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# Client-rated helpfulness of two approaches for addressing religious concerns in therapy

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# CLIENT-RATED HELPFULNESS OF TWO APPROACHES FOR ADDRESSING RELIGIOUS CONCERNS IN THERAPY

by

Alice Fridman

An Abstract

Of a thesis submitted in partial fulfillment
of the requirements for the
Doctor of Philosophy degree in
Psychological and Quantitative Foundations
in the Graduate College of
The University of Iowa

July 2010

Thesis Supervisor: Professor William Ming Liu

Multicultural competence is widely considered to be an integral part of psychological research, theory, training, and effective as well as ethical practice. While some specific components of culture have received significant attention in multicultural literature and practice, religion remains an often-neglected component of culture, with little research, training, and practical guidelines available on the topic. The current study investigated potential therapy clients' perceptions of the helpfulness of two different therapist approaches to addressing religious concerns in order to identify the approach that clients find more helpful and promote its use in practice and training. One approach was characterized by basic counseling skills, such as empathy and reflection, while the other demonstrated specific knowledge and skills for working with religious concerns. University student participants completed a measure of their religious commitment (the RCI-10), watched one of two videos depicting the therapy approaches, and rated the therapist's helpfulness and credibility. Results revealed no statistically significant differences between therapist ratings completed by participants who watched different videos or endorsed different levels of personal religious commitment. These findings suggest that not all client groups may place high importance on discussions of religion in therapy, and highlight the need for therapists to assess clients' religiosity and desire to address religious issues in counseling in order to tailor their interventions to particular clients' needs.

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CERTIFICATE OF APPROVAL

PH.D. THESIS

This is to certify that the Ph.D. thesis of

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has been approved by the Examining Committee for the thesis requirement for the Doctor of Philosophy degree in Psychological and Quantitative Foundations at the July 2010 graduation.

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# LIST OF SYMBOLS AND ABBREVIATIONS

SD Standard Deviation

df Degrees of freedom

# CHAPTER ONE

# INTRODUCTION

## Religion and Psychology

Throughout the history of psychology, the field has had a troubled relationship with religion. Some psychologists, most notably Sigmund Freud, B. F. Skinner, and Albert Ellis, considered religion to be the very antithesis of psychology (Ellis, 1980; Freud, 1928; Skinner, 1953). They viewed religion as an irrational and inaccurate belief that causes distress; a set of behaviors that is socially reinforced but has no inherent value; a lack of reason that to them was synonymous with a lack of mental health. They also contended that the faith-based, intuitive nature of religion is in opposition to the rigor and structure of the scientific study of human behavior. For these reasons, they believed that religion has no relevance to psychology, and is the domain of clergy rather than behavioral scientists. Other psychologists, however, held the opposite belief: that religion is an important component of human experience and mental health that yields many benefits, including morality and creativity. Carl Jung, Gordon Allport, and Carl Rogers, among others, believed religion and spirituality to be a significant aspect of people's internal experience and well-being – one that was important to acknowledge and discuss in therapy because of its relevance to psychological functioning (Allport, 1950; Jung, 1938; Rogers, 1980).

Recent research and theory have tended to take a more moderate position on the role of religion within the field of psychology. Although mental health professionals continue to be less religious than most of their clients (Walker, Gorsuch, & Tan, 2004), they have recognized the potential benefits of religion as a coping mechanism for many

individuals. They have also acknowledged the importance that religion holds for many of their clients and the resulting necessity of understanding the role that religious beliefs and practices play in clients' lives (Shafranske & Malony, 1990). However, the limited attention given to religion within psychological research and practice attests to the ongoing presence of attitudes similar to Freud's and Ellis' among many psychologists, who still believe that religion is largely irrelevant to their clinical and scholarly work and therefore make no effort to study it or incorporate it into therapy.

## Religion and Multicultural Competence

One area of current psychological practice to which religion appears to be particularly relevant is multicultural competence. General psychological opinion holds that "every therapeutic relationship is a cross-cultural experience" (Bergin & Jensen, 1990), and much emphasis is placed on therapists' ability to be aware of relevant cultural issues and to work competently with a wide variety of populations. The types of diversity that are most commonly discussed in the context of multicultural competence are race, ethnicity, gender, sexual orientation, age, and disability. Religion also appears to be a relevant construct to be included in multicultural competence. There is a wide variety of religious diversity in the United States, and the differences in beliefs and values that accompany different religious affiliations are highly likely to impact the worldviews and mutual understanding of clients and therapists. For these reasons, it is equally important that therapists understand and work competently with religious issues as with issues of race, gender, or sexual orientation.

Despite this apparent equality of importance between religion and other forms of diversity, however, religion has received markedly less attention as a component of

multicultural competence. It is not clear why this is the case, and there is a lack of both theory and research addressing this question. One possibility is that religion has not emerged as a salient social concern in the same way as race, sexual orientation, and other widely studied aspects of diversity. Many of the prominent multicultural dimensions focus on populations that have been visibly disadvantaged in American society in order to alleviate the inequities in psychological service access and quality that these groups face as an extension of their general societal disadvantage. Although minority religious groups also face societal disadvantages such as prejudice, discrimination, and limited recognition and acceptance of their cultural values and practices, these disadvantages are less widely recognized than racism, sexism, and other forms of oppression toward salient minority groups. Similarly, the presence of Christian privilege in American society is also not as widely recognized as the presence of male privilege and, especially, White privilege (Schlosser, 2003). It may be the case that there is less of an entrenched power and privilege differential between the dominant and minority groups in the case of religion than in the case of several other aspects of multiculturalism. The reverse may also be true: it may be that the prevalence of particular forms of Christianity in the U.S. is so powerful and entrenched that its dominance is rarely questioned and the minority, disadvantaged status of other religious groups is rarely recognized.

Another possible reason why religion receives less attention than other aspects of cultural diversity is that it is still in its early stages of development as a recognized multicultural construct. Historically, the development of scholarship on various aspects of multicultural competency has progressed through stages. The first stage is typically an acknowledgement of the importance of being competent with a particular form of

diversity, such as race. This is followed by a stage characterized by the proliferation of factual knowledge about the cultural characteristics of relevant groups, such as African Americans, Latinos, and other races. The latter stages of this developmental process typically involve a shift in focus to building general multicultural competencies for working with those groups, and then to the development of models of multiculturally relevant psychological processes, such as identity development (Ridley & Kleiner, 2003). Recent calls for attention to religion as a multicultural construct, coupled with a dearth of specific knowledge about working with religiously diverse clients, suggest that religion may be in the first stage of its development as an area of multicultural competence, and that further scholarship on this topic is likely to appear as it develops further.

## Training in Religious Competence

Although the reasons for religion's lack of prominence as a multicultural construct may not be entirely clear, what is clear is the fact that it receives fairly limited attention within the multicultural literature and within clinical training. A number of studies suggest that training in religious competence within therapy training programs is severely limited (e.g., Walker et al., 2004). Most multicultural texts focus mainly on other areas of cultural diversity while neglecting religion (e.g., Sue & Sue, 2003), and little attention is devoted to religious competence in coursework and clinical training. It is true that much more training in religious issues occurs within religiously affiliated programs; however, this training is typically focused on counseling clients from a particular religious perspective (e.g., Christian counseling) and using religious practices, such as prayer, as therapeutic interventions (Walker et al., 2004). Meanwhile, training in working with clients of diverse religious beliefs continues to fall by the wayside, and as a

result, most secular therapists do not consider themselves to be competent to address religious concerns with clients of various backgrounds (Shafranske & Malony, 1990).

Many extant research articles argue for the need to provide more extensive training in religious competence within secular psychology graduate schools and other training programs for mental health professionals (Knox, Catlin, Casper, & Schlosser, 2005; Walker et al., 2004). However, it remains unclear what this training would entail, how it would change therapists' approaches to religious issues and clients in therapy, and how clients would perceive this different approach. Is it necessary to train therapists in particular methods of assessing clients' religious backgrounds and beliefs, and to teach them specific counseling skills for discussing religious issues? Is it more important to educate them about the beliefs and practices of various religious groups, so that they are familiar with the basic tenets and customs of most clients' religious affiliations? Or is it sufficient for therapists to use the basic counseling and multicultural competence skills that are already in their repertoire to understand and counsel religiously diverse clients?

Research on client preferences about discussing religion in therapy indicates that clients want their therapists to approach their religious beliefs with openness and acceptance, and to not try to convert them to a different point of view (Knox et al., 2005). If these are, in fact, the main needs that clients have when discussing their religion in therapy, it appears that most therapists skilled in reflective listening, empathy, and acceptance of client views would be able to meet those needs without any additional training. It is also possible, however, that the desirable elements of discussing religion in therapy that clients have identified in previous research are the most basic level of religious proficiency for therapists, and that clients would benefit even more from

working with therapists who have greater knowledge about their specific religious beliefs and are skilled in assessing and addressing religious concerns.

## The Present Study

### Purpose

The purpose of the current study is to compare potential therapy clients' perceptions of the helpfulness of two different therapist approaches to discussing religious issues with clients. One approach is a basic therapeutic approach that focuses on employing core counseling skills, such as empathy, reflection, and open-ended questioning to explore and address a client's religious concerns. The second approach is more structured and involves the use of a verbal assessment of religious background and concerns, as well as the therapist's verbalization of specific knowledge about the client's religious denomination. The first approach is intended to characterize a basic therapeutic strategy rooted in core counseling skills that is likely to be used by many therapists who have no specific training in religious competence. The second approach is intended to display more extensive knowledge of client religious beliefs and more specific expertise in counseling skills for religious issues; this approach is likely to be employed by a therapist with more extensive training in religious competence. In addition to assessing participants' perceptions of these two approaches, this study also examines whether and how participants' own levels of religious commitment impact their perceptions of the helpfulness of the basic and religiously competent therapeutic approaches.

### Significance

To date, no study has used a therapy analogue format to examine potential clients' responses to different therapist approaches to discussing religious issues in therapy. It is

important to examine such responses for the purpose of ascertaining what approach is likely to be preferred by and most effective for a normative client population. The resulting information can be extremely valuable in guiding therapy training programs' decisions about what type of religious competence training to offer to their trainees. Because curriculum changes take time, effort, and money to implement, it is important to examine the likely benefits of such changes prior to making them. The current study can provide valuable information about the benefits of two different approaches to addressing clients' religious concerns from the perspectives of the clients themselves. Knowing what clients find helpful will, in turn, allow educators to design and implement training programs in religious competence with the clients' needs in mind. Such an approach to training will provide the greatest benefit to clients of psychological services in the long run by fostering those therapist skills that clients deem to be most helpful in their discussions of religion in therapy.

Because the current study uses university students as its participants, its findings are especially relevant to clinical practice in university counseling centers, and to psychological training in counseling psychology programs that often focus on the needs of this population. It is also hoped that the demographic characteristics of the study's sample, including the ranges of religious affiliations and religious commitment levels, may be similar to the characteristics of client populations in other outpatient mental health settings as well. Such similarity would make this study's findings more broadly generalizable to therapy clients in settings such as private practice and community mental health centers.

In addition to guiding therapist training, the findings of this study are also likely to be useful in guiding individual therapists in their work with religiously diverse clients. Knowing potential clients' perspectives on what approach to discussing religious issues in therapy is most helpful would allow therapists to use the preferred approach in their clinical work and thus to maximize client satisfaction and perceived benefit. It would also allow therapists to have greater confidence in the approach they use to discussing religious concerns with clients. Instead of relying solely on their own intuition or religious background for guidance in discussing religious concerns, therapists would be able to rely on empirical data to support their interventions.

An additional benefit of the present study is that it experimentally manipulates therapists' approaches to working with religious concerns. This experimental design supplements existing studies on client preferences for discussing religious issues, most of which use either real therapy clients in correlational designs or potential therapy clients who have not had the opportunity to experience discussions of religious issues in a therapy context. The design of the current study permits experimental manipulation of therapeutic approaches, which may not be feasible or ethical with actual therapy clients, and which permits causal inferences to be made between the particular therapeutic approach and participants' responses. Additionally, having potential clients view an analogue therapy session simulates an actual therapy experience and allows participants to base their responses on this experience rather than on written descriptions or on their own conceptions of what therapy is like. Such an approach allows a closer approximation of real therapy and increases the likelihood that the study's findings are applicable to actual therapeutic interactions while maintaining an experimental design that permits firm

conclusions about which therapeutic approach results in greater satisfaction and perceptions of helpfulness among potential clients.

## Definitions of Terms

Much of the extant psychological writing and research on the topic of religion discusses two separate, yet related constructs: religion and spirituality. Religion is typically defined as membership in an institutional, organized religious community, as well as adherence to the beliefs and practices of such a community (Knox et al., 2005; Rose, Westefeld, & Ansley, 2001). Spirituality, on the other hand, is typically defined as the more personal aspects of a person's relationship with a God, the universe, or other "higher power." Spirituality does not necessarily involve the practice of an organized religion, but consists of private beliefs, practices, and experiences that are aimed at maintaining a connection with transcendent entities (Knox et al., 2005; Rose et al., 2001).

Although these two constructs are theoretically distinct and are often considered separately in extant research, the terms "religion" and "spirituality" are used interchangeably throughout this paper. This is not meant to imply that religion and spirituality are identical in their expression or function in people's lives; it is clear that the two constructs refer to different behaviors and sets of beliefs. However, what religion and spirituality have in common is their significance as highly personal beliefs and practices that relate to individuals' mental health and are therefore important for therapists to understand and work with.

The reason for using these terms interchangeably in this paper is that, in the context of multicultural competence, it is important for therapists to understand and competently address issues related to all aspects of clients' religious or spiritual lives, not

just those related to the organized aspects or just those related to the internal aspects. If a therapist is knowledgeable about the worship practices of a particular religious group but does not understand how those practices relate to a client's internal experience, that therapist is not truly competent to work with that client. Likewise, if a therapist attends only to a client's personal religious experiences and neglects to address how those experiences relate to accepted practice within the client's religious community, the therapist is again displaying limited competence to work with religious diversity. As these examples demonstrate, it is crucial for a multiculturally competent therapist to be able to work with aspects of clients' religiosity that are typically termed "religious" as well as those that are typically termed "spiritual." Consequently, the distinction between these two constructs is not relevant to a study that considers religion in terms of therapist multicultural competence, and will not be made in this paper. Knox et al. (2005) similarly chose not to distinguish between the constructs of religion and spirituality in their research, suggesting that both constructs are relevant to clients' experiences in therapy and are often merged by clients themselves when discussing these experiences.

Although the constructs of religion and spirituality are not considered separately in this paper, these constructs often have been considered separately in extant research on the role of religion in therapy and mental health. Consequently, in reviewing the literature on these topics, this paper will clearly identify which construct or constructs were the focus of each individual study and how they were defined. It is especially important to provide clear definitions of the terms "religion" and "religious" because these terms have lacked theoretical clarity in past research, and have many divergent definitions that focus on different religious groups and practices. For example, some research has defined

religious clients as only those who actively practice within a particular Christian denomination, while other research has simply relied on clients' self-report of whether religion is important to them without assessing their religious practices or affiliation. In addition to distinguishing between religion and spirituality in reviewing extant research, this paper will also provide clear definitions of these two constructs as measured by the instruments discussed in the method section. This is done in order to maintain conceptual clarity about the constructs measured by the proposed empirical investigation.

It is also important to note that religion and religious practice differ widely among different demographic groups, even those who maintain similar religious affiliations. People of different races, ethnicities, countries of origin, social classes, and other demographic groups may espouse different beliefs and behaviors within the same religious affiliation. For these reasons, the participants and definition of religion will be clearly described for each study reviewed. When the terms religion or spirituality are used in this paper outside of the context of describing past research, they will denote all the beliefs and practices, both personal and organized, that a particular individual engages in for the purpose of establishing and maintaining a connection with God or another transcendent entity. The terms will include membership in particular religious groups, prayer, and attendance at places of worship, as well as personal beliefs and practices, such as meditation.

Additional terms that are used throughout this paper and need to be explicitly defined are "therapist" and "therapy." Past research has examined religion and its role in therapy among various groups of mental health professionals, including clinical and counseling psychologists, psychiatrists, social workers, marriage and family therapists,

and other mental health practitioners. Moreover, research has investigated the role of religion in the context of various types of therapy, including cognitive behavioral, psychodynamic, and numerous other types of therapy. In this paper, the terms "therapist" and "therapy" are used in their broadest sense, to refer to a wide variety of mental health professionals and methods of treatment. The term "therapist" encompasses psychologists, psychiatrists, social workers, marriage and family therapists, and all other professionals that provide direct clinical services to clients for the purpose of improving their mental health. The term "therapy" denotes the interactive process that occurs between therapists and clients for the purpose of improving the clients' mental health. It includes all major theoretical approaches to therapy and any other variations of the therapy process, as long as they use interaction between the client and therapist as a primary component.

The rationale for using these broad definitions of "therapy" and "therapist" is that clients seek many different types of therapy from many different types of therapists; thus, their experiences represent a broad range of therapeutic approaches with different mental health professionals. It is equally important that clients' religious backgrounds and concerns be addressed in a competent manner across all these different types of therapy experiences. For this reason, the research reviewed in this paper includes investigations with different therapies and different types of therapists to ensure that the conclusions are applicable to the wide diversity of actual client experiences. The use of broad definitions of the terms "therapy" and "therapist" permits incorporating findings from diverse research studies to draw conclusions about the role of religion across different therapies and therapists instead of limiting the conclusions to a particular narrow group of client experiences.

Although the use of these broad definitions suits the purposes of the present paper, past research has not defined these terms in a consistent way. Different studies have used the terms “therapy” and “therapist” to refer to particular forms of therapy (e.g., cognitive behavioral), or mental health professionals with particular training backgrounds (e.g., clinical psychologists.) When this is the case for the studies reviewed in this paper, the definitions used in individual studies are provided in order to maintain clarity about the constructs being discussed.

Now that the main terms relevant to a discussion of religion in therapy have been defined, this paper will proceed with a review of the literature on this topic.

