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CLINICAL JUDGMENTS FOR CLIENTS OF VARYING RELIGIOUS  
ORIENTATIONS: AN EXPERIMENTAL STUDY WITH  
CLINICIANS-IN-TRAINING

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by

Michele L. Henry

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The thesis of Michele L. Henry was reviewed and approved \* by the following:

Kathleen J. Bieschke  
Associate Professor of Counseling Psychology  
Thesis Co-Advisor  
Co-Chair of Committee

Keith B. Wilson  
Associate Professor and Director of ARC  
Thesis Co-Advisor  
Co-Chair of Committee

Joyce Illfelder-Kaye  
Affiliate Assistant Professor of Counseling Psychology

Edgar P. Yoder  
Professor of Agricultural Extension and Education

Spencer G. Niles  
Professor of Education  
Head of the Department of Counselor Education,  
Counseling Psychology and Rehabilitation Services

\* Signatures are on file in the Graduate School.

### Abstract

The therapeutic process is influenced by the therapists' personal experiences, expectations, and/or needs (Wallach & Strupp, 1960). Overall, these influences seem to be related to the therapists' level of attraction toward the client. The more a clinician views a client as similar, the more likely the clinician is to experience warm feelings and positive regard for the client (Feeser, 1997). Furthermore, these influences could have an impact on the clinicians' clinical judgment depending upon his/her level of awareness regarding the presenting issues in relation to variables (i.e., race or ethnicity, gender, disability, and religious orientation). If clinicians are going to provide effective services to clients who are religious, it would be important for them to have knowledge or an awareness of the factors that may impede the therapeutic process (Richards & Bergin, 1997). The purpose of the current study was to examine the extent to which differences in clinicians' clinical judgments (as measured by the Therapist Personal Reaction Questionnaire—TRPQ) for clients of varying religious orientations (extrinsic, intrinsic, and quest) attributed to clinicians' background factors (age, sex, race, field of study, highest degree earned, and number of years conducting psychotherapy), social desirability scale values, and religious orientation. A total of 186 clinicians-in-training enrolled in an APA-approved graduate program in Clinical Psychology or Counseling Psychology participated in the study. When the three religious orientations were entered as a block, the change in  $R^2$  was not significant. However, within the religious orientation block an intrinsic religious orientation was significant for the Religious Mary vignette. These results suggest that participants with an intrinsic orientation perceived the client in the Religious Mary vignette as attractive.

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## Chapter One

### Introduction

The literature in mental health and religion is often confusing and broad. Consequently, the reader may find it difficult to fully understand concepts, especially those that are often used interchangeably. Therefore, the purpose of this section is to operationalize and clarify use of the following concepts in the text. In addition, a summary of the available literature will be presented.

#### *Spirituality versus Religion*

Although there is a difference between the concepts of spirituality and religion, these concepts are often used interchangeably (Genia, 1995). Hinterkopf (1994) suggested that spirituality is defined by an experience that is (a) a presently felt phenomenon involving an awareness of a transcendent dimension, (b) manifested through new meanings, and (c) likely to lead one to personal growth. Shafranske and Malony (1990) defined spirituality as those more personal practices of a religious nature, which may or may not emanate from a particular religious institution (p. 72). Though both definitions, as defined by Hinterkopf (1994) and Shafranske and Maloney (1990), are broad, the latter definition suggests a more direct relationship to the concept of religion. Hence, it could potentially be used interchangeably with the concept of religion. Shafranske and Maloney (1990) defined religion or religiousness as adherence to the beliefs and practices of an organized church or religious institution. Adams (1995) further defined religion as a particular form of worship, theology, ritual or creed associated with one of five major world religions (Christianity, Judaism, Islam, Hinduism, Buddhism) or other minor religions. In an effort to avoid any ambiguity, the

present study will not use the concepts religion and spirituality interchangeably. Instead, the study will use the term religion, and speak of this term in a global, all encompassing manner, including the above-mentioned definitions of religion.

