of the American population represent only about 6% of the persons served by community mental health centers and only about 2% of those served by private treatment (Roybal, 1988).

Roybal (1988) also suggests that older adults face a number of practical barriers that seriously limit their access to and utilization of mental health services. They are often misinformed or simply unaware of their neighborhood resources. Mental health centers rarely make themselves known in ways that encourage utilization by older adults (Roybal, 1988). Accessibility is another significant barrier. Those who are frail, home bound, or unable to utilize transportation alone are dependent on the few mental health providers that will make home visits (Roybal, 1988). Those who are mobile face systemic barriers with insurance

companies, limited Social Security incomes, and Medicare (Roybal, 1988).

<u>Underservice.</u> Older adults have been identified as being underserved by the current mental health system (Butler & Lewis, 1982; Knight, 1986). Palmore (1980) suggests that attitudes of older adults toward mental health care, attitudes of professionals toward older adults, availability of treatment, transportation options, and finances all distance older adults from quality mental health care. As a result, Santos and Vanden Bos (1982) report that proportionately, older adults receive significantly less mental health care than other populations.

Knight (1986) in a study of the management variables as predictors of service utilization by older adults in mental health, found that older adults are frequently blamed for this under utilization (Knight, 1986). However, his data indicated the attitudes of older adults are a less important factor in this underservice than had been previously thought (Knight, 1986). When older adult attitudes were significant, their resistance to mental health services was often a result of cohort mistrust of the system or of individual skepticism. Knight (1986) found both to be easily overcome by trained professionals patiently working with older adult clients.

Knight (1986) also suggested that the attitudes of psychologists are also frequently cited as an explanation for underservice of older adults. However, ageism on the part of professionals was not demonstrated to account for insufficient mental health services for the elderly (Knight, 1986). Gatz and Pearson (1988) came to similar conclusions.

Gatz and Pearson (1988) in a paper on ageism and the provision of psychological services propose a revision of the idea of ageism. They assert that global negative attitudes do not exist among service providers, but that specific biases may. For instance some clinicians may hold onto the belief that psychotherapy is an ineffective treatment for depression in older adults, or that memory loss is inevitable in the aging process. According to Gatz and Pearson (1988) these specific biases are more likely to affect the outcome or process of treatment than they are to curb the availability of treatment. In response, they propose educating professionals about normal aging, minimizing hyperbole, and attending to the real barriers to treatment as an antidote to negative biases of older adults by service providers (Gatz & Pearson, 1988).

Lori Secouler (1992) in a paper on older adults and humiliation addresses areas in which providers' attitudes are responsible for deterring older adults from continuing mental health services. She brings up the issue that the

majority of service providers for older adults are significantly younger than their clientele. She proposes that the more industrialized a society becomes, the younger the socializers of older adults. She concludes that what results is a reversal of traditional social patterns: rather than the older adult modeling for the younger, the younger is indicating how the older should be old (Secouler, 1992). This situation places the older adult client at great risk for humiliation in the clinical relationship if the clinician is unaware of what attitudes he or she brings about older adults to the therapy room. Secouler suggests that the greatest prelude to this possible humiliation is the loss of control. As older adults struggle with various declines and losses, their control becomes even more valuable. She proposes that it is essential for clinicians to bear this in mind and avoid an attitude of paternalism or condensation that threatens this control (Secouler, 1992).

Although clinician attitude toward the aging process and aging client is essential to a successful treatment outcome, both Knight (1986) and Secouler (1992) stress that a negative clinician attitude cannot be blamed for the problem of underservice. Rather research demonstrates that it is ultimately public policy which limits the financial and physical accessibility to mental health services for older adults (Knight, 1986; Secouler, 1992).

Public Policy. Gatz and Pearson (1988) in their examination of the provision of psychological services available to older adults point out that Medicare, which is the most widely used form of health insurance for our country's older adults, offers very limited coverage for psychological services. In fact, according to Roybal (1988) present Medicare psychiatric benefits have not changed since the program was established over twenty years ago.

According to Roybal (1988), the Medicare mental health benefit structure offers markedly inferior benefits when compared to those for physical illness. He also indicates that the system fails to encourage the most available and cost effective forms of mental health care. Mental health professionals such as clinical psychologists, clinical social workers, and psychiatric nurse specialists are not recognized as independent providers by Medicare and are largely unavailable to Medicare recipients. Ironically, it is these providers who according to Roybal, often offer the most cost effective and available treatment for many types of mental health disorders in older adulthood (Roybal, 1988).

Kimmel (1988) in a paper on ageism, psychology and public policy places the responsibility for changing these policies on the federal government. However, Slava Lubomudrov (1987), in an examination of Congressional perceptions of older adults, found that the legislators who

are responsible for developing policies to serve older adults are often misinformed of the needs of this population. A content analysis of Congressional documents reporting the debate around the Reagan Social Security recommendations revealed 46.1% of all statements regarding older adults to contain a misperception or a stereotype. Of the 1,106 instances that stereotypes were mentioned in 893 speeches and statements, 82.5% were negative stereotypes. Of these, 53.4% portrayed older adults as being either in poor health or socially isolated. In contrast only one-fifth of legislators who were members of committees on aging and Social Security benefits expressed misperceptions about older adults (Lubomudrov, 1987). These data suggest that more frequent exposure to issues about aging appears to reduce the likelihood that a Congressperson will voice misperceptions about older adults (Lubomudrov, 1987).

The misperceptions of the public and the Congress perpetuate each other. According to Lubomudrov (1987) if the public is misinformed, and a legislator wishes to speak a language understood by his or her constituents, he or she may choose to communicate through equally distorted images of older adulthood (Lubomudrov, 1987). The result, Lubomudrov suggests, is a lack of funding and services for multiple needs of older adults, including mental health benefits, and perpetuation of stereotypes and misunderstandings of our country's older adults.