# CHAPTER TWO

# LITERATURE REVIEW

## Overview

The current study uses an analogue therapy design to examine potential therapy clients' perceptions of the helpfulness of two different therapist approaches to discussing religious issues in therapy. There is a wide variety of extant literature that is relevant to this topic. At the broadest level, literature pertaining to the role of religious beliefs and practices in coping and mental health examines the relevance of religion to clients' psychological processes and outcomes, and sets the stage for a discussion of the role of religion in therapy. Research on clients' and therapists' religious and spiritual beliefs and practices permits a comparison of the dominant religious cultures of these two groups, and highlights the extent of the cultural differences between clients and therapists in this respect. Similarly, literature on clients' and therapists' views on the benefits and appropriateness of discussing religion in therapy allows a comparison between their attitudes and preferred approaches to addressing religious issues in clinical work. The little existing research on religion as a dimension of cultural difference and multicultural competence highlights the importance of therapists' ability to work with religious issues as a part of their general competence in working with clients who are different from them on a variety of cultural dimensions. Finally, literature on the dearth of available training in working with religious issues points to the need for more training as well as for clarification of the content needed in such training in order to enhance therapists' competence in working with religiously diverse clients who bring religious concerns into therapy.

The following review of the literature relevant to the current study will begin with a section reviewing past and current research on both positive and negative relationships between religion and mental health. It will then describe recent data on the religious affiliations, practices, and beliefs of Americans, and relate these data to the religious beliefs and practices that are likely to be most common among psychotherapy clients. The paper will then proceed to describe research on therapy clients' beliefs and preferences about addressing religious and spiritual concerns in therapy. Following this section, the literature review will shift focus to therapists, first examining the religious beliefs and practices that are common among this group and comparing them to the religious beliefs and practices of the general American population. It will continue to a review of research on therapists' attitudes toward clients' religious beliefs and toward discussions of religious concerns in therapy. The review will then proceed to discuss the status of religion as a component of multicultural competence, and then to examine research on current therapist practices in addressing religion and religious concerns in therapy. It will then proceed to a review of the literature on the sparse training for working with religious issues that is currently available in clinical training programs. The review will conclude with the purposes and hypotheses of the current study.

## Religion and Mental Health

Existing research on religion and psychological outcomes has progressed in a way that strongly reflects the shifting and sometimes contentious relationship between religion and psychology. When researchers first began to examine the link between religion and mental health several decades ago, many of them found negative relationships between mental health and religiosity that were in keeping with many psychologists' beliefs that

religion was irrational and antithetical to psychological health. However, as attitudes toward religion within the field of psychology shifted in a more positive direction, researchers began to find more evidence of positive relationships between religion and mental health.

The negative view of religion that dominated psychology for many years is likely due to a number of factors. A primary factor is likely to be the presence of assumptions such as naturalism and mechanism within modern science, and by extension within psychology. According to Richards and Bergin (2005), naturalism, or the belief that natural laws are the sole determinant of all natural events, including human behavior and thought, pervaded modern science during the 19th and most of the 20th century. Because the founders of psychology sought to establish the field as a respected science, they too subscribed to the idea that human functioning could be explained in exclusively physical ways, with no need to consider any spiritual or transcendent concepts. This perspective may have contributed to psychology's view of religion as unhealthy and antithetical to the scientific concepts at psychology's core. Furthermore, a number of significant figures in early psychology, such as Freud, Watson, and Skinner, were atheistic (Richards and Bergin, 2005); thus, their personal views of religion may also have influenced the attitude toward religion that developed within the field of psychology.

The positive shift in psychology's outlook on religion in the last several decades is also likely due to several converging influences. One such influence is the field's movement away from the scientific psychology described above and toward a variety of new schools of thought that are more accepting of the transcendent aspects of human experience. For example, positive psychology, which became increasingly popular in the

late 1990s and early 2000s is consistent with religion's emphasis on human strengths, virtues, and development (Richards and Bergin (2005). Multicultural counseling, which gained momentum in the late 1980s and early 1990s and is now accepted as a mainstay of psychological practice, emphasizes the importance of psychologists' acceptance of and competence with the whole range of human diversity, including religion.

In addition to the emergence of these psychological movements, shifts within American society may also have contributed to the increased acceptance of religion within psychology. Richards and Bergin (2005) note that public interest in religion has surged in the last two decades, as evidenced by the proliferation of literature and media on the topic. They speculate that disillusionment with social ills such as crime, war, poverty, and family disintegration, as well as loss of faith in science's ability to solve these problems, may be contributing to this change. In addition, the public's abandonment of the hedonistic "free love" mentality of the 1960s in order to embrace more conservative and socially conscious values in the following decades may also be adding to the increased popularity of religion within the U.S. These societal trends undoubtedly influence the field of psychology, and thus may be partly responsible for its increasingly positive view of religion in recent years.

The following section will review the evidence for both negative and positive relationships between religion and mental health. It will begin with older studies that found largely negative mental health outcomes among religious clients, and progress to recent research that focuses more on the protective relationships between religion and mental health.

Negative Relationships Between Religion and Mental Health

Throughout the last century, many prominent psychologists have believed that religiosity has deleterious effects on mental health. This view is well demonstrated by Albert Ellis, who stated that:

> The emotionally healthy individual is flexible, open, tolerant, and changing, and the devoutly religious person tends to be inflexible, closed, intolerant, and unchanging. Religiosity, therefore, is in many respects equivalent to irrational thinking and emotional disturbance... The elegant therapeutic solution to emotional problems is to be quite unreligious and have no degree of dogmatic faith that is unfounded or unfoundable in fact (Ellis, 1980, p.637).

Until several decades ago, views such as this dominated the field of psychology and maintained an academic environment that was disapproving of religion and its adherents (Bergin, 1983).

Many of the early research findings on religion and mental health were consistent with this dominant professional atmosphere. Studies repeatedly found that religious individuals displayed a wide range of psychological problems. For example, in a review of studies conducted in the 1950s, Martin and Nichols (1962) concluded that religious believers were typically "emotionally distressed, conforming, rigid, prejudiced, unintelligent, or defensive" (as cited in Bergin, 1983, p. 172). In a similar vein, Rokeach (1960) portrayed religious individuals as more "tense, anxious, and symptomatic" than those who are not religious (as cited in Bergin, 1983, p. 172).

As research on this topic progressed, contradictory results began to appear. Martin and Nichols' attempt at replicating the findings of their literature review failed to show any differences between religious and non-religious students on measures of personality and mental health (as cited in Bergin, 1983). Other studies also yielded conflicting findings; for instance, while some found higher levels of anxiety among religious

individuals, others found no differences in anxiety between religious and non-religious individuals, and some even found that religious individuals displayed less anxiety than their non-religious counterparts (Bergin, 1983).

Bergin (1991) explained these inconsistencies by asserting that religion is a multidimensional construct that may manifest as either "good" (intrinsic) or "bad" (extrinsic) religion. Extrinsically religious individuals use religion as a means to an end, such as gaining status, while intrinsically religious individuals internalize religious beliefs and pursue religion for its own sake, regardless of external benefits or consequences (Bergin, 1991). In reviewing past research, Bergin (1991) consistently found that extrinsic religion was related to negative mental health traits and outcomes, such as anxiety, dogmatism, and irresponsibility. However, he found that intrinsic religion was consistently related to positive traits, such as intrinsic motivation and internal locus of control. His conclusion was that, while certain types of religiosity do correlate with mental health problems, as previously found, other types may benefit mental health. He further noted the importance of distinguishing between "good" and "bad" religiosity in research and theory, asserting that a view of religion as a unitary construct is inaccurate and likely to yield inconclusive or erroneous research findings.

Positive Relationships Between Religion and Mental Health

More recently, a wide variety of literature has suggested that religion and spirituality are important and often beneficial components of mental health. Certain aspects of religiosity, such as hope and faith, and religious activities, such as prayer and association with a supportive religious community, can be logically linked to psychological coping and well being. Many of these religious factors have also been

empirically demonstrated to correlate with positive psychological outcomes. For example, Pargament (1997) reviewed numerous studies that examined whether religiosity is related to positive psychological outcomes under stressful circumstances. The samples in these studies included individuals that are terminally ill, those experiencing serious illnesses or undergoing major medical procedures, war veterans, victims of domestic violence, and individuals with family members who have died or experienced significant health problems.

On the whole, Pargament (1997) concluded that religiosity is, in fact, linked to largely positive outcomes, though the extent of its positive relationship to mental health is dependent on factors such as the type of religious coping used, the type of difficulty a person is coping with, and the characteristics of the person. The studies he reviewed identified several types of religious coping that participants reported to be consistently helpful, such as relying on God for spiritual support, using congregational support, and reframing issues in benevolent religious terms (for example, viewing death as God's will). However, several types of religious coping also emerged as consistently harmful for participants; these included discontent with God or with one's congregation, and a view of negative life events as God's punishment.

In terms of the type of difficulty a person is coping with, religion was found to be most helpful in the most stressful circumstances, although it was often mildly helpful in less extreme situations as well. Religious coping was also found to be more helpful for poorer, older, female, and black participants than for participants who were wealthier, younger, male, and white. Pargament (1997) attributed this difference to the former

groups having less secular power and resources within our culture, and using religion as an alternative resource in times of stress.

In another study that supported the potential benefits of religion for mental health, Bowen, Baetz, and D'Arcy (2006) found that the self-rated importance of religion predicted symptom improvement following group cognitive-behavioral therapy (CBT) in patients with panic disorder (PD.) Fifty-six volunteer participants with primary diagnoses of PD and no comorbid Bipolar I, psychotic, organic brain, or substance dependence disorders attended outpatient group CBT. Treatment consisted of homework, exposure tasks, relaxation, and correction of cognitive distortions, and lasted until the participant and his or her therapist agreed that optimum benefit had been attained. Participants completed the following measures at the start of therapy (T0) and at six (T6) and twelve (T12) months following the initial interview: the Brief Symptom Inventory (BSI), the Perceived Stress Scale, the Pearlin-Schooler Mastery Scale, the Rosenberg Self-Esteem Scale, the Interpersonal Relations subscale of the Interpersonal Alienation scale, and a one-item measure of the importance of religion. The authors completed hierarchical linear regression analyses and ANOVAs to address the research questions.

The self-rated importance of religion significantly predicted outcome, with the group that rated religion as "very important" at T12 experiencing greater improvement in symptoms, as measured by the General Severity Index and anxiety/phobia subscale of the BSI, than the other groups. Perceived stress also improved for the "very important" group over time, whereas self-esteem, mastery, and interpersonal isolation did not, suggesting that importance of religion may affect outcomes by reducing perceived stress among patients with PD. However, the reasons for such a relationship between importance of

religion and stress remain unclear. Additional limitations of this study include a small sample size, the use of a single-question measure of religious importance, and the lack of a control group and standardized treatment. However, on the whole, the study was methodologically sound and demonstrated the beneficial role of high levels of religious importance to symptom improvement among patients with PD in group CBT.

Altogether, the research on the role of religion in mental health suggests that many religious beliefs and practices can be related to positive mental health. Although many studies in the 1950s and 1960s concluded that religious individuals tend to experience high rates of psychological problems, later research distinguished between "good" and "bad" forms of religiosity. This research found that individuals with extrinsic religious orientations often do experience mental health difficulties, while those with intrinsic orientations often display positive mental health. Current research continues to acknowledge that some forms of religiosity are more helpful in some circumstances and for some people; however, on the whole, this research has found a greater incidence of positive relationships between religion and mental health than was the case in earlier studies.

## Client Religiosity

As the previous section demonstrates, research has consistently found that religion is related to mental health, with recent studies finding largely positive relationships between these two constructs. However, the impact of religion on the typical therapy client cannot be fully understood without examining the role that religion plays in most Americans' lives. Knowing the population's main patterns of religious beliefs and practices, as well as attitudes toward religion, permits an understanding of the

dominant religious culture among Americans and clarifies the extent to which religious issues are relevant to mental health and to therapy for most clients. This section will review data on Americans' religious beliefs and practices, as well as their views on the importance of religion in their lives.

Bergin and Jensen (1990) reviewed data on public religious beliefs and behaviors taken from the 1985 Gallup Poll. They demonstrated that, at that time, most Americans identified as Christian and considered religion to be an important element of their lives. Specifically, 85% of the general public named either Protestantism or Catholicism as their religious preference; 84% agreed or strongly agreed that they try hard to live their lives according to their religious beliefs; 72% agreed or strongly agreed that religious faith is the most important influence in their lives; and 40% reported that they regularly attend religious services (Bergin & Jensen, 1990).

Later reviews of similar data have shown that Americans' religious beliefs and behaviors have changed little over time. A decade after the Bergin and Jensen study, McCullough (1999) reported that 96% of Americans believe in God or a universal spirit, 92% claim a religious affiliation, 60% consider religion to be important or very important in their lives, and 42% attend religious services on a weekly or almost weekly basis. Another half-decade later, Walker et al. (2004) reported that over 90% of Americans identify as either Protestant or Catholic, over 66% view religion as an important part of daily life, and 40% attend weekly religious services.

The most recent Gallup Poll data are largely consistent with these earlier trends. Information from surveys conducted in 2006 and 2007 shows that currently, 92% of Americans believe in God or a universal spirit, 84% consider religion to be important in

their own lives, 73% affiliate with either Protestant or Catholic religion, and 43% attend religious services weekly or almost weekly (Gallup Poll, 2007). Aside from a decrease in the percentage of Americans who identify as Protestant or Catholic, these findings agree with those reported in earlier studies. On the whole, they demonstrate that a large majority of Americans believes in God or other transcendent entity, and considers religion to be personally important. The data also show that, despite the recent decline, most Americans continue to identify as either Protestant or Catholic, and that close to half of all Americans attend religious services on a regular basis.

The trends described above have been consistent over the last twenty years. Assuming that most therapy clients are fairly similar to the general public in terms of religious beliefs and behaviors, these findings indicate that the normative therapy client is likely to believe in God, to be Protestant or Catholic, and to view religion as an important component of his or her life. Given these client characteristics, the relationships between religion and mental health described in the previous section are likely to be relevant for many Americans, and by extension, many therapy clients. This conclusion highlights the importance of therapists' ability to be familiar and competent with religious topics and issues in order to work effectively with their clients.

## Client Views on Religion in Therapy

Because religion has been shown to be an important component of coping and psychological functioning in a variety of populations and situations, and because many Americans assert that religious beliefs and practices are important components of their lives, it is not surprising that many psychotherapy clients express an interest in discussing religion in therapy. D'Souza (2002) surveyed the spiritual attitudes and needs of patients

with psychiatric illness, and found that most of them believed that religion is an integral component of their psychological functioning and should be addressed in therapy. Seventy-nine inpatients and outpatients at the psychiatry department of a rural hospital in Australia completed a six-item questionnaire that was shown to have good reliability (.83.) Most patients (79%) reported that spirituality is important to them, and 67.2% believed that spirituality helps them cope with psychological pain. Moreover, 82% of patients asserted that it is important for therapists to be aware of patients' spiritual needs and beliefs, and 68.7% believed that patients' spiritual needs should be considered by therapists in treating psychological illness. Thus, spirituality was important to most patients, both in their own coping and in professional treatment of psychological illness.

The author further argued that spiritual interventions are likely to enhance patients' outcomes in both physical and psychological treatments, and that the global movement toward a more holistic approach to healing in many medical and mental health fields highlights a need for training, research, and practice that are more sensitive to and inclusive of the spiritual aspects of patients' lives. However, because the data in this study do not address the nature or effectiveness of spiritual interventions, it is uncertain how patients would respond to such interventions and what outcomes these interventions would produce.

Rose et al. (2001) also performed a study that assessed therapy clients' preferences for discussing religious issues in counseling and their beliefs about the appropriateness of doing so. The hypotheses were that clients would wish to discuss religious issues and would believe that it is appropriate to do so, and that these wishes and beliefs would be positively related to clients' religious concerns, spiritual experience,

expectations about counselors, and counseling experience. Seventy four clients from nine counseling sites completed a demographic questionnaire, a measure of preferences for discussing religious issues in therapy, a measure of previous spiritual experiences, a measure of expectations about counselors, a measure of beliefs regarding the appropriateness of discussing religious concerns in counseling, a social desirability scale, and a measure of religious concerns. The authors computed the scales' means, standard deviations, and correlations, and performed hierarchical multiple regressions to determine what factors explained clients' preferences and beliefs.

The means on measures of preferences and beliefs about discussing religious issues in therapy differed from the neutral value of 3 in a positive direction (on a 1-5 Likert scale), which the authors interpreted to mean that clients preferred to discuss religious concerns in therapy and believed it appropriate to do so. However, the authors did not perform tests of significance, so it is impossible to know whether the means represented significant differences from the neutral value. Clients with higher levels of past spiritual experiences that caused them to believe in a higher power had stronger preferences for discussing religious issues in counseling and believed those discussions to be more appropriate than clients with lower levels of spiritual experience. Clients' religious concerns, expectations about counselors, and previous counseling did not predict either preferences or beliefs about discussing religious issues in therapy.

Thus, the study's main conclusions were that therapy clients prefer to discuss religious issues in counseling and believe that it is appropriate to do so, and that clients with high levels of previous spiritual experiences are especially likely to want and believe that it is appropriate to discuss these issues. The study was limited by participant self-

selection and low levels of religiosity compared to the rest of the U.S. population, as indicated by 60% of the participants reporting a current religious affiliation compared to more than 90% of the U.S. population. However, the fact that participants in this study had lower rates of religious affiliation than most Americans and on the whole still preferred to discuss religious issues in therapy indicates that normative clients, who are more likely to be religious than the study's participants, are even more likely to desire discussions of religious issues in therapy. The study also possessed the strengths of using actual therapy clients and both Christian and non-Christian participants. These strengths also explain the differences in findings between this study and previous research that used primarily Christian potential clients, and maximize the likelihood that these findings apply to actual, diverse client populations.