In general, people who identify themselves as spiritual may not necessarily participate in organized religion, as they may find comfort in general readings and/or discussion groups (Ross, 1994). Furthermore, though spirituality may be related to different forms of religion, one could still identify as spiritual and not necessarily as religious (Hinterkopf, 1994). Ross (1994) suggests that clients who identify as religious as opposed to spiritual are most often the ones who are assessed with psychopathology. Perhaps clients who identify as religious are most often assessed pathologically because of their religious vocabulary or ritualistic behavior.

### *Religious Orientation*

*Extrinsic Orientation.* Persons with an extrinsic orientation are disposed to use religion as a means to other ends. It can be defined by the extent to which a value is placed upon social interactions, relationships, and acceptance. Extrinsic values are always instrumental and functional. Persons with this orientation may find religion useful in a variety of ways—to provide security and solace, sociability and distraction, status and self-justification. In theological terms, the extrinsic type turns to God, but without turning away from self (Allport & Ross, 1967, p. 434). Examples of extrinsic type statements, as identified on the Religious Orientation Scale (Allport & Ross, 1967), include, “Although I believe in my religion, I feel there are many more important things in my life” and “Occasionally I find it necessary to compromise my religious beliefs in order to protect my social and economic well-being.”

*Intrinsic Orientation.* Persons with this orientation find their master motive in religion. It is a pure form of religious orientation, guided by faith and recognition from God and not external satisfaction. Other needs, strong as they may be, are regarded as of less significance than the relationship with God. Having embraced a creed, the individual endeavors to internalize religion and follow dutifully. Therefore, the individual lives his/her religion (Allport & Ross, 1967, p. 434). Examples of intrinsic type statements, as identified on the Religious Orientation Scale (Allport & Ross, 1967), include, “If I were to join a church group I would prefer to join a Bible study group rather than a social fellowship” and “My religious beliefs are what really lie behind my whole approach to life.”

*Quest.* The quest orientation characterizes complexity, doubt, and tentativeness. This orientation suggests an approach that involves honestly facing existential questions or those questions that focus on concerns that are rooted in the individual’s existence while resisting clear-cut answers and accepting the complexity of their examinations while growing and integrating new insights into their worldview. An individual who approaches religion in this way recognizes that he or she does not know, and probably never will know, the final truth about such matters. But still the questions are deemed important, and however tentative and subject to change, answers are sought. We shall call this open-ended, questioning orientation *religion as a quest*. (Batson & Ventis, 1982). Examples of quest type statements, as identified on the Quest Scale (Batson & Schoenrade, 1993) include, “I am constantly questioning my religious beliefs” and “There are many religious issues on which my views are still changing.”

### *Clinical Judgment*

Clinical judgments are part of the therapeutic process, and therefore therapists are susceptible to making such errors (Rosenthal & Berven, 1999). These errors may be related to the nature of client problems, the severity of the problems, the prognosis of treatment, the formulation of the etiological mechanism, and so forth (Rock, Bransford, & Maistro, 1987).

The therapeutic process is influenced by the therapists' personal experiences, anticipations, and/or needs (Wallach & Strupp, 1960). Overall, these influences seem to be related to the therapists' level of attraction toward the client. The more a clinician views a client as similar, the more likely the clinician is to experience warm feelings and positive regard for the client (Feeser, 1997). Furthermore, these influences could have an impact on the therapists' clinical judgment depending upon his/her level of awareness regarding the presenting issues as they relate to variables (i.e., race or ethnicity, gender, disability, and religious orientation). For example, clients may be assigned inappropriate diagnoses based upon the clinicians' comfort level in working with or beliefs about someone from a different racial or ethnic background (Lopez, 1989).

It is unfortunate that clinicians assign inappropriate diagnoses or make judgments regarding their lack of comfort working with and/or beliefs about individuals from a different racial or ethnic background. Atkinson et al. (1996) examined clinical judgments that African American and European American psychologists make regarding skin tone of African American clients. The results of this study suggested that race and ethnicity of the psychologist influences judgments that he/she makes about an African American female client. Furthermore, as suggested by Atkinson et al. (1996), it seems probable that

personal feelings toward the client, comfort working with the client, and optimism about the client benefiting from therapy, all have an impact on the therapeutic relationship.

Gender also influences clinical judgment, as female clients may be perceived as having more psychological difficulty than males. For example, Hardy and Johnson (1992) conducted a study investigating the effects of therapists' gender and clients' gender, socioeconomic status, and alcoholic status on therapists' clinical judgments. Relative to gender, the results of the study suggested that therapists believed it would take more sessions for females to make substantial progress than it would males.