Special needs. According to Knight's (1986) management variables' study, few areas offer community based mental health resources for the older adult. He proposes that as a result, inpatient units are often utilized to compensate for the under service of older adults (Knight, 1986). However, Roybal's (1988) examination of federal programming points out that Medicare standards are resistant to such use of an inpatient setting and will often not pay. The result is a severely restricted pool of mental health resources for older adults in many areas of our country. Knight (1986) suggests that in order to decrease the inappropriate use of inpatient services, special community services need to be designed to meet the special needs of older adults. Among these special community services, Knight (1986) proposes older adults need a continuum of mental health services as are available to all other age populations. These services may include not only in-patient and out-patient treatment programs but also full and half day programming, nutritional and medical monitoring and accessible transportation to various service sites.

One conclusion of Knight's (1986) management variable study is that ultimately the systemic factors of accessibility, assignment of staff within an agency, and reimbursement policies are what lead to the underservice of older adults. The survey of directors of California community mental health centers, found that the key

determinant to utilization of mental health services by older adults was not the number of older adults in a catchment area, but the number of service providers assigned to work with older adults (Knight, 1986). Others have found that in addition, when considerations such as physical accessibility, transportation, cost, and visibility in the community are considered, an increase in service to older adults can occur (Gatz & Pearson, 1988; Roybal, 1988).

Ageism in Mental Health

"Ageism", a term coined by Robert Butler (1982) to describe the prejudices and stereotypes that are applied to older adults sheerly on the basis of their age, has been found to permeate all areas of mental health (Kalab, 1985; Kimmel, 1988; Meeks, 1990; Palmore, 1984; Schaie, 1988; Settin, 1982; Whitbourne & Hulicka, 1990).

Training. Whitbourne and Hulicka (1990) predict that given the country's changing demographics, even clinicians who do not specialize in aging will have opportunities to apply what they have learned about the psychology of aging in their pursuits. However, despite the obvious relevance of the study of aging, Whitbourne and Hulicka (1990) point out it has failed to move into a position of central prominence in the undergraduate teaching of psychology. They hypothesized that it is often the inadvertent influence of textbooks and professor's opinions which shape the

attitudes of future clinicians toward older adults (Whitbourne & Hulicka, 1990).

According to Whitbourne and Hulicka (1990), textbooks' influence on attitudes, interests and the knowledge of students and ultimately on the public is profound. They theorize that textbooks often remain the primary source of information and attitudes on aging for the average student. Even after the details are forgotten, they hypothesize that the overall impression gained from undergraduate psychology courses is likely to remain and form a conceptual framework within which to think about older adults (Whitbourne & Hulicka, 1990). As students move into work roles, the beliefs about aging and older adults that they acquired as undergraduates can color their decisions about interactions with older adults (Whitbourne & Hulicka, 1990). Many authors have indicated that there is often little information or only negatively biased information in today's textbooks and few clinicians choose to work with populations with whom they have had little or no previous academic exposure (Harrison, 1991; Kalab, 1985; Santos & Vanden Bos, 1981; Whitbourne & Hulicka, 1990).

Whitbourne and Hulicka (1990) in an examination of 139 psychology textbooks printed between 1949 and 1989 found that texts including material on aging increased from 53.3% in the 1960s and earlier to 68.1% in the 1980s. They also found that a greater emphasis is being placed on physical

changes, health, retirement and family than on the traditional concerns of aging on intelligence, the brain and personality (Whitbourne & Hulicka, 1990). The exception is Alzheimer's disease which is increasingly discussed giving a sense of inevitability of senility in the aging process (Whitbourne & Hulicka, 1990). Others have proposed that as a result, the public overestimates its prevalence and clinicians over diagnose it (Gatz & Pearson, 1988; Lubomudrov, 1987). In the area of personality, they found a focus on problems such as disengagement and loneliness rather than on activity and success (Whitbourne & Hulicka, 1990).

Negative stereotypes have also been found to be evident in the language used in textbooks. Kalab (1985) examined introductory sociology and gerontology textbooks looking for the terminology used to describe persons over the age of sixty-five. Her assumption is that as individuals learn to place already existing names on people, they learn that names imply ways of interacting with those people (Kalab, 1985). For example, a connection between terminology and attitude has already been made in sexism and racism.

In the sociology textbooks the primary term used to describe people over the age of sixty-five is "old people" (Kalab, 1985). In the gerontology textbooks, terms such as "elderly", "aged", "older people", "senior citizens", "old", and "old people" were used (Kalab, 1985). Her

argument is that by the time a student has concluded an introductory course in sociology or gerontology, negative labeling has set stereotypes and implications for ways to interact with the over sixty-five population in the mind's of students (Kalab, 1985).

Besides textbooks, faculty provide a profound influence on students' attitudes toward aging and older adults. Monk and Kaye (1982) developed six proposals for faculty who wish to ready students for working with older adults. These proposals emerge from a study of gerontological knowledge and attitudes of undergraduate and graduate students. Low gerontological scores and negative biases toward older adults resulted for a majority of students surveyed (Monk & Kaye, 1982). In response, Monk and Kaye (1982) propose students need to be sensitized to the aging process and demographics of aging in the United States. This would be the very first step to facilitate overcoming such biases. Second, they recommend students become better acquainted with the full human life cycle (Monk & Kaye, 1982). This is in support of Whitbourne and Hulicka's (1990) finding that developmental theories focus on the needs of the child and adolescent and neglect the middle and end of the life cycle. Consequently, few students are currently exposed to the information on aging necessary to work with an aging population. Third, Monk and Kaye (1982) encourage the recognition of the unique and complex set of factors that