In another study, Knox et al. (2005) examined clients' perceptions of discussing religious issues in therapy through the use of the Consensual Qualitative Research method. Twelve clients who had participated in long-term outpatient therapy (one man and 11 women, all White, mean age of 43.4 years) completed two telephone interviews with the researchers. The interviews consisted of a standard set of questions regarding participants' religiosity and their positive and negative experiences of discussing religious issues in therapy; the researchers also asked additional questions that arose during the interviews. They then identified and revised the domains and core ideas of the participants' responses several times until they reached a consensus, and conducted a cross-analysis to ensure stability.

The results showed that participants considered religion an important part of their lives and their therapy; most did not know their therapists' religious beliefs, but perceived

therapists to be open to discussing religious issues. Participants reported that discussions of religious issues in therapy were helpful when they were initiated by clients, related to clients' presenting concerns, occurred in the first year of therapy, and when therapists were female, held religious views similar to the client's, or were perceived to be open and accepting. Participants reported that discussions of religious issues were not helpful when they were raised by therapists, occurred early in therapy, and when therapists judged clients, imposed their own beliefs, or restricted open, egalitarian discussion. Participants reported that they considered but did not raise religious issues when these issues were important but they felt uncomfortable raising them. Helpful discussions of religious issues led to positive outcomes and satisfaction with therapy, whereas unhelpful or uninitiated discussions led to negative outcomes and dissatisfaction.

The main conclusion of the study was that discussions of religion in therapy are most helpful to clients when they initiate the discussions and when therapists convey openness and acceptance – not similar views – in response. The authors also noted that the findings support the notion that clients wish to discuss religion in therapy and derive benefit from doing so, highlighting the need for more training for therapists in the area of religious multicultural competence. However, it remains unclear what this training should entail. The fact that clients in this study found it most helpful when therapists were open and accepting of their religious views suggests that training that fosters the basic skills of empathy and acceptance may suffice in preparing therapists to meet these clients' needs. An additional caveat of this study is that the White, mostly female, self-selected sample makes it uncertain whether these findings apply to more diverse client populations.

On the whole, the research reviewed in this section is unanimous in concluding that clients consider religion and spirituality to be important to their lives and psychological functioning, and believe that religion should be addressed in the course of their psychological treatment. Some studies suggest that religious clients are especially likely to want and believe that it is appropriate to discuss religion in therapy, and that clients find discussions of religion most helpful when they initiate them and their therapists willingly engage in the discussions in an open, accepting manner.

## Therapist Religiosity

From the research discussed so far, it is clear that religion is relevant to mental health, and that the majority of Americans consider themselves to be religious. It is also clear that many clients have a desire to address religion in therapy and believe that it is largely beneficial for them to do so as long as their therapists are open to such discussions and accepting of the clients' religious views. In order to more fully assess the cultural differences between clients and therapists in terms of religion, it would also be important to know how religious most therapists consider themselves to be, and whether therapists' religious beliefs and practices are largely similar to or different from those of clients.

Several studies have demonstrated that on the whole, therapists tend to be less religious than the general American public, at least in terms of traditional expressions of religiosity such as membership in a particular religious group or attendance at a place of worship. In a seminal study, Bergin and Jensen (1990) used data from a national survey of mental health professionals to examine therapists' religious values and to discuss the implications of their findings for clinical practice. In this study, religion was defined using a variety of indices, including organized behaviors such as affiliation with a

religious groups and attendance at religious services, as well as more personal behaviors, such as efforts to live according to a set of religious principles. The authors first reviewed previous research findings indicating that therapists are less committed to traditional values, including religious beliefs, than the general public. The survey on which their findings were based was conducted in 1985 with 425 largely experienced clinical psychologists, psychiatrists, clinical social workers, and marriage and family therapists (representing a 59% response rate.) The participants completed the Religious Orientation Scale (ROS), as well as additional items assessing their general values and religious affiliations, practices, and beliefs.

The participants demonstrated a high degree of consensus in endorsing values consistent with positive mental health, such as responsibility, fulfillment, and growth. Most participants (80%) claimed a religious preference, though only 41% reported regularly attending religious services. Seventy-seven percent of participants reported that they try to live according to their religious beliefs, and a slight majority (54%) were religious according to their scores on the ROS, although the authors grouped non-responders to this measure into the non-religious category, which may not be a correct assumption and may inflate the percentage of non-religious therapists. Therapists were shown to be slightly less religious than the general public on most of these items, though they were surprisingly similar in terms of attendance at religious services. The authors interpreted the minor differences between the religious beliefs and behaviors of therapists and the general public to mean that the two groups are more similar than not; however, no significance tests were performed to test this assumption. The main conclusion of this study was that while therapists show relatively low rates of conventional religious

involvement, they show a “sizeable personal investment in religion” (Bergin & Jensen, 1990, p. 6) that can be used to foster greater understanding of clients’ religious views and greater incorporation of these views into the therapy process. However, because of the methodological limitations described above, this conclusion should be considered tentative until supported by more rigorous investigation.

Similar results were also reported around the same time in another landmark study by Shafranske and Malony (1990). Their study examined clinical psychologists’ religious attitudes and their approach to religious issues in their clinical work. Four hundred and nine clinical psychologists (41% response rate) completed a questionnaire that included demographics; a scale measuring degree of belief in God; scales measuring dimensions of religiosity; items measuring attitudes toward religion and psychology training experiences; a scale measuring use of and attitudes toward specific counseling interventions; and a case study investigating clinician bias toward a religious client. Non-participants’ responses to a brief survey indicated that they were less involved in organized religion and considered spirituality to be less personally and professionally important to them than those who chose to participate. Thus, the results of the study may overestimate the importance of religion in the personal and professional activities of clinical psychologists in general.

The findings indicated that most participants do not practice organized religion but do have some spiritual beliefs and practices, and believe that spirituality is valuable for themselves and for others. These findings are especially noteworthy given that the sample in this study reported higher rates of participation in both organized and personal forms of religion than those who chose not to participate. Thus, even those psychologists

who are more religious than many of their colleagues are still less involved in organized religion than the general public. However, the findings of this study also support those of Bergin and Jensen (1990) in concluding that despite low participation in organized religion, therapists do consider religion and spirituality to be valuable components of their own and others' lives.

Similar to Bergin and Jensen (1990) and Shafranske and Malony (1990), Walker et al. (2004) found that therapists identify with and practice religion less frequently than most Americans. The purposes of Walker et al.'s meta-analysis were to examine the religious values and practices of therapists, and to explore the link between therapists' personal religiosity and their approach to religious issues in therapy. The authors identified 26 empirical studies with unique samples and consistent methodology by searching PsycINFO and Dissertation Abstracts. The sample contained 5,759 primarily White therapists from various fields, and was 58.11% male with a mean age of 46.1. The authors converted all relationships of interest to a correlation (*r*) and computed an overall averaged *r* weighted by individual study sample size. They calculated the significance of each correlation and compared the significance of the correlations with Fisher's test of significance.

The results showed that most therapists were Protestant, Jewish, or Catholic, and that marriage and family therapists were more likely to identify with organized religion and to be actively religious than other types of therapists. Religious therapists were more likely than therapists from mixed religious and secular samples to engage in both organized and personal religious practices. Therapists on the whole were found to be less religious than the general public. Consequently, religion is likely to be a salient cultural

difference between many therapists and their clients. The authors identified several limitations to this study, including differences in individual study methods and small sub-samples of particular groups of therapists. Additionally, the meta-analysis was limited by a lack of clarity in the descriptions of the statistical methods and limitations.

On the whole, the research examining therapist religiosity is consistent in arriving at two main conclusions. The first is that therapists engage in conventional forms of religious involvement, such as affiliation with religious groups and attendance at religious services, significantly less than the U.S. population as a whole. This difference in conventional religiosity between therapists and their potential clients represents a significant cultural difference that is important for therapists to attend to because it may entail significant differences in beliefs, practices, and worldview that may interfere with the therapeutic relationship if not properly addressed. The second main conclusion supported by extant research is that, despite relatively low levels of participation in organized religion, most therapists demonstrate some personal commitment to religion, and believe that religion and spirituality are important components of their own and others' lives. This belief is an important starting point for providing competent services to religiously diverse clients because it may prompt therapists to be attentive to potentially important religious issues and to be open to discussing these issues if they believe them to be important to their clients' lives.

## Therapist Views on Religion in Therapy

Given that psychologists and other therapists are typically less conventionally religious than their clientele, how do therapists view those clients that are religious, or that wish to discuss religious concerns in therapy? Are most therapists open to discussing

religious concerns in therapy? Do they believe such discussions to be important to their clients' mental health? The answers to these questions would clarify whether clients and therapists approach therapeutic discussions of religious issues with similar attitudes and expectations, or whether their perceptions of such discussions are largely divergent. Given the documented relationships between various aspects of religiosity and mental health, as well as the wide prevalence of client religiosity and preference for discussing religion in therapy, it would be appropriate for therapists to acknowledge the importance of religion for their clients and make efforts to incorporate it into therapy. This section will review research that examines therapists' attitudes toward religious clients, as well as toward discussions of religion and the use of religious interventions in therapy.

Some of the studies that assessed therapists' personal religiosity examined their attitudes toward addressing religion in therapy as well. For instance, Shafranske and Malony (1990) found that although most clinical psychologists do not practice organized religion themselves, they do recognize the value of spirituality and believe that their clients' spirituality is relevant to psychotherapy. Most participants also reported that they incorporate clients' spirituality into therapy in various ways, but the number of participants supporting different spiritual interventions became smaller as the interventions became more explicitly religious (e.g. prayer or reading scriptures.)

Walker et al. (2004) likewise found that many counselors from mixed religious and secular samples used religious interventions, such as prayer or religious metaphor, but that the frequency of using such interventions was higher among religious counselors. The relationship between personal religiosity and use of religious interventions was stronger among religious counselors than among mixed samples. Religious counselors

and those from mixed samples were equally open to discussing religious issues in counseling.

Houts and Graham (1986) performed a study in which they sought to investigate whether client religiosity affects clinicians' judgments of prognosis, pathology, and locus of clients' problems, and to determine how clinicians' own religious views affect these judgments. Forty-eight clinicians (24 religious and 24 non-religious, as indicated by scores on a measure of commitment to traditional Christian values) read identical demographic information about a client and viewed one of three 10-minute videotapes of a scripted intake interview. The client's extent of commitment to traditional Christian values was manipulated through use of religious statements in one brief portion of the interview; otherwise, the videotapes used identical wording. Thus, one videotape portrayed a non-religious client, another portrayed a moderately religious client, and the third portrayed a very religious client. The clinicians completed demographic questionnaires, as well as measures of their perceptions of the client's prognosis, psychopathology, and the causes of the client's concerns (external or internal). Two-way ANOVAs were conducted to analyze the data.

Both religious and non-religious clinicians judged the moderately religious client to have more severe psychopathology and worse prognosis than either the very religious client or the non-religious client. Religious clinicians made more internal attributions for the non-religious client's concerns than did the non-religious clinicians, whereas non-religious clinicians made more internal attributions for the religious client's concerns. Because the moderately religious client expressed more doubt about his religious beliefs than either the very religious or the non-religious client, these findings suggest that

clinicians judge prognosis to be poorer and pathology to be more severe in clients who express doubt about their religion than in those who express conviction. Whether clients are religious or not does not appear to impact clinical judgments in and of itself. However, it does appear that clinicians tend to make more internal attributions for the concerns of clients who endorse religious values different from their own, suggesting that they may interpret these clients' different beliefs as a possible source of distress and a target for therapeutic change. How these perceptions might affect the therapy process remains to be investigated.

On the whole, research on therapists' perceptions of religious clients and their views on discussing religion in therapy indicates that while therapists are typically less religious than the general public, they acknowledge the importance of religion and spirituality and are open to discussing these aspects of clients' lives. The Houts and Graham (1986) study does suggest that clinicians may have different perceptions of clients whose religious beliefs are different from their own than of clients whose beliefs are similar, but across the studies there appears to be a willingness on the part of clinicians to acknowledge and address religious issues in therapy.

## Religion as Multicultural Competence

Therapists' apparent willingness to acknowledge the importance of religion to their clients and to discuss religion in therapy is an important precursor to establishing their multicultural competence with respect to working with religiously diverse clients. As discussed earlier, research shows that religion is related to many components of psychological functioning and mental health, which makes it a potentially important topic to address in therapy. Extant research has also found that, as a rule, therapists are less

conventionally religious than the U.S. population as a whole, and are therefore likely to adhere to religious beliefs and practices that differ from those of many of their clients. These differences in beliefs and practices represent an important cultural difference between clients and therapists because religious beliefs typically influence behaviors and worldviews, and people who hold divergent religious beliefs and adhere to different religious practices are likely to also have different concepts of psychological health, dysfunction, and many other constructs that are highly relevant to the process of therapy. Because religion is relevant to mental health and because therapists are likely to encounter many clients whose religious beliefs and practices differ from their own, religion represents an important aspect of cultural diversity that therapists ought to be able to work with in a competent manner.

Despite the importance of religion as a dimension of culture and an area of multicultural competence, there is little theoretical discussion or empirical investigation of religion in the context of multicultural competence. Only a few of the studies reviewed here explicitly mentioned religion as a component of multicultural counseling. Walker et al. (2004) noted that the integration of religious issues into therapy is conceptually similar to multicultural counseling in general, and identified several therapist skills necessary to competently address religious issues. These skills included awareness of one's own religious background and beliefs, and respect and comfort with religious views that differ from one's own (Walker et al., 2004). Similarly, Knox et al. (2005) asserted that religion may be a more potent social force than other aspects of culture, such as race and gender, and stated that a lack of competence in working with religious issues is a barrier to the development of more general multicultural competence.

Despite these occasional mentions of religion as a multicultural construct, and despite much literature that calls for greater attention to religious issues in therapy and in training, there is a lack of research and theory that specifically focuses on examining religion from the multicultural perspective. This state of affairs may reflect a process of growing focus on religion as a multicultural issue that may slowly lead to the development of practical guidelines and competencies for incorporating religion into therapy. A similar process has been noted for other aspects of cultural diversity, such as age and ethnicity, and in the development of multicultural counseling in general.

Typically, attention to multicultural issues begins with attempts to define multicultural counseling and acknowledgements of multicultural competence as a critical component of effective, ethical therapy (Ridley & Kleiner, 2003). This was the case with multicultural counseling in general, when discussions of cultural diversity began to take place at the Vail Conference and in early papers on the topic (Ridley & Kleiner, 2003). A similar pattern of initial interest has occurred for specific constructs that have emerged as salient aspects of multicultural competence, such as race and gender. The same pattern is currently occurring with religion, as evidenced by the proliferation of publications examining religious issues in the context of therapy and calling for more information and training in this area (Richards & Bergin, 2000b).

The next step in the growth of multicultural competence is often the development and dissemination of specific knowledge about cultural groups, designed to help therapists become familiar with those cultures and work effectively with their members (Ridley & Kleiner, 2003). Examples of such knowledge include information on the family structures, beliefs, values, and characteristics of various ethnic groups, typically

accompanied by a discussion of these factors' relevance for therapy. Similar knowledge about major religious groups is currently limited, although isolated examples do exist (e.g., Richards & Bergin, 2000a), especially in the context of discussing religious issues that are relevant to particular ethnic groups.

The proliferation of specific knowledge about particular cultural groups is typically followed by emphasis on developing and applying general multicultural competencies, such as beliefs and attitudes, knowledge, and skills (Sue & Sue, 2003). From there, multicultural development often progresses to a focus on models of psychological processes relevant to a variety of cultural groups; examples include models of acculturation and identity development (Ridley & Kleiner, 2003). Although the extant literature includes some references to multicultural competencies in working with religiously diverse clients, these references are limited, and models of psychological processes among religious clients are almost entirely lacking.

Thus, the current state of interest and writing on religion in therapy suggests that this construct is in the early stages of growth as an area of multicultural competence. While there is definite interest in the topic, as well as consistent acknowledgement of its importance as an area of training and competence, there is limited knowledge about working with various religious groups, and there is even less focus on using general multicultural competencies and exploring models of psychological functioning with religiously diverse clients. The hope is that competence in working with religious issues will progress from its current state to the later stages discussed above, allowing for more effective and ethical clinical practice with clients of different religious backgrounds.

## Religion and the Process of Therapy

Given the limited attention that religion currently receives as an area of multicultural competence, and the lack of guidance for therapists in addressing religious issues in their clinical work, how do therapists incorporate religion into their work with clients? Research discussed earlier indicates that therapists perceive religion as important to their clients and are amenable to addressing it in clinical work; it also shows that therapists do engage in some discussion of religion and even use some religiously based interventions despite a lack of guidance on how to do so in a competent manner. How do therapists go about addressing religion in therapy, and what impact do these discussions have on clients' outcomes and perceptions of therapy? This section will review research pertaining to these questions.

In a study discussed earlier in this review, Knox et al. (2005) demonstrated some of the client-perceived outcomes that occur in the context of discussing religion in therapy. The participants in this study reported that discussions of religious issues yielded both positive and negative outcomes depending on the manner in which the issues were addressed. Positive outcomes, such as perceived helpfulness of the discussion and satisfaction with therapy, occurred when discussions of religious issues were initiated by clients, were related to clients' presenting concerns, and when therapists were perceived to be open and accepting of clients' religious views. Negative outcomes, such as dissatisfaction and lack of perceived helpfulness, occurred when therapists initiated discussion of religion and were perceived to restrict open discussion of the issues or to judge clients and attempt to impose their own religious beliefs.

In an earlier study, Kelly and Strupp (1992) investigated changes in patients' values over the course of therapy, the relationship between those changes and therapy outcomes, and the relationship between client-therapist value similarity and outcome. The values examined included the religious value of Salvation. The authors hypothesized that patients' values, especially those involving interpersonal morality, would become more similar to their therapists' values over the course of therapy; that patients' assimilation of therapist values would relate to therapists' assessment of outcome but not other outcome measures; and that the best outcomes would occur when patients and therapists agree on ideological values but differ on lifestyle values.