Religious orientation also influences the way in which clinicians respond to their clients. More specifically, responses may be influenced when the clinician and the client have different religious orientations. The clinician may not be able to relate to religious content if he/she does not identify with or lacks knowledge about the content (Genia, 1994). The lack of identification or lack of knowledge could also have an impact on the clinicians' expectations or goals for therapy. As a result, the clinician may approach therapy with his/her own agenda or need while ignoring what is best for the client (Marrow, Worthington, & McCullough, 1993). Therefore, it is critical for psychologists and clinicians to assess and inquire about the relationship between the presenting concerns and religious beliefs (Yarhouse & VanOrman, 1999). Yarhouse and VanOrman believe that, "a significant challenge when working with religious clients is determining the unique issues that affect their welfare" (Yarhouse & VanOrman, 1999, p. 560).

In general, though a therapeutic process is influenced by the clinicians' personal experiences, anticipations, and/or needs (Wallach & Strupp, 1960), the ability to work effectively with clients requires an increased awareness of differences relating to race,

ethnicity, gender, disability, and religion. Historically, religious and spiritual beliefs have not been well regarded by mental health professionals (Ross, 1994). For example, Ellis (1980) believed that anyone who embraced religiosity was emotionally unhealthy, and that the solution to emotional problems was to be quite unreligious. However, other professionals asserted different views on religion and mental health. In the words of Pheifer (1994): “Very often it is not the personal faith or a dysfunctional church that causes pathology, but it is the psychological disorder that tends to affect, among other areas of life, the religious perceptions, emotions and religious social life” (p. 92). Since views related to religion and pathology has been vocalized, a wealth of literature on religion and mental health has been published (Kelly & Strupp, 1992; Morrow, Worthington, & McCullough, 1993). Consequently, professionals, particularly psychologists and clinicians within the field, have become more knowledgeable of the role that religion plays in the lives of many clients.

Furthermore, having knowledge of the role that religion plays in the lives of clients is critical, as clients expect clinicians to be aware of their spiritual beliefs. D’Souza (2002) found that 79% of patients rated spirituality as very important and 82% thought that therapists should be aware of their spiritual beliefs and needs. In addition, 69% of the patients reported that patients’ spiritual needs should be considered in treating their psychological illness by the therapist.

If clinicians do not have knowledge of or at least sensitivity toward their clients’ religious/spiritual beliefs, the client may have a number of negative anticipations regarding therapy. For example, Keating and Fretz (1990) found that strong religious beliefs resulted in more negative anticipations about counselors. More specifically,

Christians had negative anticipations about counseling with secular counselors. Those negative anticipations included, “I feel this counselor...will ignore my spiritual concerns, will not understand some of my religious beliefs and concerns, will assume that I share the standards of many of the nonreligious people that he sees, might recommend behaviors or solutions which I consider immoral, and will doubt the usefulness of what I can learn from God talking to me through prayer and the scriptures.” (Worthington & Scott as cited by Keating & Fretz, 1990). Keating and Fretz suggested that the aforementioned anticipations might deter Christians from seeking secular counseling. Though the results of the study suggested that strongest negative anticipations were held about secular counselors, less negative ones were held about secular counselors who were spiritually empathic. In other words, less negative anticipations were held when the counselor was perceived as understanding and sensitive regarding spiritual content. Therefore, it seems important for clinicians to understand that having knowledge of or at least sensitivity toward their clients’ religious/spiritual beliefs is critical.