relate to the older adult and the aging experience. Concepts such as ageism, negative stereotyping, inaccessibility and widowhood as well as systems such as Social Security, Medicare, and Medicaid need to be understood in order to understand aging in our society. Fourth, they suggest that faculty focus on a scholarly and conceptual presentation of gerontological matter in the classroom (Monk & Kaye, 1982). In order to stimulate student interest in conducting future research, students need to be exposed to the dynamic and challenging field of gerontology today. Fifth, Monk and Kaye (1982) recommend there be guaranteed entry points to intensified gerontological study for those interested. Due to what they perceive as an acute shortage of gero-clinicians, interested students should be encouraged to and have opportunities to expand their knowledge. Finally, they support incorporation of gerontological instruction in all existing studies (Monk & Kaye, 1982). This is in support of Whitbourne and Hulicka's (1990) conclusion that even those students without a special interest in aging will most likely be called upon to deal with aging clients or relatives at some point in today's aging society.

According to Monk and Kaye (1982) the goal of these proposals is to give students a broad based and accurate understanding of the psychological, social, and biological processes of aging. With such an understanding, it is hoped

more students will be equipped for working with older adults and hopefully opt to do so (Monk & Kaye, 1982).

Assessment. Another area susceptible to ageism in the treatment of older adults is assessment. Both Palmore (1984) and Meeks (1990) pose that mental illness among older adults is often not recognized, but assumed to be "normal" aging. Palmore (1984) indicates that it is still widely assumed that mental illness among older adults ("senility") is an inevitable and normal process of aging. According to Palmore, there are many aged today who are thought of as "senile", who if they were younger would probably be thought of as eccentric, neurotic, depressed, or even schizophrenic (Palmore, 1984).

Some have suggested that assessment of older adults remains a challenge to clinicians who have not had appropriate training or background in normal aging (Billig, 1987; Pat-Horenczyk, 1988). Meeks (1990) hypothesized that older adults would be diagnosed and treated differently due to age alone. In her survey of fifty-five psychologists responding to case vignettes of "young", "middle age", and "elderly" clients, cognitive deficits were attributed to depression in the "young" and "middle age" clients and to medical diagnoses in the "elderly" clients (Meeks, 1990). In addition, results indicated that older adults are frequently seen as more likely to have a medical problem and assigned a poorer prognosis than a younger person by

clinicians. Although her results indicate that client age is related to the diagnosis of depression, it was related in a way consistent with previous epidemiological research. Therefore, her data did not clearly link ageism to the diagnostic process. However, the data did indicate that the complexity of diagnosing the older adult population requires special training and background in aging (Meeks, 1990).

The need for further training in the assessment of older adults was also found in a study of clinical psychologist's ratings of older and younger adult clients by Ray, McKinney, and Ford (1987). In this study older adult clients were consistently viewed as less ideal for treatment and more difficult to help. When presented with clinical vignettes of depressed and agoraphobic clients of varying ages, clinical psychologists assigned significantly poorer prognoses to older clients than younger clients (Ray, et al., 1987). In addition the clinicians viewed older clients as less ideal for their practices than younger clients.

A study by Pat-Horenczyk (1988) found similar results. Sixty-eight therapists of varying degree levels from three psychiatric facilities were given a vignette of a depressed patient; half of the vignettes indicated an older adult patient, the other half a younger patient. The results found that therapists tended to assess the depressive disorder as less severe in the older adult patient, to recommend less dynamic treatment for the older patient, and

to express a lower level of motivation to treat the older patient (Pat-Horenczyk, 1988).

Greene, Adelman, Charon, and Hoffman (1986) in a study of the doctor-older adult patient relationship, found dramatic differences in the treatment of older and younger patients. Physicians provided better questioning, information and support with the young patients than with older patients (Greene, et al., 1986). They were more respectful of younger patients and raised more psychosocial issues with young patients (Greene, et al., 1986). In contrast to stereotypical beliefs, the older patients did not bring non-specific problems to their physicians and in addition were not invited to discuss such issues as were the younger patients (Greene, et al., 1986). As a result, service providers often have misperceptions of what is of concern to older adults and lack an accurate understanding of older adult's lives (Crane & Kremer, 1987).

A study done by Hillerbrand and Shaw (1989) on age bias in psychiatric consultation supports this same finding. They studied psychiatric consultation reports of 41 patients at a veterans hospital. Among their results, they found that the mental status exam was often less complete and briefer with older patients. In addition, an assessment of suicidal ideation was often absent or far less complete than with younger clients (Hillerbrand & Shaw, 1989). This is of particular concern since it is the depressed older adult

male that is at highest risk of suicide (Billig, 1987). Overall, the psychiatric consult with older adults was less complete and more often resulted in an "age appropriate" diagnosis (Hillerbrand & Shaw, 1989).

Settin (1982) found similar results in a study of clinical judgement of psychologists in gero-psychology practice. Perceptions of and diagnosis of a 72 year-old stimulus client were significantly more negative than those of a 46 year-old stimulus client presenting with the same complaints (Settin, 1982). In addition surveyed psychologists were less comfortable and less interested in treating the older adult stimulus client who was rated as less liked (Settin, 1982).

Levenson (1981) points out nothing magical happens between the sixty-fourth and sixty-fifth year of life except in the minds of health care providers. Research has indicated that pathology does not significantly change, but provider's perceptions do change (Zevon, Karuza, & Brickman, 1982; Levenson, 1981). However, as Settin's (1982) study demonstrates, clinical psychologists are no more immune to the stereotyping process than any other health professional or society at large. In fact, they may even be more susceptible to stereotyping older adults. By definition of their work, Greene, Adelman, Charon, and Hoffman (1986) posit that clinicians see the ill, the frail, and the confused on a more regular basis than they see the well

older adult. These experiences may contribute to the belief in stereotypes and the clinging to a medical model which attributes a passive role to older adults seeking help (Greene, et al., 1986). Ultimately, they encourage the older adult in a client or patient role to become more assertive and communicative to compensate for incomplete assessments and inaccurate diagnoses made on the basis of stereotypes (Greene, et al., 1986).