Thirty-six patient-therapist dyads engaged in time-limited dynamic psychotherapy completed the Rokeach Value Survey, which consists of two scales that measure the values placed on specific life goals (Terminal) and personal qualities (Instrumental). Both therapists and patients also completed an assessment of patient outcomes. All three measures were completed at pre-therapy, termination, and 1- and 2-year follow-up. Patients rated changes in importance of their values retrospectively, and completed a subscale of the Minnesota Multiphasic Personality Inventory as a standardized measure of interpersonal impairment and outcome. Independent clinicians rated patient outcomes using the Global Assessment Scale at pre- and post-therapy. The study used patient measures collected at follow-up and therapist measures collected at termination.

Most patient values (64%) changed in a direction opposite of their therapists' values over the course of therapy. The majority of patients reported changes in values related to personal goals and competency, but reported stability in values related to social goals and morality. Most values tended to increase in importance for patients over the

course of therapy, and the only value on which patients and therapists were significantly different was Salvation, which was less important for therapists than for patients. Increased similarity to therapist values in terms of social and personal goals related to better ratings of outcome by the therapists, but not to the other outcome measures. Therapist-patient dyads that were similar on one scale of the Rokeach Value Survey and different on the other scale had better patient outcomes on all measures than dyads that were either similar or dissimilar on both subscales.

The results of this study support previous findings that patient values change in therapy, but conflict with findings that assert that patients' values become more similar to those of their therapists (Kelly & Strupp, 1992). They also suggest that increased similarity to therapists' values is only related to therapists' assessment of outcomes, and that it is optimal for patients to work with therapists whose values are neither too different from nor too similar to their own. The only exception to this pattern is the value of Salvation. The authors noted that this religious value was typically rated as either very important or very unimportant, that it was significantly more important for patients than for therapists, and that it related to independent clinicians' ratings of patient outcomes, suggesting that similarity on this value can be used to match patients and therapists to ensure optimal outcomes. Limitations of this study include its scant descriptions of different types of values, its lack of explanation for differences between the current findings and those of previous research, and its use of retrospective self-report ratings of changes in patients' values.

In another examination of client outcomes related to religious issues in therapy, McCullough (1999) conducted a meta-analysis with the aim of comparing the efficacy of

standard and religion-accomodative approaches to counseling for depression. The author identified five studies, with a total of 111 client participants, by searching electronic databases. The studies met the following four criteria: (1) they compared a religion-accomodative approach to counseling with a standard approach; (2) they randomly assigned clients to treatments; (3) their participants endorsed symptoms of depression; and (4) they offered equal amounts of treatment to clients in religion-accomodative and standard conditions. All the studies compared either Beck's Cognitive Therapy or Rational-Emotive Therapy to religiously-oriented, manualized versions of these treatments. Effect size estimates were based on scores on the Beck Depression Inventory (BDI) at one-week follow-up as this data point was available across studies. Effect sizes were calculated from means and standard deviations and corrected for attenuation, and clinical significance data (symptom reduction below a score of 9 on the BDI) was examined where available.

Although the effect size indicated that clients in religion-accomodative counseling had slightly lower BDI scores than those in standard treatment, this difference was not significant. Likewise, a higher percentage of clients in religion-accomodative counseling scored below 9 on the BDI at follow-up, but this difference was also not significant. These results show that standard and religion-accomodative approaches to counseling for depression appear to be equally efficacious, making the choice between the two a matter of client preference rather than differential efficacy. Although this meta-analysis was limited by the small number of studies examined, as well as some methodological flaws within the studies themselves, its major strengths included stringent criteria for study

inclusion, consistent methodology across studies, and thoroughness and clarity in its discussion of the methods, findings, and limitations.

On the whole, the findings of research that has examined the process and outcome of incorporating religious issues into therapy appear to be mixed. Although there are no studies that directly address the question of how therapists go about integrating discussion of religious issues into therapy, the diversity of interventions used in extant studies indicates that there is no dominant method that therapists currently use to address religion. In the studies reviewed above, incorporation of religion ranged from using religiously oriented adaptations of manualized treatments, to unstructured discussion of religious concerns, to a complete lack of explicit discussion of these issues. This variety of approaches currently used to address religion in therapy further supports the need to examine the usefulness of the different approaches and to determine which may be more helpful for clients than others.

Findings on clients' outcomes and responses following the incorporation of religion into therapy also vary. Some studies indicate that positive outcomes occur following open, accepting discussions of client's religious concerns, and some indicate that matching clients and therapists on religious values also improves outcomes, particularly when religion is very important to the client. Other studies, however, indicate that integrating religion into standard treatment approaches does not affect clients' outcomes, and some studies even suggest that discussing religion in therapy can be harmful if therapists approach the discussions in a manner that is close-minded or judgmental. Some of these divergent findings likely result from the different constructs being examined in the studies: the methods used to incorporate religion into therapy vary

widely, as do the outcomes being measured. The main conclusion that can be drawn from this research is that client outcomes and satisfaction depend strongly on the method used to incorporate religion into therapy – a conclusion that again highlights the need to determine which methods are most helpful.

## Religion and Psychology Training

Research has demonstrated the importance of religion and spirituality to mental health, the desire of clients to discuss religion in therapy, the willingness of therapists to engage in such discussion, and the fact that therapists often do engage in such discussion and even in the use of religious interventions with their clients. Despite all these findings, which together suggest that religion is an important component of both mental health and mental health services, research also shows that training in religious competence is lacking in psychology graduate training programs.

Shafranske and Malony (1990) reported that although most clinical psychologists believe that spirituality is important in clinical work, a large majority of them reported that they received little or no training for addressing spiritual issues in therapy and believe that they and other psychologists are not competent to address these issues. Furthermore, their use of religious interventions and beliefs about their own competence in this area were influenced by their personal religious views rather than theoretical orientation or training. However, these conclusions should be interpreted cautiously due to a lack of consistency between the study's results and discussion sections on the topic of participants' sense of competence with religious issues. Regardless, the study's finding that most clinical psychologists consider spirituality to be important for themselves and their clients but lack the training necessary to competently address religious issues in

therapy does point to the need for increased training in this area. Such training would minimize risks, such as using inappropriate spiritual interventions or imposing therapists' religious views on clients, that arise when therapists base their approach to religious issues on their own religious views instead of professional training.

Similarly, Walker et al. (2004) found that counselors who are religious implement religious interventions more often than those who are not, and noted that these interventions risk being inappropriate or imposing the counselors' values on their clients because they are guided by personal faith rather than professional training. They further noted that more training and research are needed in the area of religious multicultural competence. However, this study was also limited by some inconsistency between the results and discussion (with the discussion implying a lack of competence among non-religious counselors, while the results merely indicated less frequent implementation of religious interventions), so its findings should also be interpreted with caution.

Altogether, the extant studies on available training and therapists' sense of competence in working with religious issues indicate that most therapists receive no training and do not consider themselves competent in this area. Those therapists that do discuss religious issues with clients and consider themselves competent to do so often base their approach on their personal religious faith rather than on professional training, creating the risk of using inappropriate interventions or imposing their own values on their clients.

## Summary of Literature Review

On the whole, the literature reviewed in this chapter depicts the relevance of religion to psychological functioning and therapy, and highlights the need for further

investigation of helpful strategies for incorporating religious issues into clinical work. Research on the relationship between religion and mental health shows that early studies concluded that religion was psychologically unhealthy. However, more recent studies distinguish between positive and negative ways of being religious and find that intrinsically religious individuals are mentally healthy, often more so than their less religious counterparts.

Literature on the religiosity of therapists and of their potential clients indicates that religion is a salient cultural difference between these two groups. On the whole, therapists are significantly less religious than the general American public, especially in terms of conventional expression of religiosity such as attendance at places of worship. However, research does show that therapists often consider religion to be an important component of life, and are willing to discuss it with their clients, who typically prefer to have such discussions in therapy. This openness on the part of therapists represents an important step in building multicultural competence with religious issues. Unfortunately, religion appears to be in the early stages of its development as an area of multicultural counseling, and there is currently little attention devoted to it within this field.

In terms of practical methods for addressing religion in therapy, literature shows that therapists use a wide range of approaches, with no systematic rationale or strategy for using one approach rather than another. Client outcomes following religious interventions or discussions of religion in therapy also vary. While some clients report benefits from addressing religious concerns and show improvement on various measures of psychological functioning, others show no improvement or even report harmful effects. The nature of client outcomes appears to depend heavily on the therapeutic

approach used, emphasizing the need to identify and use the most helpful approaches. Unfortunately, the current lack of training in addressing religious issues in therapy makes it difficult to establish consistent practices, and perpetuates therapists' reliance on their own religious backgrounds for guidance in this task.

## The Present Study

This literature review clearly indicates the necessity for greater knowledge about helpful methods for addressing religious issues in therapy. It also highlights the need for the availability of further training in this area, and for guidelines on the strategies that such training should teach. One useful source of such guidance is clients' perceptions of the benefits of different therapeutic approaches to discussing religious concerns.

### Purpose

The aim of the current study is to compare potential clients' assessments of the helpfulness of two different approaches to addressing religious concerns in therapy. One approach focuses on exploring a client's concerns using core counseling skills such as empathy and reflection, while the other uses a structured assessment of religious background and concerns, as well as statements of specific knowledge about a client's religious culture. The study also examines the impact of the participants' own religious commitment on their views of the two approaches. The ultimate goal of the study is to aid therapists in making informed decisions about whether to focus on core skills or specific knowledge and assessment strategies in discussing religion with their clients. It is also hoped that the findings of the study will help psychology educators design training programs that teach consistent, effective methods for addressing religious issues in therapy. In addition, because the study examines therapeutic approaches from potential

clients' point of view, the resulting practice and training recommendations are likely to maximize the benefits clients receive from discussing religion in therapy by promoting those therapeutic approaches that clients find most helpful.

## Hypotheses

There are two main hypotheses for this study. The first is that participants will perceive the structured, knowledge-based approach to addressing religious concerns to be more helpful than the approach based in core counseling skills. Previous studies have demonstrated that therapy clients do benefit from open-minded exploration of religious issues, which is consistent with a core counseling skills approach. However, it is likely that this approach represents the most basic level of therapist competence and client benefit, and that an approach that encompasses more advanced knowledge and therapist skill is likely to be even more helpful for clients than the basic approach.

The second hypothesis is that participants who are highly religious will show a stronger preference for the structured, knowledge-based approach. Because religion is more important for these participants, they are more likely to prefer an approach that encompasses specific knowledge and assessment of their religion than participants for whom religion may not be as salient or central to their lives.

# CHAPTER THREE

# METHODS

## Participants

Participants in this study were primarily undergraduate students recruited from introductory educational psychology courses at a large, public university in the Midwest; one participant was a graduate student who taught one of these courses. The benefits of using university student participants are that the findings of the study are likely to be particularly relevant to clinical work with clients at university counseling centers and to training within graduate programs in counseling psychology. The findings may also be applicable to therapy clients in other outpatient clinical settings, such as private practice and community mental health centers, though it may be important to ascertain that the demographic characteristics of those clients, such as age, gender, ethnicity, and religious affiliation and commitment, are similar to the characteristics of this study's sample prior to applying the study's findings to those client populations.

Participants were first recruited through written in-class announcements about the research study. As this method yielded an insufficient number of participants over most of the data collection period, in-person announcements about the research study were also made in introductory educational psychology courses during the last two weeks of data collection in order to increase participant numbers. Thirty nine of the study's 120 participants took part in the study following the in-person recruiting announcements. Students in all educational psychology courses are routinely encouraged to participate in research in order to promote their involvement in the university's academic community. Students' research participation was reported to their instructors; however, research

participation was not considered when computing their grades and students were not penalized if they chose not to participate in this or any other research project. Thus, students were able to make an unconstrained choice regarding their participation in this study.

Table 1. Demographic Characteristics of Sample

| Demographic | Percent |
|---|---|
| Gender | |
| Male | 24.8 |
| Female | 75.2 |
| Ethnicity | |
| Arab-American/Arab/Persian | 0.9 |
| Asian-American/Asian | 3.4 |
| European-American/White/Caucasian | 90.6 |
| Hispanic/Latino/Latina | 0.9 |
| Other | 4.3 |
| Background Religious Affiliation | |
| Christian | 90.6 |
| Jewish | 1.7 |
| Non-religious | 4.3 |
| Other | 3.4 |
| Current Religious Affiliation | |
| Christian | 79.5 |
| Jewish | 1.7 |
| Agnostic | 2.6 |
| Atheist | 0.9 |
| Non-religious | 7.7 |
| Other | 7.7 |

A total of 120 participants took part in the study; data from three participants were not included in the analyses as experimenter observation and review of the participants' responses on study measures suggested that those three participants were not attentive to the stimulus materials and/or measures (e.g., they provided the same response on all items on a particular measure). Thus, the final sample included 117 participants. This

sample size is larger than the samples used in many past analogue therapy studies, most of which included 100 participants or fewer (e.g., Houts & Graham, 1986; Hoyt, 2002; Smith, Kleijn, Trijsburg, Segaar, van der Staak, & Hutschemaekers, 2009), suggesting that a sample size of 117 is sufficient for the purposes of the current study. In addition, a sample size of 120 typically provides ample power to detect a moderate effect size in 2x2 MANOVAs (McDonald, Seifert, Lorenzet, Givens, & Jaccard, 2002); thus, 117 participants should provide adequate power to test the hypotheses of the current study.

Participants' demographic characteristics are presented in Table 1. In addition, participants' mean age was 20.54 years, with a standard deviation of 2.87 and a range of 18 to 34 years. These data indicate that the majority of participants in this study were female, Caucasian, Christian, and were of traditional college age. These demographic characteristics are consistent with past research using university students as participants, and are similar to the typical demographic characteristics of most clients at college counseling centers (Benton, Robertson, Tseng, Newton, & Benton, 2003).

## Experimental Conditions

There were two experimental conditions in the current study. In the first, participants viewed a videotaped mock therapy segment that portrayed a basic therapeutic approach to discussing a client's religious concerns; this approach focused primarily on the use of core counseling skills. In the second condition, participants viewed a videotaped mock therapy segment that portrayed a culturally competent approach to discussing the same concern. This approach focused on structured assessment of the client's religiosity and religious concerns, as well as on the therapist's verbalization of specific knowledge about the client's religious affiliation. The content of each videotape

is described in further detail in the "Basic Therapeutic Approach" and "Culturally Competent Approach" sections below. Participants were randomly assigned to either the basic or the culturally competent therapy condition, and each participant only viewed one of the two therapy videotapes.

The content of the videotaped mock therapy segments was read verbatim from scripts developed with the input of two expert judges, Kathleen Staley, Ph.D. and James Griffin, Psy.D. Both judges provide therapy services on a full-time basis. Dr. Staley, a psychologist at a large university counseling center, conducts therapy from a Christian perspective with clients that request it. Dr. Griffin is a psychologist in a private practice that also offers time-limited therapy from a Christian perspective. The judges' role in the development of scripts was to provide initial guidance about techniques that are commonly used when working with clients in a religiously competent manner and that should be included in the stimulus videotapes. Once the first draft of the scripts was developed, both judged provided suggestions for revisions to improve the scripts' portrayal of the study's experimental conditions. After this feedback was incorporated into the scripts, both judges reviewed the scripts a second time and agreed that the scripts accurately depicted and distinguished a basic approach and a culturally competent approach to discussing a client's religious concerns.

The therapist and client were the same in both videotapes to eliminate variance in responses due to differences in therapist or client qualities. Thus, variables such as client and therapist likeability and attractiveness were held constant across conditions and are believed not to have affected participants' patterns of responses to the stimulus tapes. The client was portrayed by a White female who appeared to be of traditional college age,

while the therapist was portrayed by a White female who appeared to be middle-aged; both actors were intern-level doctoral trainees in psychology. They were chosen for their knowledge of basic therapy processes and their ability to depict these in the videotapes. In addition, the demographic characteristics of the actors were similar to typical characteristics of clients and therapists in university counseling settings, and the client's similarity to most of the study's intended participants in terms of age, gender, and ethnicity was intended to facilitate participants' identification with the client in the analogue therapy segment.

In both videotapes, the client presented an identical concern and provided the same basic information and responses over the course of the therapy segment in order to ensure that factors other than the experimental manipulation of therapeutic approach were as similar as possible across the two conditions. The client's primary concern in both cases was depression, and the first seven minutes of the two tapes, during which the therapist explored this concern, were identical. Toward the end of the initial seven-minute portion of both tapes, the client shared that feelings of guilt were one of her depressive symptoms, and specified that the guilt was related to failing to continue attending church after moving away from her family to go to college. After this point, the videotapes diverged: the therapist implemented the basic therapy approach in one of them and the culturally competent approach in the other.

The presenting concern and development of the analogue therapy segments described above were chosen because depression is a common presenting issue in therapy, and because clients are more likely to bring up religious issues in the context of other concerns than to present them as the primary focus of therapy. In addition, it was

hoped that the commonplace nature of the client's presenting concern would enable study participants to empathize with the client regardless of their own religious views. During the latter portion of the therapy segment, the client also revealed her Christian religious background. The purpose of this disclosure was to allow the therapist in the culturally competent condition to demonstrate specific knowledge about the client's religion; Christianity was chosen because it is the dominant religious affiliation among therapy clients and represents a common religious identity that many of the study's participants are likely to be familiar with.

The videotape of the basic therapy approach was approximately fifteen minutes long, while the videotape of the culturally competent approach was approximately seventeen minutes long. Previous therapy analogue studies have typically used videotapes of approximately ten minutes; thus, the videotapes in this study were somewhat longer than those used in similar past research (Houts & Graham, 1986). The goals of the videotapes in this study were to allow ample time to provide an accurate representation of a therapy session segment and to demonstrate each of the experimental approaches while keeping the stimulus materials brief enough to maintain the participants' attention and permit experimental sessions to be completed in a reasonable amount of time.