Furthermore, having knowledge of and sensitivity toward their religious clients, may help clinicians to become more aware of their biases. Gelso and Fretz (1992) noted that unexamined expectations held by clinicians are a real danger to clients, as these expectations may be the result of clinicians’ worldviews and stereotypes about people (e.g., race or ethnicity, gender, and lifestyle preference). Therefore, if these expectations remain unexamined, the clinician may jump to conclusions and make invalid assumptions about clients (Rosenthal & Kosciulek, 1996). Furthermore, Gelso and Fretz stated, “the task of the counseling psychologist is to be able to maintain a balance in obtaining and utilizing etic (based on universal norms) and emic (based on what is important to a

particular culture) information, especially when any discrepancy exists between the cultures of the clinician and the client—whether it is a function of age, gender, race/ethnicity, lifestyle, religion, or whatever” (p. 336). The researchers suggested that counseling psychologists would be able to maintain a balance in obtaining and utilizing etic and emic information if they possess knowledge and skills of specific cultural groups as well as the majority culture. Otherwise, if a client believes that he/she has felt and seen the manifestation of God’s presence, the clinician may assess the client as having an extreme ideology (Gartner, Harmatz, Hohmann, Larson, & Gartner, 1990). More specifically, the assessment may be delusional without considering other pertinent background information and the context in which it was presented. Hence, it would be important to consider emic information.

In general, it is important to understand that a clinician who is unknowledgeable of the tenets that are practiced within one’s religion would have a difficult time differentiating between religious beliefs and rituals from delusions and compulsions (Greenburg & Witztum, 1991). Consequently, this lack of differentiation may lead to one of many concerns that clients have regarding the clinician understanding them (Worthington & Scott, 1983). For example, it is important for clinicians to understand the following; clinicians may ignore spiritual concerns by compartmentalizing the treatment, focusing only on psychological and interpersonal issues, instead of also addressing issues that are spiritual. However, focusing on spiritual issues may lead to resolving the former (Richards & Bergin, 1997), as there may be a strong correlation between the clients’ psychological/interpersonal and spiritual issues. Second, clinicians may treat spiritual beliefs and experiences as pathological. Because clinicians may be



influenced by their personal attitudes and biases, they may not understand the various tenets of one's religion (Greenburg & Witztum, 1991). Third, clinicians may fail to comprehend spiritual language or concepts, and therefore religious clients are often misunderstood. For example, some Christians may speak naturally about hearing God's voice, speaking in tongues (spiritual language), or fasting and praying for the manifestation of God's miraculous power (Worthington, 1986). Fourth, clinicians may assume that clients who are religious share nonreligious cultural norms, which seems closely related to the following anticipation. Fifth, clinicians may recommend therapeutic behaviors that clients consider immoral. Therefore, it is important for clinicians to understand possible discrepancies between their religious values and those of the average client (Bergin, 1980). An understanding of these discrepancies would prevent any further harm that could possibly lead to the final problem. Otherwise, clinicians could possibly make assumptions, interpretations, and recommendations that discredit communications from God as a valid way of knowing. Consequently, clients may feel ignored or challenged with regard to their religious values or beliefs, which would compromise the efficacy of treatment.

#### *Statement of the Problem*

There seems to be a growing number of individuals who are religious and seek therapy or counseling outside of religious structures (e.g., churches or synagogues). The need to search for therapy outside of a religious structure could pose a serious dilemma for many individuals who are religious, as they would either have to choose between clergy/religious counselor who could provide spiritual guidance, but is unprepared to address clinically sophisticated content or a skilled clinician who is unknowledgeable or

uncomfortable with religious content (Genia, 1994). Considering the latter may also cause individuals who are religious to ponder whether or not it is “morally acceptable” to seek help in nonreligious settings. Consider the following vignette presented by Richards and Bergin.

Jack was a 48-year-old Christian who was affiliated with a conservative denomination. He was married with three children and had been struggling with severe depression for nearly 2 years. When Jack lost his job because of poor performance, he became even more depressed and began contemplating suicide. Despite encouragement from his wife and pastor to ask his physician for an antidepressant, Jack resisted doing so saying; “I just need to have more faith in God’s healing power.” Jack also rejected suggestions from his wife to seek mental health counseling saying, “Those immoral, anti-God psychotherapists can’t be trusted.” Unfortunately, his pastor agreed with him. Six weeks after losing his job, Jack committed suicide by shooting himself in the head with his handgun (Richards & Bergin, 2000, p. 11)

This vignette illustrates a tragic outcome that might have been prevented had this Christian felt comfortable seeking mental health treatment. One might surmise that Jack’s feelings of distrust were based upon preexisting thoughts of how a secular psychotherapist would treat or judge a Christian’s presenting concerns. Furthermore, his pastor, an individual for whom he seemed to have respect and trust, supported his feelings.