To alleviate the responsibility of older adults to actively advocate to be treated fairly, Levenson (1981) in an editorial on ageism and curricula, proposes health care providers must be taught carefully to assess and care for older adults. He recommends a mentor model in which clinicians are taught about interacting with older adults by a thoughtful, enthusiastic, knowledgeable, and supportive role model (Levenson, 1981). It is the goal of such a program to avoid depriving older adults of the same benefits of optimal care enjoyed by younger populations (Levenson, 1981).

Reverse ageism. According to Gatz and Pearson's (1988) work on ageism and the provision of psychological services there are two emphases when it comes to portraying older adults. Older individuals are either portrayed as exemplars of those that have made unusual achievements in advanced years or are seen as institutionalized, helpless, and a burden to their loved ones (Gatz & Pearson, 1988). This

latter view is simply known as ageism. However, the former, the urge to overcompensate for ageism and create an emphasis on exemplars, can cause a phenomenon known as reverse ageism.

Whitbourne and Hulicka (1990) suggest that with the trend to accentuate positive aspects of aging, and to remain "politically correct", the focus falls upon the exceptional older adult. Such attention appears to reflect an attempt to communicate the message that aging need not be a period of decline and loss (Whitbourne & Hulicka, 1990). However, such overly optimistic appraisals of aging do as much harm as negative stereotyping. Braithwaite (1986) proposes that the rise of an anti-discrimination response may be a function of the existence of any stereotypes reaching public consciousness. For instance, once a stereotype is exposed and deemed unacceptable in the public arena, a marshalling of ideological forces within the society emerges committed to compensating for past injustices and prejudices (Braithwaite, 1986).

Kimmel (1988) implies that this process can be just as damaging as a lack of appreciation to the challenges of old age. Lubomudrov (1987) shares a similar point of view. His research suggests that once a group is believed to be stronger than they actually are, criticism around any advocacy on their behalf emerges. According to Lubomudrov, this is the reason behind recent government Social Security

cuts and refusal for older adult programs (Lubomudrov, 1987).

Treatment. Gatz and Pearson (1988) speculate that because there are more older adults in today's society, a sense of uniqueness, and special survivorship is no longer present to this generation. They suggest that in order to be a notable older adult today, one must accomplish something to gain status which was once awarded simply on basis of age (Gatz & Pearson, 1988). Kimmel (1988) poses that although more attention is given today to older adult patients, consumers, and voters, both negative and false positive stereotypes are normally the focus of this attention.

According to Gatz and Pearson (1988) the treatment process can fall victim to a similar pattern. They suggest that there may be an anti-discrimination response on the part of clinicians whereby they exaggerate the competencies and excuse the failings of older adults as normal (Gatz & Pearson, 1988). They hypothesize that this could explain how clinical psychologists by going out of their way to not denigrate older adult clients, fail to recognize legitimate psychological problems (Gatz & Pearson, 1988).

Besides anti-discrimination, negative stereotypes are also at risk for entering into treatment with older adults. Levenson (1981) in an editorial on ageism and curricula theorizes that the very roots of ageism, the reawakened

parental conflicts, awareness of one's vulnerability and mortality, are all evoked in therapy with older adults. According to Levenson, if a mental health professional's goal is to rid himself or herself of these negative feelings, treatment may be short, damaging, and most likely ineffective for the older adult client. In order for treatment to be successful, Levenson advocates that the clinician be aware of the above issues and rather than focussing on being rid of them, focus on the client's experience and struggle with those same issues (Levenson, 1981).

Research. Ageism has also crossed the line between treatment and research. Researchers have been shown to not explore areas to which they have not been exposed, just as practitioners tend to not serve populations with whom they have had no academic exposure (Santos & Vanden Bos, 1982). In addition, studies of older persons have been accused of reflecting little or no recognition of the appropriateness of a particular research paradigm for older adult subjects (Schaie, 1988). It has been suggested that many studies fail to recognize the many methodological issues that must be considered when selecting and experimenting with populations of older adult subjects (Schaie, 1988; Haitsma, 1986).

Many have indicated that a major shortcoming of research with older adults has been the almost exclusive use

of cross sectional data (Blazer & Palmore, 1976; Markides, 1983; Markides, Levin, & Ray, 1988). Cross sectional data makes it very difficult to delineate the effects of aging from cohort membership and period of observation (Markides, 1983). According to Markides (1983), the interplay of cohort, period, and age makes it paramount that researchers employ longitudinal designs when studying older adults. Yet relatively few researchers have done so (Blazer & Palmore, 1976; Markides, 1983; Markides, Levin, Ray, 1988).

Schaie (1988) points out another major flaw in many gerontological studies is the failure to distinguish between normal age changes and disease. Green (1981) also emphasizes the need for precision in definition of variables. This, according to Green, is particularly important in examining research on the relationship between characteristics of respondents and their attitudes toward the elderly (Green, 1981). For example, according to Schaie (1988), reports of small but reliable age differences and age changes often lead to the erroneous conclusion that age related deficit is universal and characterizes all members of the population under study. Because, data on psychological age changes can readily become the basis for public policy decisions, gerontological studies have been urged to become more precise, less biased and of a higher quality than what has been the norm (Green, 1981; Schaie, 1988).