Basic Therapeutic Approach

In the basic therapeutic condition, the therapist used the core counseling skills of empathy, reflection, and open-ended questions to explore the client's presenting concern throughout the therapy segment. The therapist did not conduct a systematic assessment of religious issues or verbalize specific knowledge about the client's religious background,

but instead communicated an open, empathic attitude through nonverbal behaviors and by following the clients' statements with appropriate reflections and questions. In order to represent an appropriate therapeutic strategy likely to be used by many therapists who lack specific training in religious competence, this approach conveyed the beliefs and attitudes (e.g., openness, lack of judgment) identified by Sue and Sue (2003) as one component of multicultural competence. However, the therapist in this condition did not display knowledge and skills specific to working with the client's religious concerns, and therefore lacked the two other components of Sue and Sue's multicultural competence.

Culturally Competent Approach

The therapist in this condition demonstrated all three of the multicultural competencies identified by Sue and Sue (2003): beliefs and attitudes, knowledge, and skills. The therapist demonstrated appropriate beliefs and attitudes in a manner similar to that used in the Basic Therapeutic Condition – through empathic nonverbal behaviors and reflection of the client's statements. The therapist verbalized specific knowledge about the client's religious background by making several statements about Christian beliefs and worship practices in the context of the discussion. For example, she stated that "in some Christian families, the sacraments – things like baptism and confirmation – can also be an important part of worship, and an important part of bringing up children" prior to asking the client whether these practices were important in her family. Finally, the therapist displayed skills specific to addressing religious concerns by conducting a brief systematic assessment of the client's religious beliefs, practices, and concerns.

The religious assessment used was based on the Level I ecumenical assessment approach advocated by Richards and Bergin (2005). This approach is designed for use

during initial contacts with clients of various religious backgrounds; its purpose is to gather basic information about clients' religious worldviews and to determine whether religion is a component of the presenting concerns. The assessment consists of seven questions that assess clients' current and past religious affiliations, beliefs, and practices; religious concerns; reliance on religion as a source of support; and willingness to address religion in therapy. In this study, four of the questions were chosen for inclusion in the videotapes (based on feedback from the study's two expert judges on which questions are most useful and most commonly used) in order to maintain the brevity of the videotapes. This assessment method is well suited to the purposes of the current study because it is brief and appropriate for use as an initial evaluation of the relevance of religious issues to therapy. The use of this assessment, in conjunction with demonstration of specific knowledge and appropriate beliefs and attitudes, fulfills all three multicultural competencies identified by Sue and Sue (2003) and thus differentiates the culturally competent approach from the basic therapeutic approach.

## Measures

### Demographic Form

The demographic form used in this study asked for basic information about the participants, including age, gender, ethnicity, and past and current religious affiliation. It was important to assess these participant characteristics in order to determine the generalizability of the study's findings to a variety of diverse client populations, and because the demographic characteristics assessed have been identified by research as relevant correlates of religiosity and its relationship to mental health.

The Religious Commitment Inventory-10 (RCI-10)

The RCI-10 (Worthington, Wade, Hight, Ripley, McCullough, Berry, et al., 2003) is a 10-item measure of religious commitment. The authors of the measure define religious commitment as "the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living" (Worthington et al., 2003, p. 85). The items in the scale provide descriptions of religious attitudes and activities, such as "My religious beliefs lie behind my whole approach to life" (Worthington et al., 2003, p. 87), and respondents rate how true each item is of them on a 5-point Likert scale.

The RCI-10 is a continuous measure, with higher scores reflecting higher degrees of religious commitment; it has a mean of 26 and standard deviation of 12 in general samples of U.S. adults, and a mean of 23 and standard deviation of 10 in university student samples (Worthington et al., 2003). Although factor analyses have demonstrated the presence of two subscales representing Intrapersonal and Interpersonal Religious Commitment, these subscales have been highly correlated in all research with the RCI-10, suggesting that it is most appropriate for use as a one-factor measure (Ripley, Worthington, & Berry, 2001).

The authors of the RCI-10 suggest that a score one standard deviation above the mean can be used to differentiate highly religious individuals from those who are low to moderate in religious commitment (Worthington et al., 2003). They note that individuals who are highly religious according to this measure are more likely to view events and interactions, including therapy, in terms of their religion than individuals who are moderately religious or not religious. Therefore, it is important to distinguish between highly religious and less religious participants in the current study. Because the RCI-10 is

recommended for use as a dichotomous measure of religiosity by its authors, and has been used in this fashion in at least one study (Ripley, Worthington, & Berry, 2001), it was used as a dichotomous measure of religiosity in this study as well. Thus, participants' total score on the RCI-10 was used as the measure of religious commitment; scores above 33 (one standard deviation above the mean for university student samples) were categorized as indicating a high level of religious commitment, and scores of 33 and lower were categorized as low-to-moderate religious commitment.

The authors examined the psychometric properties of the RCI-10 in six studies using religiously and geographically diverse samples of undergraduate students, church attendees, and clients at a variety of secular and religious counseling agencies (Worthington et al., 2003). The results demonstrated strong internal consistency reliability (full scale alphas ranging from .88 to .98) and construct validity (as indicated by significant correlations with religiosity measured by self-reports and the Rokeach Value Survey) (Worthington et al., 2003). On the whole, the RCI-10 is very well suited to the purposes of this study due to its brevity, its purpose as a basic screening instrument, and its appropriateness for use with religiously diverse populations.

Counselor Rating Form-Short Version (CRF-S)

The CRF-S (Corrigan & Schmidt, 1983) is a 12-item instrument that measures three main components of perceived counselor credibility: attractiveness, expertness, and trustworthiness. Each item provides an adjective (e.g., "expert") and asks respondents to rate the extent to which that adjective describes the counselor on a 7-point Likert scale ranging from *not very* to *very*.

Factor analyses of the CRF-S have demonstrated the presence of three subscales that measure attractiveness, expertness, and trustworthiness, and scores on these three scales are often examined separately. However, research has consistently shown that the three factors are highly correlated; as a result, several studies have used the total CRF-S score as a one-factor measure of counselor credibility, and several authors have presented theoretical support for this use of the measure (Corrigan & Schmidt, 1983). Because this study aims to examine overall perceptions of therapist and intervention helpfulness, using total scores on the CRF-S as a measure of therapist credibility is more appropriate than examining separate scores for therapist attractiveness, expertness, and trustworthiness. For this reason, this study used total CRF-S scores to measure perceived therapist credibility.

Several studies of the psychometric properties of the CRF-S have demonstrated adequate reliability (with full scale alphas ranging from .76 to .96) and validity (as evidenced by its ability to detect meaningful differences between counselors on the target dimensions), and have shown that the CRF-S compares favorably to the long form of the same instrument (Corrigan & Schmidt, 1983; Epperson & Pecnic, 1985; Hoyt, 2002). These studies were conducted with samples of outpatient clients at community mental health centers and undergraduate students viewing segments of videotaped therapy sessions. The demonstration of the adequate psychometric properties of the CRF-S with an undergraduate sample makes this measure especially well suited to the design of the current study. Moreover, its brevity provides an additional benefit to using this measure in research.

Perceptions of Helpfulness

Participants' perceptions of the helpfulness of the mock therapy segments was assessed using a three-item index; each item was rated on a 7-point Likert scale ranging from *not at all* to *very much*. The items included assessed (a) participants' willingness to see the therapist for a personal problem; (b) participants' willingness to refer a friend to the therapist; and (c) participants' rating of the overall helpfulness of the therapist in the video they watched. Participants' ratings of all three items were added to yield a total score, which was used to measure overall perception of therapist helpfulness, with higher scores indicating higher perceived helpfulness.

The use of single-item measures such as the helpfulness measure in this study is common in research on perceptions of therapy, and the face-valid items typically yield high levels of internal consistency and predictive validity (Hoyt, 2002; Thompson, Worthington, & Atkinson, 1994). Hill et al. (1994) also found that responses to one-item measures of session helpfulness were stable over time, consistent between clients and therapists, and predictive of session outcome measures. Thus, while the specific helpfulness measure used in this study has not been empirically investigated and should be used cautiously, there is some research evidence that similar measures have adequate psychometric properties for research use. Some authors have cautioned that single-item measures such as this are hypothetical measures of therapist influence that exaggerate the impact of therapy (Hoyt, 2002). However, the aim of this study is not to measure the impact of actual therapy sessions on real clients, but to measure observers' responses to a hypothetical therapy interaction. Because of this, and because most typical therapy

outcome measures are not suited for use with potential rather than actual therapy clients, the helpfulness measure described above is appropriate for use in this study.

## Procedures

Participants attended experimental sessions held at specified times in the same building as their classes. Between one and seven participants took part in each experimental session. After reading and signing consent forms, participants completed the demographic form and the RCI-10. They then viewed one of the two videotapes, and completed the CRF-S and the Helpfulness items after being given instructions to rate the items as they apply to the therapist they just viewed. Following completion of these measures, participants were debriefed about the purposes of the study and given opportunity to ask questions, and their participation was concluded.

## Statistical Analyses

Participants' demographic characteristics were examined by means of descriptive statistics. The characteristics of participants' responses to study measures were also examined by computing means, standard deviations, ranges, and Cronbach's alphas for all measures used, as well as by reviewing the correlations between these measures. The hypotheses of the study were examined by means of a 2x2 (therapy approach x participant religious commitment) factorial MANOVA. This statistical procedure allowed the examination of the interaction between the independent variables (therapeutic approach and participant religious commitment), as well as their main effects. Separate ANOVAS were planned for each dependent variable to ascertain the nature of any significant interactions; however, the MANOVA results indicated that additional statistical analyses were unnecessary (see Results section below).

# CHAPTER FOUR

# RESULTS

## Descriptive Statistics

In general, participants in this study responded to measures of religious commitment, counselor credibility, and counselor helpfulness similarly to participants of past studies (see Table 2). In past research with university students using the RCI-10 as a measure of religious commitment, mean scores ranged from 22.8 to 25.7, and standard deviations ranged from 10.2 to 11.9 (Worthington et al., 2003). Cronbach's alpha coefficients of the measure have ranged from .92 to .98 (Worthington et al., 2003). Thus, the mean, standard deviation, and reliability coefficient of the RCI-10 observed in this study are consistent with those found in past studies. Past research has used RCI-10 scores one standard deviation above and below the mean to distinguish respondents high in religious commitment from those whose religious commitment is low to moderate (Ripley et al., 2001). The mean score in this study is well within one standard deviation of the means found in past research with college students, suggesting that the mean RCI-10 score in this study represents low-to-moderate religious commitment.

Table 2. Descriptive Statistics of Measures Used

| Measure | Mean | SD | Score Range | Cronbach's α |
|---|---|---|---|---|
| RCI-10 | 24.29 | 9.99 | 10 - 49 | .94 |
| CRF-S | 60.40 | 12.18 | 21 - 84 | .92 |
| Helpfulness | 12.83 | 4.58 | 3 - 21 | .90 |

Past research using the CRF-S in an analogue design to measure college students' perceptions of counselor credibility has found means ranging from 54.80 to 63.40, standard deviations ranging from 11.66 to 13.43, and alpha coefficients ranging from .76 to .96 (Corrigan & Schmidt, 1983; Epperson & Pecnic, 1985; Hoyt, 2002). These numbers are similar to the mean, standard deviation, and reliability statistics found in the current study; it is also notable that the research that yielded these statistics is similar to this study in terms of design and participant characteristics. The mean score on the CRF-S observed in this study is well above 48, which is the middle point of the measure's possible range (12-84), suggesting that on average, participants in this study rated the counselors' credibility as high.

Although the exact items used in this study to measure perceptions of counselor helpfulness have not been used in past studies, measures that are very similar in content and structure are available for comparison of descriptive and reliability statistics. For example, Hoyt (2002) used a three-item measure of global satisfaction with therapy which asked research participants to use a 7-point Likert scale to rate their willingness to see a therapist for help with a personal problem, their willingness to refer a friend to this therapist, and their overall assessment of the therapist's helpfulness. These ratings were made by university students after watching videotaped vignettes of therapy sessions; the participants in the study were similar to the participants in the current study in terms of age, gender, and ethnicity. Because Hoyt's (2002) study is similar to the current study in terms of design and participant characteristics, and because the measure Hoyt used is highly similar to the current measure of perceived helpfulness in terms of number,

structure, and wording of items, the measure used by Hoyt (2002) provides a useful comparison for the helpfulness measure used in the current study.

Hoyt (2002) found that on a 3-item measure of satisfaction with therapy, means for different therapists ranged from 11.87 to 13.80, and standard deviations ranged from 4.96 to 5.36. The mean of the helpfulness measure in the present study is very similar to the means found in Hoyt's research, and the standard deviation in the present study is somewhat lower than the range reported by Hoyt (2002). Hoyt also reported an internal consistency reliability coefficient of .94 for his sample, which is slightly higher than the Cronbach's alpha coefficient observed in the present study. The mean score of the helpfulness measure in this study is very close to the middle point of the measure's possible range (4-21, with a midpoint of 12), suggesting that on average, participants in this study viewed the counselor as moderately helpful.

Table 3. Correlations Between Measures

| | RCI-10 | CRF-S | Helpfulness |
|---|---|---|---|
| RCI-10 | | | |
| Pearson Correlation | 1 | .067 | .194* |
| Sig. (2-tailed) | | .476 | .036 |
| CRF-S | | | |
| Pearson Correlation | .067 | 1 | .773** |
| Sig. (2-tailed) | .476 | | .000 |
| Helpfulness | | | |
| Pearson Correlation | .194* | .773** | 1 |
| Sig. (2-tailed) | .036 | .000 | |

*Correlation is significant at the .05 level (two-tailed)

** Correlation is significant at the .01 level (two-tailed)

Correlations among the measures used in this study are reported in Table 3. As expected, there was a significant positive correlation (r = .77) between the CRF-S and the Helpfulness measure, suggesting that participants' ratings of the therapist's credibility were strongly related to their ratings of the therapist's helpfulness. In addition, the significant positive correlation between the RCI-10 and the helpfulness measure (r = .19) is interesting, as it indicates that as participants' reported religious commitment increased, so too did their perception of the helpfulness of the therapist they observed. However, it should be noted that the correlation between the RCI-10 and the helpfulness measure is fairly modest, and should be interpreted with caution. The lack of a significant correlation between the RCI-10 and the CRF-S suggests that participants' ratings of their religious commitment were not strongly related to their ratings of counselors' credibility.

## Study Hypotheses

### Group Means and Standard Deviations

Table 4 shows participants' mean scores on the dependent measures. Throughout the following discussion, it should be noted that while some of the means differ, these differences do not imply statistical significance and thus should be interpreted with caution. It is interesting that, on the helpfulness measure, mean scores for the basic therapy approach and the culturally competent approach are highly similar for participants with low to moderate religious commitment. Participants high in religious commitment had higher mean scores on the helpfulness measure in both the basic and the culturally competent conditions, consistent with the positive correlation observed between the RCI-10 and the helpfulness measure. In addition, the mean helpfulness score for highly religious participants was higher when they observed the culturally competent

approach to therapy than the basic approach. This pattern of mean scores suggests that while participants who were low to moderate in religious commitment rated the therapist's helpfulness very similarly across the two therapy conditions, participants high in religious commitment generally gave the therapist higher helpfulness ratings than did low-to-moderately religious participants, and rated the therapist as more helpful when she demonstrated the culturally competent therapy approach than the basic approach.

On the CRF-S, participants with low to moderate religious commitment again had very similar mean scores in the basic and culturally competent therapy conditions. Both of these mean scores were also highly similar to the mean score of highly religious participants who saw the basic therapy condition. However, the mean score for highly religious participants who observed culturally competent therapy was higher than any of the other three means on the CRF-S, suggesting that this group of participants tended to rate the therapist in the culturally competent condition as more credible.

Table 4. Group Means and Standard Deviations on Dependent Measures

| | Low-to-moderate religiosity | | High religiosity | |
|---|---|---|---|---|
| | Basic Therapy Approach | Culturally Competent Approach | Basic Therapy Approach | Culturally Competent Approach |
| Helpfulness | | | | |
| Mean | 12.60 | 12.42 | 13.79 | 14.36 |
| SD | 4.16 | 4.57 | 6.42 | 3.70 |
| N | 43 | 48 | 14 | 11 |
| CRF-S | | | | |
| Mean | 60.03 | 59.80 | 60.07 | 64.82 |
| SD | 12.34 | 12.76 | 13.04 | 7.45 |
| N | 43 | 48 | 14 | 11 |

Hypothesis 1

The first hypothesis of this study was that participants would perceive the structured, knowledge-based approach to addressing religious concerns to be more helpful than the approach based in core counseling skills. This hypothesis was examined by means of a 2x2 (therapeutic approach x participant religious commitment) factorial MANOVA (see Table 5 for a summary of MANOVA results). This test showed that the main effect for therapeutic approach was non-significant [$F(2,111) = .56$, $p = .57$]. This indicates that the culturally competent therapy approach and the basic therapy approach did not differ significantly in terms of ratings of therapist credibility and helpfulness. It should be noted that the main effect for religious commitment was also non-significant [$F(2,111) = 1.18$, $p = .31$], suggesting that ratings of therapist credibility and helpfulness did not differ significantly between highly religious participants and participants who were low-to-moderate in religious commitment.

Table 5. Summary of MANOVA Results

| Effect | Wilks' Lambda Value | F | Hypothesis df | Significance | Partial Eta Squared |
|---|---|---|---|---|---|
| Therapy Approach | .99 | .56 | 2 | .57 | .01 |
| Religiosity | .98 | 1.18 | 2 | .31 | .02 |
| Approach x Religiosity | .99 | .53 | 2 | .59 | .01 |

Hypothesis 2

The second hypothesis was that participants who are highly religious would show a stronger preference for the structured, knowledge-based therapy approach. This

hypothesis was also examined with a 2x2 (therapeutic approach x participant religious commitment) factorial MANOVA, which showed that the interaction between therapeutic approach and participant religious commitment was not significant [$F (2, 111) = .53$, $p = .59$]. This finding indicates that highly religious participants and those who were low-to-moderate in their religiosity did not differentially rate the therapist in the two therapy conditions.