Based upon the content of the vignette, Jack did not seem to obtain sufficient, if any formal counseling from his pastor or other clergy given the nature and depth of his presenting concerns. Kloos, Horneffer, and Moore (1995) conducted a study and the results support the general concerns that religious leaders have related to mental health treatment. They found that religious leaders were most concerned about psychologists not being considerate of spiritual beliefs and “psychologizing” the spiritual aspects of religious groups and individuals. Moreover,

Bergin (1980) suggested that Christians are hesitant to seek help from secular clinicians because of the differences in assumptions that would be formed with regard to life, normalcy, and treatment of disordered behaviors. The hesitancy that Christians feel may not be unwarranted provided that some professionals may not feel adequately prepared to work sensitively and effectively with clients who hold deeply spiritual beliefs (Richards & Bergin, 2000).

### *Need for the Study*

It is well known that therapy is not value free (Bergin, 1980; Beutler & Bergan, 1991), and therefore clinicians bring biases to the therapeutic relationship. Furthermore, it is important for clinicians to understand how their religious orientation or lack thereof influences their clinical judgment. In light of the impact that religious orientation has on clinical judgment, it seems conceivable that individuals who are religious would have serious concerns about seeking help from a clinician who is unknowledgeable or uncomfortable with religious content. Having a lack of knowledge or comfort may be an issue for some clinicians based upon the extent of their religious affiliation or lack thereof. Furthermore, the extent of their affiliation would have an impact on clinical judgment. For example, Gartner et al.(1990) reported three findings from their study. First, they found that clinicians were influenced by patient ideology (extreme political or religious group). Second, clinicians rated clients more negatively whose ideologies were opposite of their own. Third, patient-client ideology interaction was strongest for clinicians whose own beliefs were more extreme. In general, the extent of affiliation seemed to have an impact, as extreme ideology resulted in a rating that was more negative.

Though the literature has attempted to address the impact of religious orientation on clinical judgment, it is limited and deficient, as few studies have directly explored clinical judgment in relation to clients who are religious. The majority of studies that have included a religious dimension are dated, and none of these studies have exclusively explored clinicians in training. Instead, clinical psychologists or other mental health professionals within the field were recruited for these studies.

Therefore, it would be important to understand how clinicians, particularly those who are in training, make clinical judgments regarding religious clients. The results from a study conducted by Rosenthal and Berven (1999) suggested the importance of understanding clinicians in training. The researchers asked White graduate students in rehabilitation counseling to review case materials for a client, portrayed as African American to one group and as White to the other. The results suggested that in the African American condition, the client was judged to have less potential for education and employment. In light of these results, Rosenthal and Berven suggested that bias should be addressed as part of graduate education and training.

Furthermore, exploring clinicians during the training years is critical, as significant professional and personal growth as well as the attainment of knowledge occurs during this time (Gelso & Fretz, 1992). Because significant growth occurs, clinicians may discover their fears in relation to the therapeutic relationship. For example, clinicians may be hesitant to raise diversity issues in therapy, as they fear disrupting the relationship. They may also be hesitant, as countertransference reactions may emerge. If either of the aforementioned or similar issues emerged, the clinician may inadvertently exhibit more biases and less empathy toward the client who is religious.

Also, based upon the nature of the therapeutic relationship, client values or beliefs could potentially change in the direction of the clinicians' values. In their study, Kelly and Strupp (1992) found that values of the patient had changed in the direction of the therapists' values by at least 50%. Other studies have also found that clients tend to change their values in the direction of their therapists (Beutler & Bergan, 1991; Worthington, 2002).

Overall, it is important to study how clinicians in training make clinical judgments, as the literature shows that clients who are religious have concerns about engaging in therapy. If training programs (e.g., counseling psychology, clinical psychology, and counselor education, and rehabilitation counseling) are going to prepare their students to work effectively with religious clients, comprehensive guiding principles for their training are needed. Furthermore, it is important for clinicians to understand that their client's religious beliefs are just as important as their racial, ethnic, gender, or cultural background (Bergin, Payne, & Richards, 1996). Because the beginning stage of a clinician's clinical training is critical, it would also be important to explore how he/she makes clinical judgments with regard to clients who are religious. The purpose of the current study was to examine the extent to which differences in clinicians' clinical judgments (as measured by the Therapist Personal Reaction Questionnaire—TRPQ) for clients of varying religious orientations (extrinsic, intrinsic, and quest) attributed to clinicians' background factors (age, sex, race, field of study, highest degree earned, and number of years conducting psychotherapy), social desirability scale values, and religious orientation.