Sexism and ageism. Aging is a women's issue. Demographics show women most often outlive their life partners and face old age alone (Harrison, 1991; Gallup & Jones, 1989). Yet according to Harrison's examination of older women in our society, researchers, writers and clinicians persist in seeing the older adult segment of our population as a sexless population. According to Harrison, this contributes to the invisibility of older women in society (Harrison, 1991). Other researchers have expressed similar concerns that the concept of ageism is clearly compounded by sexism for older women (Heggen & Long, 1991; Kimmel, 1988).

Researchers have found that older women cope differently than men, are diagnosed and treated by professionals differently, and as a consequence, often perceive themselves differently (Wilcox, 1992; Koenig, 1988; Long & Heggen, 1988). Sheinkin and Golden (1985) in a paper on older women in therapy, point out that women in later life experience a convergence of biological, psychological, and environmental forces unique to women that require them to let go of old forms and find or create new images which can guide or vitalize them.

Demographics suggest that when an older adult walks into a therapy room, odds are a female client has walked in (U.S. Department of Commerce, 1992). Long and Heggen (1988) suggest that older women bring their own special strengths

and weaknesses to therapy as well as a very different relationship with the Judeo-Christian religious tradition than their male counterparts. Long and Heggen (1988) distributed a questionnaire to 77 active clergy (seventy-six men, one woman) in an attempt to tap into their definitions and judgements of spiritual health for men and women. Their results found that clergy perceive the religiously healthy woman differently from the religiously healthy man (Long & Heggen, 1988). Spiritually healthy women were described as "follower, gentle, emotional, self sacrificial, submissive, sensitive...". In contrast the spiritually healthy man was described as "self reliant, a leader, independent, aggressive, ambitious, helpful...". Long and Heggen (1988) conclude that clinicians need to be aware of women's roles in varying religious traditions in order to appreciate the strength of the internalized religious stereotypes that they bring with them to therapy (Long & Heggen, 1988).

Heggen and Long (1991) in a later paper suggest it may be these very internalizations that bring older women to therapy. They propose that Christian women who are socialized to defer to men may have more mental health problems and become more susceptible to depression with age. They theorize that as older women survive the loss of their life partners and are forced into more independent and assertive secular roles, the experience of a role very different for their religious teaching's ideal may lead to

conflict and ensuing mental health problems (Long & Heggen, 1988). According to Sheinken and Golden's (1985) research on older women in therapy, it is just such a crisis that calls clinicians to assist their clients in finding valued female images from religion, culture, and life experiences for modeling and empowerment.

Effective Treatment

Peake and Philpot (1991) offer the following considerations to ensure effective therapy with older adult clients. "The therapist must have and convey an appreciation of developmental issues" (Peake & Philpot, 1991). This has been stressed by other researchers in relation to the importance of exposing students to developmental material which includes the end of the life cycle (Kalab, 1985; Whitbourne & Hulicka, 1990). "The therapist must allow or encourage an appreciation of the impact of losses." According to Peake and Philpot, learning to do therapy with older adults involves not only a sensitivity to the process of reacting to loss, but also a resourcefulness in identifying and reapplying old ways of recovering from loss. "The therapist must keep in mind the complicated interactions of the physical, psychological, and spiritual dimensions of aging." The therapist is urged by Peake and Philpot to consider what is pathology and what is age appropriate. In later years the relationship between the physical and psychological becomes more evident with the

normal physical declines of aging. However, not all psychological concerns should be attributed to physical causes or vice versa. And finally, "the therapist should realize that it is possible to clarify and preserve a person's complex identity in a therapeutic fashion". According to Peake and Philpot, an older adult does not identify him or herself with the past, but with the total life experience. Thus, they encourage clinicians to elicit from older adults a life story which will reveal life themes and an identity which is the product of life experiences and not the result of recent life losses (Peake & Philpot, 1991).

Religious issues. According to Koenig (1990) little has been written about the importance of addressing religion or its utility in psychotherapy or supportive counseling with older adults. However, the research that has been reviewed above suggests that religious beliefs and behaviors can have a positive influence on older adults. Many researchers have found that religious beliefs and activities of older adults based in the Judeo-Christian tradition may be associated with higher life satisfaction, a sense of well being, fewer depressive symptoms, less disability and perception of pain, and better adjustment (Blazer & Palmore, 1976; Koenig, George, & Siegler, 1988; Koenig, Kvale, & Ferrel, 1988; Koenig, Moberg, & Kvale, 1988; Manfredi &

Pickett, 1987; Markides, 1983; Markides, Levin, & Ray, 1987).

Koenig (1990) asserts such beliefs and behaviors can be supported by clinicians without fear of encouraging harmful influences. Often in addressing religious beliefs with older adults, positive, healthy religious attitudes and behaviors can be reinforced. Integrating religious themes into treatment with a religious older adult client can according to Koenig, be particularly helpful in maintaining client interest and cooperation with treatment (Koenig, 1990).

Others have expressed concern that at some time, religious themes may emerge as a neurotic or psychotic illness (Bergin, 1986; Koenig, 1990; Lovinger, 1984). Bergin, Masters, and Richards (1987) suggest that such instances need to be carefully assessed and differentiated from the more positive attributes of religion. Koenig, (1990) in this situation suggests relating to the client at a religious level in order to gain trust. Once in a secure relationship with the therapist, the client may be able to correct misperceptions and false beliefs which may lie at the root of illness (Koenig, 1990). Whether to address pathology or encourage health, Koenig (1990) advocates that preparing to deal with religious issues in therapy with older adult clients is essential for clinicians (Koenig, 1990).

Responsiveness. Research has shown that many clinicians are not attuned to their client's religious beliefs and the impact of these beliefs upon their lives (Beit-Hallahmi, 1975; Houts & Graham, 1986; Jenson & Bergin, 1988; Shafranske & Gorsuch, 1984; Worthington & Scott, 1983). Kelly (1990) suggests that clinicians can increase their responsiveness to client religiousness if they have an understanding of the degree and quality of a client's religiousness, and the connections between client issues and religion.