# CHAPTER FIVE

# DISCUSSION

## Study Purpose and Significance

The purposes of the current study were twofold: to compare potential therapy clients' perceptions of the helpfulness of two different therapist approaches to addressing religious concerns, and to examine what impact potential clients' own level of religiosity has on their views of the helpfulness of the two different approaches. Recent research shows that training programs often offer little or no training for therapists in the area of client religion, both in terms of knowledge and intervention skills and as a component of general multicultural competence. Moreover, the research indicates that therapists often do not feel competent to address religious concerns with their clients, or rely mainly on their own religious background rather than professional standards for guidance in how to approach religious concerns. This study sought to address this gap in clinical training and knowledge by examining what university students find more helpful: a basic therapy approach to discussing religious issues that is likely to be used by many therapists with no specific training in this area, or an approach that incorporates specific knowledge and assessment techniques and is likely to be used by therapists with specific training and competence in working with religious issues.

The information gained from this study is likely to be useful in both clinical training and therapy practice. Knowing whether potential therapy clients prefer a particular approach to working on religious concerns can provide valuable guidance for therapists working with clients who present with those concerns. Relying on research findings rather than personal religious experience in approaching such work can give

therapists confidence that the interventions they use are empirically supported and perceived by clients as helpful, and may improve client outcomes and satisfaction. In addition, knowing whether highly religious clients and those who are lower in religiosity respond best to different approaches to addressing religious issues can help therapists tailor their interventions to particular clients' needs and preferences based on those clients' characteristics.

Furthermore, information about which approaches potential clients view as most helpful can inform clinical training programs' decisions about whether and how to provide more specific religious competence training to their students. Knowing what interventions clients find to be beneficial can allow educators to emphasize those interventions in their programs, and may thus result in increased therapist competence and greater client benefit when working with religious concerns. Because the current study used university students as participants, its findings are particularly relevant to clinical practice in university counseling centers, and to training in counseling psychology programs that often focus on the needs of this population. However, the findings may also be cautiously applied to other training programs and client populations that have characteristics similar to those of the current study's sample.

## Findings

The results of this study did not reveal the expected differences in therapist ratings between the basic therapy approach and culturally competent approach, or between participants who were high and low-to-moderate in terms of religious commitment. The mean scores on the dependent measures were fairly similar across groups and experimental conditions; although some of the means differed in a manner

consistent with the study's hypotheses, none of the differences were found to be statistically significant. Thus, the study's hypotheses were not supported. No significant differences were found between participants' rating of therapist credibility and helpfulness in the basic and culturally competent therapy conditions, and highly religious participants and those who were low-to-moderate in religiosity also did not rate the therapist differently across the two conditions.

These findings are consistent with some of the findings of past research. For example, McCullough (1999) found no significant differences in efficacy between standard and religion-accommodative versions of manualized treatments for depression, suggesting that clients benefitted equally from both versions of the treatments. This is consistent with the current study's finding that participants found a basic and a culturally competent approach to addressing religious concerns in therapy to be equally helpful. This study's findings also make sense in light of Knox et al.'s (2005) research, which concluded that clients find discussions of religious concerns in therapy to be helpful when clients initiate these discussions, the discussions are relevant to clients' presenting concerns, and therapists show openness and acceptance toward clients' religious views. All three of these components were present in both experimental conditions in the current study; thus, Knox et al.'s finding that clients identified these components as important determinants of therapist helpfulness helps explain why participants in this study may have rated therapist helpfulness similarly across the two experimental conditions.

Despite these areas of consistency with past research, this study also conflicts with the findings of some previous studies. For example, Rose et al. (2001) found that therapy clients with higher levels of past spiritual experiences and beliefs in a higher

power had stronger preferences for addressing religious issues in therapy than clients with lower levels of spiritual experience and belief. The fact that the current study did not find differences in therapist ratings between participants who were high and low-to-moderate in religious commitment is somewhat inconsistent with the findings of Rose et al. (2001); based on their conclusions, it would be reasonable to expect a therapist who competently addresses religious concerns to be rated as more helpful by highly religious participants than by participants who are less religious. It is possible that the use of a therapy analogue design in this study may have contributed to this inconsistency in findings since Rose et al. (2001) interviewed actual therapy clients for their research.

There are a number of possible reasons why the expected pattern of results was not found in this study. Some of the psychological factors that may have contributed to the lack of significant differences in therapist ratings between experimental groups include greater responsiveness to the common elements in the two therapy conditions than to their differences, different reactions to the therapy segments than participants would experience in actual therapy situations, and the possible effect of participants' low levels of religiosity on their perceptions of the basic and culturally competent approaches. In addition, methodological limitations that may have affected the study's findings will be discussed in the next section.

Common Factors

It is possible that participants in this study provided similar ratings of the therapist regardless of the therapist's approach or the participant's level of religious commitment at least partly as a result of the therapist's general characteristics and skills. Thus, these characteristics and skills may have functioned as common factors that may have

contributed to participants' perceptions of the therapist as similarly credible and helpful across different situations.

An extensive amount of research asserts that common factors such as therapist warmth, empathy, genuineness, and ability to collaborate with clients account for large proportions of the change that occurs in therapy, clients' ratings of their relationships with their therapists, and clients' ratings of the therapists themselves (Asay & Lambert, 2002). Thus, these factors are commonly considered to be very powerful determinants of client outcomes and responses to therapists. Consequently, such factors are also likely to account for a large proportion of research participants' perceptions and ratings of a therapist they observe in an analogue study format.

Because the therapist in this study was portrayed by the same person in both conditions, characteristics such as her warmth and level of empathy were essentially held constant across participants and experimental conditions. Furthermore, in addition to using the same therapist in both videotapes, the study also used an identical seven-minute segment in the beginning of both tapes prior to beginning the two different interventions. Thus, common factors that are already likely to be a potent influence on participants' perceptions of the therapist were potentially made even more prominent across this study's experimental conditions by using portions of videotape during which the therapist displayed identical wording and mannerisms.

An additional factor that may have contributed to similar ratings of the therapist across participants and experimental conditions is that one component of multicultural competence defined by Sue and Sue (2003) – beliefs and attitudes – was also displayed by the therapist in both the basic and the culturally competent therapy conditions. This

component consists of an open, non-judgmental attitude toward the client and her or his culture and concerns, and is thus similar to the common factors described above. Because past research has indicated that clients generally find it helpful when their therapists display such open, accepting attitudes, it is likely that participants in this study consistently viewed this aspect of the therapist's demeanor as helpful regardless of the specific intervention the therapist was performing or the participant's own level of religious commitment.

Thus, overall, the therapist's characteristics and demeanor toward the client, her multicultural beliefs and attitudes, and even some of her specific wording and behavior, were the same across participants and therapy conditions in this study. While there were also differences in the therapist's approach in the two experimental conditions, it is possible that the consistent elements in her presentation had a greater impact on participants' perceptions of her than the differences between the approaches she used and any differences in participants' therapy preferences that may have stemmed from their differing levels of religious commitment.

### Differences From Actual Therapy Experiences

Another potential reason for the lack of significant findings in this study is that participants may have responded differently to the scripted therapy segments than they would to actual therapy experiences. The stimulus materials used in this study were brief depictions of therapy interactions that the participants observed and did not participate in. Arguably, viewing these stimulus materials is quite a different experience from actively participating in ongoing therapy that focuses on personally relevant topics.

It is possible that elements that would have affected clients' ratings of therapists in actual therapeutic interactions may have been less salient to participants in this study. Specifically, the brevity of the stimulus materials provides a therapy analogue but may not fully capture the impact that consistent use of multiculturally competent interventions would have in ongoing therapy. Thus, the different interventions in the study may have had less impact on participants' perceptions of the therapist than they might have if used consistently in therapeutic interactions.

Similarly, because participants were observing the therapeutic interventions and not actively participating in them, they may have been less engaged and personally invested in the interventions and their helpfulness, and thus may not have differentially responded to the two approaches to the same extent that they might if they actually experienced them in therapy. In short, the experiences of this study's participants with the analogue therapy videos may not accurately represent what their experiences might be with the same therapist and the same interventions in actual therapy. Thus, while in actual therapy they may have viewed the therapist as more helpful and credible if she performed the culturally competent intervention, particularly if the participants themselves were highly religious, the videos used in this study may not have approximated a real therapy experience to a sufficient extent to elicit these differences in perception.

Participant Religious Commitment

A final reason why no differences in therapist ratings were observed in this study for participants who viewed different therapy conditions or had different levels of religious commitment may be that, on the whole, participants in this study displayed fairly low levels of religious commitment when compared with the general U.S.

population. Although this study's participants were similar to other university students in terms of average religious commitment levels, they were less religiously committed than typical American adults, and their mean level of religious commitment was in the low-to-moderate range.

Thus, although there was a range of religious commitment levels among the participants, most of them were not highly religious. It is plausible that individuals for whom religious commitment is not a highly important aspect of life may be less likely to notice or attribute strong importance to a therapist's approach to discussing religious issues with a client. Because religion, and by extension religious concerns, are not likely to be highly important to participants with low-to-moderate levels of religiosity, they may not view a therapist's handling of these concerns as personally relevant and may not regard it as a significant determinant of that therapist's helpfulness or credibility. Thus, the majority of participants in this study may have used factors other than the therapist's approach to addressing religious concerns to determine their perceptions and ratings of that therapist. The participants' potential reliance on factors other than therapeutic intervention to determine their perceptions of the therapist makes it even more likely that they used the common factors described above to evaluate the therapist, and thus rated her similarly across the experimental conditions.

On the whole, the possibility that the factors described above contributed to a lack of significant findings in this study suggests that it may not be appropriate to conclude that a lack of significant differences between experimental groups means that potential clients find basic counseling approaches as helpful as culturally competent approaches when addressing religious concerns, or that a client's own level of religiosity does not

influence perceptions of different therapy interventions. Instead, it may be more accurate to say that potential clients that are low-to-moderate in religiosity and demographically similar to traditional college students may not place high importance on a therapist's approach to working with religious issues when evaluating the therapist in a brief therapy analogue format.

It is still likely that religiously and demographically diverse clients participating in ongoing therapy may find an approach characterized by greater skill and knowledge in discussing religious concerns more helpful than a more basic approach characterized only by an open, accepting attitude. It is also likely that actual therapy clients who are highly religious may find a culturally competent approach especially helpful. However, the participant population and methodology involved in this study did not capture these differences that might exist in actual therapy situations. Instead, the study showed that for research participants who are not highly religious, common factors such as a therapist's personal characteristics and demeanor are a more potent factor in determining ratings of a therapist in an analogue therapy segment than differences in the participants' levels of religious commitment or in the therapist's approach to working with religious concerns.

## Methodological Limitations

Several methodological limitations of this study are important to note as they may have had some influence on the study's findings. The first limitation has to do with the characteristics of the study's participants, who were fairly homogenous in terms of their demographic characteristics. As noted earlier, the majority of participants in this study were female, Caucasian, Christian, and of traditional college age. They were also low-to-moderate in their level of religious commitment. While these demographic characteristics

are similar to those of typical client populations at university counseling centers, they do limit the generalizability of this study's findings to populations that may be more demographically diverse. Specifically, the young age of these participants may make it more likely that they are at a developmental stage where religious affiliation and commitment are less important, or more in question, than they are at other phases of life. Thus, the participants' youth may partly explain the low-to-moderate level of religious commitment observed in this sample. Given these demographic characteristics, it may be the case that in determining perceptions of a therapist's helpfulness, this specific sample emphasized factors other than therapist approach to addressing religious issues or the interaction between therapist approach and their own level of religiosity. However, therapist approach and personal level of religious commitment may still be important factors in evaluations of therapy for clients who are older, more religious, and more diverse in terms of gender, ethnicity, and religious beliefs. The homogeneity of this study's participants makes it difficult to determine how other populations may respond to the basic and culturally competent therapy approaches used in this study.

An additional characteristic of this study's participants that may have impacted their responses to the experimental conditions is their level of motivation. Because most participants were young and not highly religious, the interventions portrayed may have had limited personal relevance for them, which may have adversely affected their level of interest and motivation in watching and responding to the interventions. Observation of participants at experimental sessions indicated that while some participants appeared interested and invested in their participation in this study, many of them appeared to put forth a minimal amount of attention and effort. It is possible that some students

participated in the study because they were encouraged to do so in their courses and not because they had intrinsic interest in the study's topic or in research participation. The low level of interest and motivation among some participants may have caused them to be less conscientious in watching the stimulus tapes and responding to measures, and may have led them to respond similarly regardless of which intervention they observed, and thus may have contributed to the lack of significant findings in this study.

Another potential limitation in the study's methodology that is important to note is the length and content of the stimulus videotapes. Most therapy analogue studies have used videos that are 10 minutes in length or shorter, and that depict differences in therapy conditions from the beginning to the end of the tape (Houts & Graham, 1986; Smith et al., 2009). Thus, in those studies, participants are required to maintain attention to the stimulus materials for a relatively brief amount of time and are exposed to the different experimental conditions throughout the videos, so even if their attention varies over the course of the video, they may be able to respond to differences that are present in those portions of video that they do attend to.

In this study, the stimulus videotapes ranged from fifteen to seventeen minutes. This is significantly longer than the videotapes used in previous studies, and it is possible that participants had difficulty sustaining attention throughout the longer tapes, especially in an analogue format where they were not actively participating in the experimental interventions. This is especially important because the tapes were fairly similar; aside from the therapist's questions and statements after the first seven minutes of each tape, many elements of the two videos were identical, including the client's presenting concern, the therapist's mannerisms, and even some of the therapist's specific statements

and behaviors. The intention behind this similarity was to eliminate variance in participants' responses due to any factors besides the two different interventions of interest in this study. However, it is possible that this similarity between the two tapes limited participants' ability to detect and respond to components that were different between the basic and culturally competent therapy approaches.

This may be especially true because the first seven minutes of the two tapes were identical. Because participants' attention to stimulus videos is likely to be best early in the viewing and may vary more during later portions of the video, it may be that all participants were most attentive during the early, identical parts of the tapes and possibly less attentive during the latter parts of the tapes, when differences between the two therapy approaches were shown. Therefore, the similarities between the two conditions may have been more salient to participants than their differences due to the length and similarity of the stimulus videos, and thus a "priming effect" may have emphasized the common elements of the two videos and contributed to the lack of significant differences in participants' perceptions and ratings of the therapist across experimental groups.

A final methodological limitation of this study is limited clarity in the measurement of both religious commitment and therapist helpfulness. The RCI-10 contains questions that appear to assess both extrinsic aspects of religion (e.g., "I keep well informed about my local religious group and have some influence in its decisions") and intrinsic ones (e.g., "Religious beliefs influence all my dealings in life"). In addition, the instrument has items that seem to refer to aspects of both religion (e.g., "I make financial contributions to my religious organization") and spirituality (e.g., "It is important to me to spend periods of time in private religious thought and reflection").

Although it contains all these elements, the authors of the RCI-10 do not specify to what extent it assesses extrinsic vs. intrinsic religion, or religion vs. spirituality. Thus, the RCI-10 reflects the lack of clarity present in extant research about the precise constructs and components of religion and spirituality that are measured by different instruments. This, in turn, makes it difficult to interpret findings obtained with the RCI-10 as it is uncertain whether the measure provides a holistic assessment of religious commitment or emphasizes a more specific component of religion or spirituality.

Similarly, the Helpfulness measure used in this study also lacks clarity about the precise construct being measured. While the first two items on this measure ask about participants' willingness to see or refer to a particular therapist, the last item asks about a seemingly different construct – participants' perceptions of the therapist's helpfulness in an observed intervention. Thus, it is unclear whether a single helpfulness construct is being measured or whether the Helpfulness instrument actually assesses two different components of perceptions of a therapist. This lack of clarity about the constructs measured by both the RCI-10 and the Helpfulness instrument limits the current study by making it difficult to interpret its results and ascertain whether its lack of significant findings reflects actual psychological phenomena or whether it is due to measurement flaws.

## Directions for Future Research

A number of strategies can be used in future research to clarify the reasons for the lack of significant findings in this study and to further understand potential therapy clients' perceptions of the helpfulness of various therapist approaches to addressing religious concerns. Analogue studies can replicate the current study while removing its

methodological limitations in order to determine whether addressing these limitations yields different findings. Specifically, it may be helpful for future analogue research to use stimulus materials that are briefer than those used in the current study and that demonstrate the different interventions throughout the tape. These changes may help maintain participants' attention throughout the stimulus materials and more fully show differences between the interventions of interest in order to ensure that participants are responding to the intended aspects of the tapes rather than to any unintended effects that may result from priming or tape length. In addition, in order to more fully understand participants' perceptions of therapist credibility in similar studies in the future, it may be helpful to examine their scores on the CRF-S subscales (attractiveness, expertness, and trustworthiness) in addition to the total score. This would allow researchers to determine whether a therapist's use of different approaches to addressing religious concerns impacts different components of perceived credibility in different ways.

Another potentially beneficial strategy for future analogue studies may be to use a religious concern that is more neutral than the one used in the current study. In this study, the client in the stimulus tapes expressed guilt related to not maintaining family religious traditions, which may have a negative connotation for some participants and thus may have an unintended effect on their responses. Showing a client with a more neutral religious concern, such as existential questions related to life goals, would eliminate such unintended effects and thus more clearly demonstrate the effect of the different interventions.

Because it is possible that participants' patterns of responding in this study were related to the analogue format of the study, it is also important to conduct research with

culturally competent interventions for addressing religious concerns in the context of actual therapeutic interactions. Because the interventions used in a therapy context are longer-term and more personally relevant than interventions viewed in an analogue format, participants may respond to these differently from how they responded to interventions used in the current study. In addition, because the ultimate goal of research in this area would be to develop educational and therapeutic practices that maximize therapist competence and client benefit, it is of paramount importance to investigate how different approaches to working with religious concerns function in real-life therapy situations as this is the context in which these approaches would ultimately be used.