*Significance of the study*

Previous studies have not explored ways in which clinicians in training make clinical judgments about religious clients. It is important to study clinicians at this stage of their professional development, as "...theories in which we have been trained and our indoctrination into a particular therapeutic approach...have a profound influence" (Smith & Dumont, 1997, p. 340). Shafranske and Malony (1990) found that 67% of the psychologists, who participated in their study, agreed with the statement, "Psychologists, in general, do not possess the knowledge or skills to assist individuals in their religious or spiritual development." Prest, Russel, and D' Souza (1999) reported that 92.2% of their graduate student participants reported that they had not received training in their clinical program to help them integrate religious issue into practice.

The literature also shows that clients tend to change their values in the direction of their therapists. Therefore, it would be important to explore this issue, as clinicians in training develop and hone their theoretical orientation and clinical skills. Data related to clinicians in training would be useful in evaluating and enhancing training programs, particularly those that may spend minimal time introducing and discussing the nature and implications of working with religious populations or neglect to address these populations at all. In light of neglecting to address religious populations, Richards and Bergin (2000) conducted an informal survey of leading books on cross-cultural and multicultural counseling and psychotherapy, which revealed that most of them rarely mention religious aspects of diversity. As a result, a growing number of clinicians are not adequately prepared to work with religious populations. Clinicians lack related training in both theory and practice. Not only does training in religious diversity seem to

be omitted during graduate training, but it also seems to be omitted during postgraduate training as well (Shafranske & Maloney, 1990). Training in religious diversity is critical, as religious beliefs and practices can promote coping and healing (Richards & Bergin, 1997).

Though individuals who identify as religious recognize the role that coping and healing has in their lives (Pargament, 1997; Richards, 1991), they also recognize the benefits of formal therapy (Kloos & Moore, 1995). Therefore, understanding how to work with individuals who are religious has become more important over the years, as the demand for therapeutic services outside religious institutions increase. Consequently, there is a growing demand for “similar-minded” or clinicians who would at least be sensitive to religious issues.

Therefore, if graduate programs are going to provide adequate training for their students, it seems important to have an understanding of their clinical judgments for clients who are religious. Therefore, exploring the difference between the ways in which clinicians in training who are religious and nonreligious make clinical judgments for clients who are religious would provide more information to enhance the development of training programs.

## Chapter Two

### Mental Health and Religion

Traditionally, the impact of religion on mental health has been viewed as pathological, regardless of its importance in the lives of many people (McRae, Thompson, & Cooper, 1999). Within the field of mental health, psychologists, including Sigmund Freud, Albert Bandura, B.F. Skinner, Carl Rogers, Carl Jung, among others, have shared perspectives on the unhealthy relationship between mental health and religion (Masters & Bergin, 1992). Today, psychologists continue to share perspectives on the relationship between mental health and religion. For example, Ellis (1981) offered a critical perspective of religion. He believed that religion was related to irrational thoughts, which would then lead to poor mental health. In contrast, other scholars (Bergin & Jensen, 1990; Myers & Truluch, 1998) believe that it is critical for psychologists or clinicians to understand the relationship between religion and mental health and its impact on the lives of their clients. The aforementioned scholars also purport that understanding the relationship between religion and mental health could ensure that religious clients would receive the services they need. Conversely, there is a higher likelihood of interpreting client beliefs as pathological if psychologists do not understand their clients who are religious (Bergin & Jensen, 1990). Furthermore, psychologists who pathologize religious clients may do so because they lack knowledge or comfort with religious content.

If clinicians are going to provide clients who are religious with effective services, it would be important for them to have knowledge or an awareness of the factors that may impede the therapeutic process with this population (Richards & Bergin, 1997).