Kelly (1990), in an article on counselor responsiveness to client religiousness, differentiates eight types of religious clients to assist clinicians in determining whether to use religious or nonreligious interventions. He suggests that religiously committed clients, religiously loyal clients, spiritually committed clients, and religiously and spiritually open clients are responsive to religiously or spiritually oriented interventions (Kelly, 1990). In contrast, Kelly (1990) suggests it would be inappropriate, ineffective, and perhaps unethical to use such interventions with superficially religious clients, religiously tolerant and indifferent clients, nonreligious clients, and clients hostile to religion. Such a taxonomy is helpful only as far as a client can be identified with one of these groups.

Older adult clients may not display such an either/or presentation. The real task for clinicians is to respond to material offered by clients in addition to offering an opportunity for religious and spiritual issues to be verbalized if such issues are relevant to a particular client (Kelly, 1990).

Intrinsic versus extrinsic. A more frequently used approach to discriminating *how* a client is religious was developed by Allport and Ross (1967). Their distinction of intrinsic and extrinsic religious orientation is a useful way to distinguish positive from negative features of religiousness (Bergin, Masters, & Richards, 1987). Extrinsically motivated people are thought to use their religion as a means to obtain status, security, self justification, and sociability (Bergin, et al., 1987). Intrinsically oriented individuals internalize their beliefs and live by them regardless of the external consequences (Bergin, et al., 1987). Individuals with an intrinsic orientation have been found to have lower anxiety and a better sense of self control; an intrinsic orientation can facilitate many areas of healthy functioning (Bergin, et al., 1987). This provides further reason for clinicians to attend not only to a clients' religious beliefs but to how a client is religious in order to promote those beliefs and behaviors which are encouraging to mental health.

When a religious orientation is evident in an older adult client, the religious factor can be used therapeutically to encourage independence and growth. An intrinsic orientation has been found to be responsive to taking responsibility for treatment and welcome movement towards health (Allport & Ross, 1967; Zevon, Karuza, & Brickman, 1982). On the other hand, when an extrinsic orientation is evident, an older adult client may be experiencing the losses of status once held in a religious group, reduced social contacts, or diminished security with age. In this case, Bergin and his colleagues (1987) suggest a clinical goal may be to assist the individual in moving towards a more intrinsic orientation to facilitate responsibility, a sense of internal control, and ultimately restore self esteem.

Techniques. Zevon, Karuza, and Brickman (1982) in a paper exploring four models of psychotherapy suggest that clinicians use interventions with older adult clients which allow clients to retain responsibility for solutions. Often the older age of a client will encourage clinicians to use a medical model of treatment and place the older client into a passive role (Zevon, et al., 1982). Ironically, Zevon, Karuza, and Brickman (1982) suggest this is often the role preferred by older adult clients who are accustomed to being passive while a medical doctor treats them actively. However, allowing older adult clients to retain

responsibility for solutions encourages self empowerment and the use of their own effective coping skills (Zevon, et al., 1982). Koenig, George, and Siegler (1988) anticipate that such a process will often elicit religious beliefs and attitudes. They suggest this can be encouraged and utilized by the therapist in the therapy process as a means of coping (Koenig, George, & Siegler, 1988).

Bergin and Payne (1991) assert that as with any other approach, using a spiritual approach implies hypotheses and techniques of change. They suggest that there are essentially two categories of counseling techniques used with religious or spiritual issues (Bergin & Payne, 1991). There are those grounded in traditional psychological theories or professional secular sources which are then adapted to religious content, and there are those originating specifically from within spiritual or religious frameworks which are used therapeutically (Bergin & Payne, 1991).

Research done by Propst, Ostrom, Watkins, Dean, and Mashburn (1992) illustrates the application of psychological techniques with religious content. They compared the efficacy of cognitive behavioral therapy, one with religious content and one without, to standard pastoral counseling treatment and a waiting list control for religious clients. Their results showed that religious individuals receiving a religious cognitive therapy reported more reduction in

depression and greater improvement in social adjustment and general symptomatology than did individuals receiving standard cognitive behavioral therapy (Propst, et al., 1992).

Work done by Bergin (1980) and Lovinger (1984) illustrates the second category of counseling techniques. He has successfully used the concept of forgiveness, with its roots in religion, as a spiritual therapy technique (Bergin, 1980; Bergin & Payne, 1991). Lovinger (1984) also suggests religious techniques for therapeutic benefit. Religious imagery is just one of many techniques he advocates as useful in the therapy process of religious clients (Lovinger, 1984).

According to Koenig (1990), older adults often have reduced resources due to changes in social status, health, mobility and finances. Koenig, Kvale and Ferrel (1988) suggest that one of longest held and most powerful resources brought to therapy by older adult clients is religious belief. Kivley (1986) advocates that clinicians whom are willing to recognize and address religious issues in therapy will often gain a greater trust of their older adult clients. Koenig, George, and Siegler (1988) have also found that those who support healthy religious coping behaviors will also find their older adult clients to not only be more agreeable to treatment but benefit more from treatment.

Older adults have not traditionally been thought of as candidates for long term insight oriented therapy. This exclusion has until recently extended to other modes of treatment. However, as the baby boomer segment and future cohorts of our population reach older adulthood, we can expect this trend to change. Current and future cohorts of older adults have experienced the popularization of psychology in society and witnessed an acceptance of seeking mental health services. As Medicaid standards and insurance coverage changes in our society, more and more older adults are anticipated to seek treatment. Religious beliefs and affiliation offer a wealth of assistance to older adult clients. Religion can be tapped into and utilized or reclaimed as a support system, a sense of meaning, a source of personal identity and a resource for coping skills for those affiliated or willing to re-affiliate.