Studies aimed at more precisely delineating the components of culturally competent practice with clients presenting with religious concerns would also be a very important research avenue to pursue. The culturally competent intervention used in this study was developed based on current models of general multicultural competence and religious/spiritual assessment. It included components that these models identified as important, such as demonstration of specific knowledge and skills relevant to a client's religious concerns and investigation of the client's religious background, current religious beliefs, and relationship of religious issues to the client's presenting concerns. Specific investigation of the use of each of these theoretical components in clinical practice would be helpful in identifying those components that are most important to client outcomes and evaluations of therapy. Such investigations would help clarify what constitutes culturally competent practice when working with religious concerns and provide much-needed practical guidance for therapists who work with these issues.

As a final note on future directions for research in this area, it is important to mention that future research on clinical work in the area of religion and spirituality should make effort to include participants with a high degree of demographic diversity. Because it is important that therapists are competent in working with clients who are diverse in many respects, including religious affiliation and commitment, and because participants' religious and other cultural characteristics may influence how they respond to different therapeutic interventions, it is imperative that research studies include diverse participants in order to make their findings applicable to as many diverse therapy clients as possible.

## Implications for Clinical Practice

The participants in this study perceived a therapist as equally credible and helpful when she used a basic approach and a culturally competent approach to addressing religious concerns. This finding suggests that for these particular participants, factors other than the therapist's intervention were more salient in determining their perceptions of her. However, past studies have found that some therapy clients experience greater benefit and helpfulness with some therapeutic approaches to religious concerns than with others. In addition, multicultural theory suggests that the more salient a particular cultural characteristic is to a given client, and the more impact it has on the client's life and worldview, the more important and beneficial it is to address that component of the client's culture in therapy.

Thus, examination of this study's findings in conjunction with the findings of past research suggests that while some clients view religion and spirituality as integral to their lives, and by extension their mental health, others consider it to be less central or not

important at all in their lives. While the former group's experiences in therapy may be strongly influenced by whether and how religious and spiritual issues are addressed, members of the latter group may place less importance on this topic in therapy and may base their perceptions of therapy's helpfulness on other aspects of a therapist's characteristics, qualities, and interventions.

These differences highlight the importance of therapists' assessment of clients' needs and preferences during the early part of therapy in order to determine what aspects of culture and mental health hold high importance for a given client. Such an assessment should include questions about a client's religious affiliation, beliefs, and practices, as well as about the role of religion and spirituality in the client's life and presenting issues. After such an assessment, therapists can tailor the focus and interventions of therapy to a particular client's needs and preferences, and can integrate the client's religiosity into therapy to the extent that the client finds this beneficial.

It is possible that many clients at university counseling centers may not view religion as an important issue to discuss in therapy as they are typically not high in religious commitment and are demographically similar to this study's participants, who did not perceive the culturally competent intervention as more helpful than the basic intervention. However, it is still important for therapists to do the initial assessment of religiosity when working with university students. Many of them may express little interest in integrating religious or spiritual issues into their clinical work, and therapists can use this information to guide them in focusing on other topics in working with these clients. However, some university students are highly religious, and it may be particularly helpful for counseling center therapists to identify these students and give them the

opportunity to address religion in therapy as they may have limited other opportunities to process this important aspect of their lives on a secular campus where many students may not share their religious views or commitment.

In addition to conducting an initial screening of clients' religiosity, therapists can continually seek feedback from clients about the helpfulness of therapeutic discussions on this topic and about any additional needs or suggestions clients may have in this area. Finally, therapists may also find it helpful to elicit clients' feedback about their reactions to addressing religion and therapy and any benefits or drawbacks they may have perceived in that process. This feedback can be helpful in further guiding therapists in choosing interventions to try when discussing religious issues with other clients.

## Conclusion

Participants in this study did not demonstrate a preference for either a basic approach or a culturally competent approach to a therapist's discussion of religious concerns in therapy. This finding suggests that for some clients, a therapist's approach to working on religious concerns may not be an important determinant of therapy's helpfulness. While discussions of religion and spirituality may benefit some therapy clients, and some clients may find particular approaches to these discussions to be more helpful than others, therapists should not assume that all clients will derive interest or benefit from such discussions. Moreover, they should not apply a uniform approach to addressing religious concerns with all clients. Because religion is an important part of life for many people, clients should be given the opportunity to share their views of religion and provide input on the role it should have in their therapy. To this end, therapists can assess clients' religiosity, religious concerns, and desire for discussion of religion early in

therapy, and then use their responses to a few initial screening questions to determine whether further exploration and integration of religion and spirituality into therapy is warranted or whether the client is likely to benefit from a different focus in her or his clinical work.

# APPENDIX A

## RECRUITMENT FLYER

**RESEARCH OPPORTUNITY**

**Study Title: Client-Rated Helpfulness of Two Approaches for Addressing Religious Concerns in Therapy**

You are invited to participate in a research study that examines responses to different ways of addressing religious concerns in therapy. The goal of the study is to identify helpful approaches therapists can use when addressing religious issues. If you decide to participate, you will be asked to fill out a demographic form and a brief questionnaire about your religious beliefs and practices. You will then watch a 15-minute video of a scripted therapy session and provide ratings of the therapist and the session you watched. Your participation in this study would last for approximately 40 minutes.

All the information you provide for the study will be kept completely confidential and your participation is entirely voluntary. You will receive credit in your course for your participation. This study is being conducted by Alice Fridman. If you have any questions, she can be reached at alice-fridman@uiowa.edu or 847-224-0695.

Experimental sessions will occur on the following days and times (through 3/12/2010):
Wednesdays at 12:30, 1:30, and 2:30pm
Fridays at 10:30am, 11:30am, and 12:30pm (except February 12)

All sessions will take place in Lindquist Center room N186 (located inside the first-floor computer lab, in the north wing of the building.)

If you choose to participate, please complete the form below, tear it off, and give it to your instructor. Please write down the date and time you signed up for here:_____

You will also receive an email reminder to attend. If you are not able to attend the time you signed up for but would still like to participate, please email the researcher at alice-fridman@uiowa.edu.

↑ Keep this portion ↑

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↓ Give this portion to your instructor ↓

Name:_____ Email:_____
Instructor Name and Section Time:_____
Please circle the date and time you plan to participate:

| Wednesdays | Fridays |
|---|---|
| January 20: 12:30pm, 1:30pm, 2:30pm | January 22: 10:30am, 11:30am, 12:30pm |
| January 27: 12:30pm, 1:30pm, 2:30pm | January 29: 10:30am, 11:30am, 12:30pm |
| February 3: 12:30pm, 1:30pm, 2:30pm | Feb. 5: 10:30am, 11:30am, 12:30pm |
| February 10: 12:30pm, 1:30pm, 2:30pm | Feb. 19: 10:30am, 11:30am, 12:30pm |
| February 17: 12:30pm, 1:30pm, 2:30pm | Feb. 26: 10:30am, 11:30am, 12:30pm |
| February 24: 12:30pm, 1:30pm, 2:30pm | March 5: 10:30am, 11:30am, 12:30pm |
| March 3: 12:30pm, 1:30pm, 2:30pm | March 12: 10:30am, 11:30am, 12:30pm |
| March 10: 12:30pm, 1:30pm, 2:30pm | |

# APPENDIX B

# INFORMATION SHEET

**Project Title: Client-Rated Helpfulness of Two Approaches for Addressing Religious Concerns in Therapy**
**Principal Investigator and Research Team Contact: Alice Fridman, 847-224-0695**

We invite you to participate in a research study. The purpose of this research study is to examine responses to different ways of addressing religious concerns in therapy. Specifically, the study investigates relationships between therapeutic interventions for religious issues, religiosity, counselor ratings, session evaluation, and willingness to see a counselor. The goal is to identify helpful approaches to working with religious issues in psychotherapy.

We are inviting you to participate in this research study because you are enrolled in an Educational Psychology and Measurement course at the University of Iowa. Approximately one hundred and twenty people will take part in this study at the University of Iowa.

If you agree to take part in this study, your involvement will last for approximately one hour.

You will be asked to complete a demographic form that asks you for your age, gender, ethnicity, about background or past religious affiliations or identity and about your current religious affiliations or identity. You will then complete a second questionnaire about your religious beliefs and practices such as reading about your faith, spending time with others of your religious affiliation, and the role of your religious beliefs in your life. Then, you will be asked to view one of two 15-minute videos of a scripted mock therapy session. Following the video, you will be asked to complete two more paper questionnaires that will assess your evaluation of the therapist and the session that you viewed. After this, the investigator will collect your questionnaires and your participation in the study will be complete. On all questionnaires in this study, you are free to skip any questions that you prefer not to answer.

We will keep the information you provide confidential, however federal regulatory agencies and the University of Iowa Institutional Review Board (a committee that reviews and approves research studies) may inspect and copy records pertaining to this research. To help protect your confidentiality, we will store paper questionnaires in a locked cabinet in a private office. Electronic data will be stored in a password-protected file on a personal computer. Neither questionnaires nor computer data will contain information that could be used to personally identify you. It will not be possible for the researchers to link you to your responses on the questionnaires. If you are participating in this study to fulfill a course requirement or for extra credit, we will report your attendance at this session to your course instructor so that you may receive proper credit. If we write a report or article about this study or share the study data set with others, we will do so in such a way that you cannot be directly identified.

You may experience some discomfort answering questions about your religious beliefs or viewing the scripted therapy session. You may skip any questions you do not wish to

answer or withdraw from the study without penalty or loss of credit. If you have any concerns about your responses or the information presented in the study, please inform the researchers and you will be given a referral to the University of Iowa Counseling Service for psychological assistance. If this occurs, the researcher will give you a phone number you can call to make an appointment at the Counseling Service and ask any questions you may have about the services available there.

You will not benefit personally from being in this study. However we hope that others may benefit in the future from what we learn as a result of this study.

You will not have any costs for being in this research study. You will receive one hour of extra credit in your course for participating in this study. Instead of being in this research study, you have other options for receiving extra credit your Educational Psychology and Measurement course. Other options may include volunteer work or laboratory assignments. Information about other options for receiving extra credit in your course is listed in the course syllabus.

Taking part in this research study is completely voluntary. If you decide not to be in this study, or if you stop participating at any time, you won't be penalized or lose any benefits for which you otherwise qualify.

We encourage you to ask questions. If you have any questions about the research study itself, please contact: Alice Fridman, B.A. at 847-224-0695, or William M. Liu, Ph.D. (faculty supervisor) at 319-335-5295. If you experience a research-related injury, please contact Ms. Fridman or Dr. Liu at the phone numbers listed above.

If you have questions about the rights of research subjects, please contact the Human Subjects Office, 300 College of Medicine Administration Building, The University of Iowa, Iowa City, IA 52242, (319) 335-6564, or e-mail irb@uiowa.edu. To offer input about your experiences as a research subject or to speak to someone other than the research staff, call the Human Subjects Office at the number above.

If you agree to be in the study, please tell me now and we will give you the first study questionnaires to complete. If you wish to consider your participation, we can arrange for you to attend another session after you have had a chance to consider your participation. If you do not wish to be in the study, please let me know now or at any time.

Thank you very much for your consideration of the study. You may keep this information sheet for your records.

# APPENDIX C

# STUDY MEASURES

Demographic Form

1. Age:

2. Gender:
   - Male
   - Female
   - Transgender

3. Ethnicity:
   - African-American/Black/African
   - American Indian or Alaskan Native
   - Arab-American/Arab/Persian
   - Asian-American/Asian
   - East Indian
   - European-American/White/Caucasian
   - Hispanic/Latino/Latina
   - Native Hawaiian or Pacific Islander
   - Multi-racial
   - Other

4. Religious Affiliation or Spiritual Identity:

   Background/Past
   - Christian (Specify: )
   - Jewish
   - Muslim
   - Buddhist
   - Hindu
   - Agnostic
   - Atheist
   - Non-religious
   - Other (Specify: )

   Current
   - Christian (Specify: )
   - Jewish
   - Muslim
   - Buddhist
   - Hindu
   - Agnostic
   - Atheist
   - Non-religious
   - Other (Specify: )

**RCI-10**

**Instructions:** Read each of the following statements. Using the scale to the right, CIRCLE the response that best describes how true each statement is for you.

| | **Not at all** true of me 1 | | **Somewhat** true of me 2 | | **Moderately** true of me 3 | **Mostly** true of me 4 | | **Totally** true of me 5 | |
|---|---|---|---|---|---|---|---|---|---|
| 1. I often read books and magazines about my faith. | 1 | 2 | 3 | 4 | 5 | | | | |
| 2. I make financial contributions to my religious organization. | 1 | 2 | 3 | 4 | 5 | | | | |
| 3. I spend time trying to grow in understanding of my faith. | 1 | 2 | 3 | 4 | 5 | | | | |
| 4. Religion is especially important to me because it answers many questions about the meaning of life. | 1 | 2 | 3 | 4 | 5 | | | | |
| 5. My religious beliefs lie behind my whole approach to life. | 1 | 2 | 3 | 4 | 5 | | | | |
| 6. I enjoy spending time with others of my religious affiliation. | 1 | 2 | 3 | 4 | 5 | | | | |
| 7. Religious beliefs influence all my dealings in life. | 1 | 2 | 3 | 4 | 5 | | | | |
| 8. It is important to me to spend periods of time in private religious thought and reflection. | 1 | 2 | 3 | 4 | 5 | | | | |
| 9. I enjoy working in the activities of my religious affiliation. | 1 | 2 | 3 | 4 | 5 | | | | |
| 10. I keep well informed about my local religious group and have some influence in its decisions. | 1 | 2 | 3 | 4 | 5 | | | | |

# Counselor Rating Form – Short (CRF-S)*

We would like you to rate several characteristics of the therapist you just viewed. For each characteristic on the following page, there is a seven-point scale that ranges from "not very" to "very." Please mark an "X" at the point on the scale that best represents how you view the therapist. For example:

FUNNY

not very _X_:_____:_____:_____:_____:_____:_____ very

WELL DRESSED

not very _____:_____:_____:_____:_____:_X_:_____ very

These ratings might show that the therapist does not joke around much, but dresses wisely.

Though all of the following characteristics are desirable, therapists differ in their strengths. We are interested in knowing how you view these differences.

* Corrigan, J. D., and Schmidt, L. D. (1983). Development and validation of revisions in the Counselor Rating Form. *Journal of Counseling Psychology*, *30*, 64-75.

FRIENDLY

not very _____:_____:_____:_____:_____:_____:_____ very

EXPERIENCED

not very _____:_____:_____:_____:_____:_____:_____ very

HONEST

not very _____:_____:_____:_____:_____:_____:_____ very

LIKABLE

not very _____:_____:_____:_____:_____:_____:_____ very

EXPERT

not very _____:_____:_____:_____:_____:_____:_____ very

RELIABLE

not very _____:_____:_____:_____:_____:_____:_____ very

SOCIABLE

not very _____:_____:_____:_____:_____:_____:_____ very

PREPARED

not very _____:_____:_____:_____:_____:_____:_____ very

SINCERE

not very _____:_____:_____:_____:_____:_____:_____ very

WARM

not very _____:_____:_____:_____:_____:_____:_____ very

SKILLFUL

not very _____:_____:_____:_____:_____:_____:_____ very

TRUSTWORTHY

not very _____:_____:_____:_____:_____:_____:_____ very

Perception of Helpfulness

*Instructions:* The following three statements refer to the therapist you just observed. For each statement, circle the number (1 through 7) that best describes how true the statement is from your perspective.

1. I would be willing to see this therapist for help with a personal problem.

| not at all | | | | | | very much |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

2. I would be willing to refer a friend to this therapist for help with a personal problem.

| not at all | | | | | | very much |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

3. Overall, the therapist was helpful in the interaction I just observed.

| not at all | | | | | | very much |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

# APPENDIX D

# BASIC THERAPY SCRIPT

Dissertation Script – Basic Therapy Condition

Therapist: So, tell me what brings you in today.

Client: Well, I've just been feeling really depressed.

T: Aw, I'm sorry to hear that. Can you tell me a little bit about how you've been feeling?

C: Yeah. It's not that I'm sad all the time – but I get sad sometimes for just no apparent reason. It's not usually like that. My mood just fluctuates, and it's like I can't control it and I don't understand why I'm upset at any particular time.

T: Uh-huh.

C: I'm really irritable too – my reactions to minor things are just overblown. And I guess the most problematic thing is that I have absolutely no desire or motivation to do anything. Normally, I'm a pretty active person – I really like to spend time with my friends, I like to go out, I like to be outside. And I've always been a good student – I mean, I've always procrastinated, but I always get my work done – I can work really hard when I have to. And I've always wanted to get good grades – I guess that's the difference. Now it doesn't even matter to me. I still finish the big assignments, but I don't even care if I do a crappy job, I just spend the minimum amount of time on it to get it done, and I don't care what grade I get. And the little assignments don't even get done anymore.

T: Gosh, that sounds like a big change for you. So you're normally very active, and a very good student, it sounds like. And now, it's a struggle to be motivated and to get your work done. What about the other aspects of you life that you mentioned – your friends, going out, being outdoors? How has that been?

C: It's not as bad as the schoolwork, but I'm definitely not as involved with that stuff as I would normally be. I mean, it just feels like work to do all that sometimes. Most nights, when I get home from class, I just want to sit in front of the TV and vegetate and not do anything. It seems like so much effort to call someone and go somewhere, and have to talk to them and do whatever we're doing. Even when my friends drag me out, I don't really have a good time – I just kind of wait it out and go home. Some nights, I'm so unmotivated to get off the couch and do anything that I don't even make dinner.

T: Wow. So do you end up skipping dinner pretty often then?

C: No, not too much, just once in a while.

T: How has your appetite and your sleep been?

C: My appetite is actually fine – I get hungry, I'm just too unmotivated to get up and fix myself something to eat. And as far as my sleep goes, that actually hasn't been so good. I

definitely have a hard time falling asleep, and then I end up not getting enough sleep and I'm always tired the next day.

T: Aw, that sounds frustrating.

C: Yeah, and it doesn't help my mood any. It's hard not to be irritable when you haven't slept enough.

T: Definitely. What about your energy level during the day? What is that like?

C: It's low, I mean, it's definitely sluggish. I guess that goes along with the low motivation – I don't want to do anything, I don't have the energy to do anything, it kind of feels the same. And like I said, I am definitely not as active as I normally would be. It feels like a lot of work to do anything – even walking up the stairs is like a major chore.

T: Wow, so you are really feeling sluggish and disinterested compared to how you would normally feel.

C: Yeah, pretty much.

T: How's your concentration? Are you able to focus when you try to do work, or when you're doing some other task?

C: Um, I think the only time I stay focused on something is when I watch TV. I can sit there for hours, and not want to move, like I said. But as far as work goes, it's pretty hopeless. I can open a book and sit in front of it for an hour and not read a single word.

T: Uh-huh. (pause) What about feelings of guilt or worthlessness, have you had anything like that?

C: It's interesting that you ask that… I mean, worthlessness, definitely, since I feel like I'm being such a slacker with school. It makes me wonder whether I should even be here, I feel like I'm just wasting time and money going to college and just skating by like this, not putting in any effort and not really learning anything.

T: Oh gosh, that's hard.

C: Yeah… but the guilt thing too is interesting, because I've been thinking about why I might be feeling like this, and I wonder if, I don't know, somehow it's my fault.

T: What do you mean?

C: I don't know, I just wonder sometimes if I'm not taking as good care of myself as I should be, and I feel guilty about that. I mean, I never had problems like this is in high school, when I lived at home. And now that I'm on my own and I make all these

decisions about what to do and how to spend my time, it seems like I've let a lot of things go by the wayside that I used to do to take care of myself, that were important to me.

T: Like what?

C: Well, exercise, for one. That was something that used to make me feel really good before, but I just never got into the habit of doing it regularly since I've been here, and I think maybe that's contributing to me not feeling so great.

T: Yeah, that definitely could be.

C: Yeah. And then there's my family – we were really close when I lived at home, but now, obviously I don't see them very often, and I feel like we're growing apart a little bit, like we have less and less in common. Like, for example, we used to go to church every Sunday, and they still do that, but I don't think I've been to church once since I moved here. I mean, I was never big into the whole religion thing, but it's important to my family, and it was always part of what we did. It just seems like the right thing to do, to go to church at least sometimes, to keep up with that a little more than I do, and I do feel guilty that I haven't done that.

BEGIN BASIC EMPATHY-BASED INTERVENTION

T: Yeah – that sounds like a pretty negative feeling, to realize that you are not doing something that is important to your family and their way of life, and to feel guilty about that.

C: Yeah, I feel *really* bad about it.

T: (nods) Yeah, you seem pretty sad when you talk about it. (pause) Tell me more about that.

C: Well, my family is Christian, and like I said before, we went to church most Sundays, for about as far back as I can remember. And we always celebrated all the major religious holidays, like Christmas and Easter and stuff. It wasn't like my parents were super-religious, they didn't really talk about it much outside of church – but it was just part of what we did as a family, it was kind of implied that that was the expectation, that we would all go to church every week. Like a family tradition, you know. And my siblings and I are all baptized, and we were all confirmed in the church too – it seems like those things were kind of like church on Sundays, just expected as part of our lives. Sunday school was like that too – they were all things like… almost like having dinner with your family once a week or something, you just assumed you were going to do them because that's just what you did. And I guess there were little everyday things too. Like, for example, my dad would typically say grace before meals, and my mom quoted scripture a lot, especially if one of us kids had a problem of some kind or asked for advice about something.

T: So you went to services most Sundays, celebrated all the major Christian holidays and rites of passage, your parents incorporated prayer and scripture into some of their daily routines… It sounds like your family treated church and religion as an activity or a tradition that was important to them, that was a basic part of your family life?

C: Exactly – and that's still kind of the way that my parents look at religion now. They still go to church every week, and so does my little brother, who still lives at home. My mom has asked me about me going to church here once or twice, and she doesn't say outright that she doesn't like it that I don't go, but I get the sense that she's not too happy about it, you know? Like that's something important that I haven't kept up with. They raised me to go to church and believe that that's important, and because I don't go much anymore, that's disappointing to them.

T: What's that like for you, sensing that your parents are disappointed about that?

C: It's hard. I mean, that's where the guilt comes in about not doing what I'm supposed to, it kind of feels like I'm not living right in some way because I've let that part of my life kind of slide.

T: You know, as you talk about this, I get the sense that you feel like you should be going to church, but something is getting in the way of you actually doing that. What do you think is going on there?

C: Hmm, that's a good question… I think part of it may be that my outlook on religion must be different from my parents' in some way, because otherwise I would be going to church like I always did, and this would not even be an issue. I think that I think of going to church as a family activity, an important part of my family's life that I'm expected to keep up in my own life, but I haven't really thought about it outside of that context. So maybe what's going on is that my guilt about it comes from not pleasing my parents by not going to church, and not from something more internal to myself, like feeling I should have a closer relationship with God or something like that.

T: Earlier, you mentioned things like you felt like you were not living right in some way, or not taking care of yourself as well because you are not going to church. Are those things also related to feeling like you're not pleasing your family, or do you think those are more internal, like things that maybe you value that you're not doing?

C: I think it's a little of both. I mean, it definitely comes from my family – I know that they think church is important for living right and taking care of yourself, mentally or spiritually or whatever. And in some ways, I can see it as just their attitude, kind of separate from my own. But in other ways, I learned what's important from them, you know – so I think that internally, I also feel like maybe those things are important... Or that they *should* be important to me, like I should want to keep up with them, and then when I don't, it's like I don't have my priorities straight or something, and I wonder why church isn't more important to me and why I'm not motivated to go on my own.

T: So, to bring this full circle to what we started with – tell me how you believe these feelings of guilt and lack of motivation relate to you feeling depressed right now.

C: Well, I definitely think that they are part of the whole problem. They probably don't explain all of the mood swings and sleep problems and lack of interest in school and everything – but they definitely go along with the general lack of motivation that I was talking about. Like, I wonder if these feelings are contributing to the problem and at the same time, they're a symptom of the problem too. Like, I'm not taking care of myself like I normally would by doing these activities like exercising and going to church, and that's causing me to feel a little depressed –and at the same time, the depression is causing me to be unmotivated and uninterested in a lot of things, and that keeps me from getting up the momentum to look into joining a church, or to get up on a Sunday morning and go to a service. (pause) Plus, it's making me feel guilty like we talked about, and that seems to be a big part of my bad moods – feeling guilty about not going to church, about disappointing my family, as well as about being a bad student since I don't have the motivation to get my work done and do a good job on it like I normally would.

T: So, it sounds like the major issue we will want to work on with you is improving this depressed mood that you're experiencing, and maybe as part of that, we could talk about all the different components of that that you've brought up – the mood swings, the sleep difficulties, the lack of motivation, the feelings of guilt... How does that sound?

C: That sounds good, sounds like it should be helpful. I think I just didn't quite put some of these things together before. Like, I knew I felt guilty about all these things, like not taking care of myself like I should, not going to church, disappointing my family… and I knew I felt depressed, but I don't think I quite realized that me feeling guilty was kind of part of the depression, or that it was contributing to my bad moods. So yeah, I think all the things you mentioned would be important to address. And I think it could also be helpful for me to figure out what's important to *me* as far as what I believe and going to church and all that stuff.

T: Great, it sounds like we are on the same page as far as what we are going to focus on. So, let's pick up with that when I see you next week.

C: Sounds good. See you next week.

T: Bye.

C: Bye.

# APPENDIX E

# CULTURALLY COMPETENT THERAPY SCRIPT

Dissertation Script – Culturally Competent Therapy Condition

Therapist: So, tell me what brings you in today.

Client: Well, I've just been feeling really depressed.

T: Aw, I'm sorry to hear that. Can you tell me a little bit about how you've been feeling?

C: Yeah. It's not that I'm sad all the time – but I get sad sometimes for just no apparent reason. It's not usually like that. My mood just fluctuates, and it's like I can't control it and I don't understand why I'm upset at any particular time.

T: Uh-huh.

C: I'm really irritable too – my reactions to minor things are just overblown. And I guess the most problematic thing is that I have absolutely no desire or motivation to do anything. Normally, I'm a pretty active person – I really like to spend time with my friends, I like to go out, I like to be outside. And I've always been a good student – I mean, I've always procrastinated, but I always get my work done – I can work really hard when I have to. And I've always wanted to get good grades – I guess that's the difference. Now it doesn't even matter to me. I still finish the big assignments, but I don't even care if I do a crappy job, I just spend the minimum amount of time on it to get it done, and I don't care what grade I get. And the little assignments don't even get done anymore.

T: Gosh, that sounds like a big change for you. So you're normally very active, and a very good student, it sounds like. And now, it's a struggle to be motivated and to get your work done. What about the other aspects of you life that you mentioned – your friends, going out, being outdoors? How has that been?

C: It's not as bad as the schoolwork, but I'm definitely not as involved with that stuff as I would normally be. I mean, it just feels like work to do all that sometimes. Most nights, when I get home from class, I just want to sit in front of the TV and vegetate and not do anything. It seems like so much effort to call someone and go somewhere, and have to talk to them and do whatever we're doing. Even when my friends drag me out, I don't really have a good time – I just kind of wait it out and go home. Some nights, I'm so unmotivated to get off the couch and do anything that I don't even make dinner.

T: Wow. So do you end up skipping dinner pretty often then?

C: No, not too much, just once in a while.

T: How has your appetite and your sleep been?

C: My appetite is actually fine – I get hungry, I'm just too unmotivated to get up and fix myself something to eat. And as far as my sleep goes, that actually hasn't been so good. I

definitely have a hard time falling asleep, and then I end up not getting enough sleep and I'm always tired the next day.

T: Aw, that sounds frustrating.

C: Yeah, and it doesn't help my mood any. It's hard not to be irritable when you haven't slept enough.

T: Definitely. What about your energy level during the day? What is that like?

C: It's low, I mean, it's definitely sluggish. I guess that goes along with the low motivation – I don't want to do anything, I don't have the energy to do anything, it kind of feels the same. And like I said, I am definitely not as active as I normally would be. It feels like a lot of work to do anything – even walking up the stairs is like a major chore.

T: Wow, so you are really feeling sluggish and disinterested compared to how you would normally feel.

C: Yeah, pretty much.

T: How's your concentration? Are you able to focus when you try to do work, or when you're doing some other task?

C: Um, I think the only time I stay focused on something is when I watch TV. I can sit there for hours, and not want to move, like I said. But as far as work goes, it's pretty hopeless. I can open a book and sit in front of it for an hour and not read a single word.

T: Uh-huh. (pause) What about feelings of guilt or worthlessness, have you had anything like that?

C: It's interesting that you ask that… I mean, worthlessness, definitely, since I feel like I'm being such a slacker with school. It makes me wonder whether I should even be here, I feel like I'm just wasting time and money going to college and just skating by like this, not putting in any effort and not really learning anything.

T: Oh gosh, that's hard.

C: Yeah… but the guilt thing too is interesting, because I've been thinking about why I might be feeling like this, and I wonder if, I don't know, somehow it's my fault.

T: What do you mean?

C: I don't know, I just wonder sometimes if I'm not taking as good care of myself as I should be, and I feel guilty about that. I mean, I never had problems like this is in high school, when I lived at home. And now that I'm on my own and I make all these

decisions about what to do and how to spend my time, it seems like I've let a lot of things go by the wayside that I used to do to take care of myself, that were important to me.

T: Like what?

C: Well, exercise, for one. That was something that used to make me feel really good before, but I just never got into the habit of doing it regularly since I've been here, and I think maybe that's contributing to me not feeling so great.

T: Yeah, that definitely could be.

C: Yeah. And then there's my family – we were really close when I lived at home, but now, obviously I don't see them very often, and I feel like we're growing apart a little bit, like we have less and less in common. Like, for example, we used to go to church every Sunday, and they still do that, but I don't think I've been to church once since I moved here. I mean, I was never big into the whole religion thing, but it's important to my family, and it was always part of what we did. It just seems like the right thing to do, to go to church at least sometimes, to keep up with that a little more than I do, and I do feel guilty that I haven't done that.

BEGIN CULTURALLY COMPETENT INTERVENTION

T: Yeah – that sounds like a pretty negative feeling, to realize that you are not doing something that is important to your family and their way of life, and to feel guilty about that.

C: Yeah, I feel *really* bad about it.

T: (nods) Yeah, you seem pretty sad when you talk about it. (pause) Tell me a little more about your religious background – what's your family's view on religion? What kind of beliefs and practices were you raised with?

C: Well, we're Christian, and like I said before, we went to church most Sundays, for about as far back as I can remember. And we always celebrated all the major religious holidays, like Christmas and Easter and stuff. It wasn't like my parents were super-religious, they didn't really talk about it much outside of church – but it was just part of what we did as a family, it was kind of implied that that was the expectation, that we would all go to church every week. Like a family tradition, you know.

T: So you went to services most Sundays, and it sounds like you celebrated the major Christian holidays as well… I know that in some Christian families, the sacraments – so things like baptism and confirmation – can also be an important part of worship, and an important part of bringing up children. I'm wondering, were those important in your family growing up?

C: Yeah, definitely. Both my siblings and I are all baptized, and we were all confirmed in the church too – it seems like those things were kind of like church on Sundays, just expected as part of our lives. Sunday school was like that too – they were all things like… almost like having dinner with your family once a week or something, you just assumed you were going to do them because that's just what you did.

T: What about things like prayer, or reading the scriptures – are those aspects of Christianity important in your family?

C: Yeah, there were little everyday things. Like, for example, my dad would typically say grace before meals, and my mom quoted scripture a lot, actually, especially if one of us kids had a problem of some kind or asked for advice about something.

T: So your parents really incorporated prayer and scripture into some of their daily routines. It sounds like your family treated church and religion as an activity or a tradition that was important to them, that was a basic part of your family life?

C: Exactly.

T: And is that still the way that your parents look at religion now?

C: Yeah, I think so. They haven't changed anything about the way that they approach it, they still go to church every week, and so does my little brother, who still lives at home. My mom has asked me about me going to church here once or twice, and she doesn't say outright that she doesn't like it that I don't go, but I get the sense that she's not too happy about it, you know? Like that's something important that I haven't kept up with. They raised me to go to church and believe that that's important, and because I don't go much anymore, that's disappointing to them.

T: What's that like for you, sensing that your parents are disappointed about that?

C: It's hard. I mean, that's where the guilt comes in about not doing what I'm supposed to, it kind of feels like I'm not living right in some way because I've let that part of my life kind of slide.

T: You know, as you talk about this, I get the sense that you feel like you should be going to church, but something is getting in the way of you actually doing that. So I'm curious about your own current religious views – do you believe that it's important to have faith and go to church, and to approach religion similarly to how your parents approach it, or do you have a different outlook on that?

C: Hmm, that's a good question… Obviously, my outlook must be different from my parents' in some way, because otherwise I would be going to church like I always did, and this would not even be an issue. But I don't think I've ever thought much about my own views on religion. I think that I think of it more as a family activity, going to church, and I haven't thought about it outside of that context. Like my guilt about it comes from

not pleasing my parents by not going to church, and not something more internal to myself, like feeling I should have a closer relationship with God or something like that. So yeah, I guess my view on religion is that it's a part of my family's life that I'm expected to keep up in my own life, but I haven't thought about it much beyond that.

T: Earlier, you mentioned things like you felt like you were not living right in some way, or not taking care of yourself as well because you are not going to church. Are those things also related to feeling like you're not pleasing your family, or do you think those are more internal, like things that maybe you value that you're not doing?

C: I think it's a little of both. I mean, it definitely comes from my family – I know that they think church is important for living right and taking care of yourself, mentally or spiritually or whatever. And in some ways, I can see it as just their attitude, kind of separate from my own. But in other ways, I learned what's important from them, you know – so I think that internally, I also feel like maybe those things are important... Or that they *should* be important to me, like I should want to keep up with them, and then when I don't, it's like I don't have my priorities straight or something, and I wonder why church isn't more important to me and why I'm not motivated to go on my own.

T: So, to bring this full circle to what we started with – tell me how you believe these feelings relate to you feeling depressed right now. Do you think that you not going to church and having these feelings of guilt about it are contributing to the way that you are feeling?

C: Yeah, I definitely think that's part of it. I don't think that it explains all of the mood swings and sleep problems and lack of interest in school and everything – but it definitely goes along with the general lack of motivation that I was talking about. Like, I wonder if it's contributing to the problem and at the same time, it's a symptom of the problem too. Like, I'm not taking care of myself like I normally would by doing these activities like exercising and going to church, and that's causing me to feel a little depressed –and at the same time, the depression is causing me to be unmotivated and uninterested in a lot of things, and that keeps me from getting up the momentum to look into joining a church, or to get up on a Sunday morning and go to a service. (pause) Plus, it's making me feel guilty like we talked about, and that seems to be a big part of my bad moods – feeling guilty about not going to church, about disappointing my family, as well as about being a bad student since I don't have the motivation to get my work done and do a good job on it like I normally would.

T: So, it sounds like the major issue we will want to work on with you is improving this depressed mood that you're experiencing, and maybe as part of that, we could talk about all the different components of that that you've brought up – the mood swings, the sleep difficulties, the lack of motivation, the feelings of guilt... How does that sound?

C: That sounds good, sounds like it should be helpful.

T: Yeah… And do you think that your concern about not going to church and feeling like you're disappointing your family would be important to talk about as part of our work together?

C: Yeah, definitely. I think I didn't quite put two and two together before – like, I knew I felt guilty about that, and I knew I felt depressed, but I don't think I quite realized that me feeling guilty was kind of part of the depression, or that it was contributing to my bad moods. So yeah, I think that would be important to address.

T: OK. And just one last question: do you think it would be helpful to spend some time exploring your own views about religion, or talking about whether there are any religious practices that you want to have as part of your life now?

C: (nodding) Yeah, for sure, I think that could be helpful for me, to figure out what's important to *me* as far as what I believe and going to church and all that stuff.

T: Great, it sounds like we are on the same page as far as what we are going to focus on. So, let's pick up with that when I see you next week.

C: Sounds good. See you next week.

T: Bye.

C: Bye.

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