CHAPTER 5

SUMMARY AND CONCLUSIONS

Summary

American culture is currently experiencing two distinct but simultaneous phenomena: a resurgence of religious beliefs and a population explosion of those over age sixty-five (Miller, 1992; Schumer, 1984; United States Department of Commerce, 1992; Worthington, 1991). Both of these populations, the religious client and the older adult client, have historically been underserved by mental health clinicians. However this "graying and praying" of America is demanding attention and posing a new challenge to psychotherapists. The integration of religious issues in the process of therapy is one possible result of this challenge.

The current cohort of older adults experienced the popularization of psychology within their lifetime. This cohort and future cohorts are more psychologically sophisticated and more likely to seek out mental health services than previous generations. Although older adults are now a minority among those being served by psychotherapists, the trend is for their numbers to increase. The integration of older adults with younger adults into the average clinician's caseload is inevitable.

In addition there is also a new resurgence of religious beliefs within our culture. Older adults who do seek treatment are going to be even more likely to express their feelings and concerns through religious language, ideas and belief systems. These two trends and their combination are challenging clinicians of all backgrounds to prepare for a possible influx of older adults with religious issues into the therapy room. However, up until now, it is the rare clinician who is professionally prepared to do so.

Training and Educational Implications

Some have compared the role of the modern psychotherapist to that of the secular priest (London, 1986; Stern, 1973). Although the modern science of psychology has worked hard to distance itself from religion and philosophy, clients' concerns have not. Individuals seek out healing, approval, and reassurance from clinicians as did earlier generations from religious leaders.

Religious issues in the form of values, morals, and life philosophies remain very much the concerns of modern clients. Unfortunately, most psychotherapists are not well suited for the role of secular priest (London, 1986). Neither training nor personal experiences have prepared therapists to deal with morals and religious issues in the course of therapy (London, 1986; Shafranske, 1990; Presley, 1992). To compound the problem, few are trained to work

with older adult clients (Santos & Vanden Bos, 1982; Shafranske & Gorsuch, 1984; Monk & Kaye, 1982)

Religious issues arise with more frequency and more intensity with an older adult population (Barden, 1985; Blazer, 1991; Brink, 1985; Hall, 1985; Koenig, 1990; Koenig, Kvale, & Ferrel, 1988; Koenig, George, & Siegler, 1988; Koenig, Moberg, & Kvale, 1988). Religious issues emerge in response to the loss, transition, and pain that often accompany the aging process. Often such experiences have no other vocabulary or source of meaning as clients struggle for integrity over despair. It is this struggle that seems to pull older adults in the direction to either deepen or reclaim their faith. Stripped of sources of meaning that have provided identity through the life span: friends, jobs, spouses, sometimes homes and families, older adults often utilize or return to religious traditions of their youth to find a source of meaning and integrity.

With the flourishing of both religious issues and older adults in therapy, clinicians are urged to learn about religious values and older adults in order to more effectively serve this clientele. Graduate programs have begun to offer certifications and specialized training in gerontology, and, the time has come for seriously considering the same in religion for secular psychotherapists.

Religious issues in the training of psychotherapists. Abundant research has pointed to the relationship between and blending of religious and psychological issues (Blazer & Palmore, 1976; Blazer, 1991; Brink, 1985; Ellor, 1990; Koenig, 1990; Markides, 1983; Miller, 1992; Moberg, 1972; Payne, 1990 Young & Dowling, 1987). The consensus seems to be that if religion were discussed more openly in therapist training, therapists would heighten their sensitivity and awareness to religious concerns of their clients. However, graduate training programs are not currently doing this. Psychotherapists are continuously being graduated with little or no knowledge or understanding of religions other than their own. They lack the skills or training in assessing, understanding, or integrating religious issues in the course of therapy.

Frequently graduate programs have classes educating students in the culturally different, but religious frameworks are rarely included in such classes. Shafranske and Maloney (1990) in their survey of 409 APA Division 12 clinical psychologists found that only 5% of their subjects reported that religious or spiritual issues were presented in their training. Only 10% of those surveyed had some theological training. Their data reveal that psychologists in general receive little education and training in the area of psychology and religion.

This literature review has suggested that religious issues are an important source of meaning, support, identity and coping skills for older adults. Until training programs are able and willing to integrate religious issues into course work and supervision, few therapists will be adequately equipped to deal with these issues in therapy. Consequently, clinicians are inadequately prepared to deal with a significant and valuable aspect of their client's lives. Lack of preparation and training leaves older adult religious clients vulnerable to misunderstanding or even avoidance by clinicians.

Exploration of the religious dimension in the counseling session can offer a deeper sense of understanding of the client. Secular psychotherapists, when prepared, can function as facilitators for older adult clients with religious questions and concerns. This process can renew healthy coping skills, assist in the development of new social networks, and reaffirm a sense of identity and source of meaning for older adult clients.

<u>Gerontology in the training of psychotherapists.</u> Therapeutic values are inherent in any theory of counseling. Not only do theories, techniques, and criteria reveal pervasive value judgements, but all theories take as their primary goal helping clients change for the better. The whole concept of change implies value judgements. What needs to be changed, by whom, why, to what, when? Answers

to these questions are formulated in a clinician's mind as early as an initial meeting with a client.

Often these preliminary answers are based upon first impressions or stereotypes rather than on the client's goals. Older adults are particularly vulnerable in this process. Numerous studies have shown that older adults are seen as less attractive, less likeable, and less likely predicted to respond to treatment by mental health care providers (Crane & Kremer, 1987; Greene, et al., 1986; Hillerbrand & Shaw, 1989; Levenson, 1981; Pat-Horenczyk, 1988; Ray, McKinney, & Ford, 1987; Settin, 1982; Zevon, et al., 1981). Often the recommended treatment modality for older adults is pharmacological rather than psychotherapeutic. Where disservice occurs is when the recommendation is made out of the clinician's fears or biases rather than out of the client's needs.

Training of mental health care providers is critical to the nature and quality of care older adults receive. Negative stereotypes of the aging process and of the abilities of older adults pervade our society. In order to combat such a pervasive belief system, gerontological training, and education needs to be provided to all mental health care providers in our aging society.

Peake and Philpot's (1991) quality assurance considerations in the therapy of older adults is a good place to begin. According to Peake and Philpot (1991),

clinicians' need to have a basic understanding of the entire developmental life cycle, an appreciation of the role of loss in later years, and have an awareness of the complicated interactions of the physical, the psychological, and the spiritual aspects of aging. Without such an appreciation and understanding of the aging process, clinicians' are apt to fall victim to their own negative stereotypes and risk harm or at least underservice to older adult clients (Peake & Philpot, 1991).

Individual responsibility. Despite the amount of education and training provided by graduate school programs, the burden of fair and quality treatment remains with the ethics of the practitioner. Religion has as strained a relationship with psychology as does the older adult in our society. The predicted burgeoning of these two into the therapy room is challenging the psychotherapist to not only further education but an examination of personal beliefs.

In order to appreciate and understand the religious beliefs of another, the practitioner is called to an understanding of his or her own belief systems. Without personal clarity, the therapist falls risk to confusing his or her own issues with the client. In addition, it has been recommended that therapists be prepared to be open about their own religious beliefs with clients who ask or whom are likely to be influenced by the therapist's belief systems (Bergin, 1991; Worthington, 1986).

In order to professionally explore a client's spiritual or religious concerns, the therapist is encouraged to gain a thorough awareness of his or her own religious beliefs (Miller, 1992; Spilka, 1992). Whatever therapists profess to believe, and even though it is difficult to remain value-neutral, it is vitally important that they not impose their values and beliefs on clients (Kudlac, 1991). Bowman (1989) indicates therapeutic misadventures with religious material generally arises from two sources: ignorance and unexamined countertransferences. Ignorance about the client's religious tradition can be easily remedied. According to Bowman (1989) countertransference about religion is by far the most common source of therapist's error.

Working with older adult clients runs the risk of awakening powerful countertransferences within the therapist unique to the relationship with aging. A novice therapist can become the idealized child, praised and rewarded by the client for understanding and empathy. At the opposite extreme death anxieties, fear, and revulsion may be aroused by working with someone of advanced years. Dealing with these issues requires an awareness of personal feelings surrounding the process of aging and death, and an ability to separate them from the therapy process.

Part of this self awareness extends to a recognition of limitations. A client from a different religious background than the therapist's may bring questions or concerns to

therapy which are unfamiliar to the therapist. Often the resolution to this situation is striking an alliance with a local clergy person. This relationship can provide guidance in difficult cases and considerably increase chances of success with the explicitly religious client.

A similar solution may be ideal for working with the older client. Due to difficulties in differential diagnoses and the increasingly intertwined relationship between physical and mental health for an older adult client, it can be advantageous to have a working relationship with a geriatric practitioner for consult and referral.

Conclusions

As Erikson posits, despair is the negative possibility, and integrity the positive. Therapists working with older adults need to be very aware of the two possibilities. By neglecting to address or acknowledge religious issues in therapy, the therapist may be unknowingly leading an older client in the direction of despair. Often religion provides the structure and vocabulary for older adults to make sense of their life situations and their own anticipation of death. Whether the importance of religion in the lives of older adults is due to their cohort, a cultural bias, or the process of aging, it is nonetheless consistently important. The task of the therapist is to facilitate a reentry into or a confirmation of a belief system which gives meaning and purpose to the older client. Most often

this belief system will have religious overtones if not be explicitly religious.

The "graying and praying" of America is challenging psychotherapists to prepare themselves to address religious issues with aging clients in therapy. The purpose of this study has been to review and attempt to integrate two recent trends in psychotherapy research: religious issues and the older adult client. Recent literature has been reviewed in three distinct areas of research: religious issues within psychotherapy, religion and aging, and older adults in therapy. It is the hope that this work will spur more research and training in the area of religious issues with older adults and contribute to a greater understanding of the connection between religion and psychology. It is only then an integration process can take place between religious issues and therapy for the benefit of the older adult client.

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VITA

The author, Susan J. Reardon, is the daughter of John and Josephine (Russo) Reardon. She was born in Bristol, Connecticut.

Her elementary and secondary education was obtained through the public schools of Bristol, Connecticut. She graduated from Bristol Eastern High School in June, 1985. In August of 1985, Ms. Reardon entered the College of the Holy Cross in Worcester, Massachusetts. She received a Bachelor of Arts in psychology in May, 1989. She also received a certificate for completion of course work through the Worcester Consortium Gerontology Studies Program.

Her internship experiences have included work with older adults through Elder Home Care of Worcester, Massachusetts and the Council for Jewish Elderly in Chicago, Illinois. She has also worked with adolescents and adults in private psychiatric facilities in Bristol and Chicago. Currently she is working as a therapist for the Community Counseling Centers of Chicago.

The thesis submitted by Susan J. Reardon has been read and approved by the following committee:

Dr. Manuel S. Silverman, Director
Associate Professor, Counseling and Educational Psychology
Loyola University of Chicago

Dr. Gloria Lewis
Associate Professor, Counseling and Educational Psychology
Loyola University of Chicago

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is, therefore, accepted in partial fulfillment of the requirements of the degree of Master of Arts.

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Date

Director's Signature