Obtaining knowledge of the role that religion plays in the lives of clients is critical, as clients anticipate that clinicians will be aware of their spiritual beliefs. D'Souza (2002) found that 79% of patients rated spirituality as very important and 82% thought that therapists should be aware of their spiritual beliefs and needs. In addition, 69% of the patients reported that patients' spiritual needs should be considered in treating their psychological illness by the therapist.

If clinicians lack knowledge of or at least sensitivity toward their clients' religious/spiritual beliefs, the client may have a number of negative expectations regarding therapy. For example, Keating and Fretz (1990) found that strong religious beliefs resulted in more negative expectations about counselors. More specifically, Christians had negative expectations about counseling with secular counselors. Those negative expectations included, "I feel this counselor...will ignore my spiritual concerns, will not understand some of my religious beliefs and concerns, will assume that I share the standards of many of the nonreligious people that he sees, might recommend behaviors or solutions which I consider immoral, and will doubt the usefulness of what I can learn from God talking to me through prayer and the scriptures. Keating and Fretz suggested that these expectations might deter Christians from seeking secular counseling. Though the results of the study suggested that strongest negative expectations were held about secular counselors, less negative ones were held about secular counselors who were spiritually empathic. This finding supports the importance of clinicians having knowledge of or at least sensitivity toward their clients' religious/spiritual beliefs.

As clinicians become more knowledgeable and sensitive to their clients who are religious, they may also become more aware of their biases. Gelso and Fretz (1992)

noted that unexamined expectations held by clinicians are a real danger to clients, as these expectations may be the result of clinicians' worldviews and stereotypes about people (e.g., gender, race, ethnicity, and lifestyle preference). Furthermore, Gelso and Fretz stated, "the task of the counseling psychologist is to be able to maintain a balance in obtaining and utilizing etic (based on universal norms) and emic (based on what is important to a particular culture) information, especially when any discrepancy exists between the cultures of the clinician and the client—whether it is a function of age, gender, race/ethnicity, lifestyle, religion, or whatever" (p. 336).

Each of the following factors will be discussed in this chapter: therapists' clinical judgment, religious orientation, the clients' concern regarding the therapist ignoring religious content, and the purpose of the present study.

### *Clinical Judgment*

A therapeutic process is influenced by the therapists' personal experiences, expectations, anticipations, and/or needs (Wallach & Strupp, 1960). Overall, these influences seem to be related to the therapists' level of attraction toward the client. The more a clinician views a client as similar, the more likely the clinician is to experience warm feelings and positive regard for the client (Feeser, 1997). Furthermore, the aforementioned influences could have an impact on the therapists' clinical judgment contingent upon his/her level of awareness regarding the presenting issues as they relate to race or ethnicity, gender, or religion, to name a few. Furthermore, considering the impact of client and therapist religious orientation on clinical judgment is important. In particular, it is important to consider therapists who are in training. The results from a study conducted by Rosenthal and Berven (1999) suggested the importance of

understanding clinicians in training. The researchers asked White graduate students in rehabilitation counseling to review case materials for a client, portrayed as African American to one group and as White to the other. The results suggested that in the African American condition, the client was judged to have less potential for education and employment. In light of these results, Rosenthal and Berven suggested that bias should be addressed as part of graduate education and training.

Furthermore, exploring clinicians during the training years is critical, as significant professional and personal growth as well as the attainment of knowledge occurs during this time (Gelso & Fretz, 1992). Because significant growth occurs, clinicians may discover their fears in relation to the therapeutic relationship. For example, clinicians may be hesitant to raise diversity issues in therapy, for fear of disrupting the relationship. They may also be hesitant, as countertransference reactions may emerge. If either of the aforementioned or similar issues emerged, the clinician may inadvertently exhibit more biases and less empathy toward the client who is religious. Furthermore, based upon the nature of the therapeutic relationship, client values or beliefs could potentially change in the direction of the clinicians' values. In their study, Kelly and Strupp (1992) found that values of the patient had changed in the direction of the therapists' values by at least 50%. Other studies have also found that clients tend to change their values in the direction of their therapists (Beutler & Bergan, 1991; Kelly, 1990).

Overall, it is important to study how clinicians in training make clinical judgments that could be potentially harmful to clients who are religious, as the literature shows that clients who are religious have concerns about engaging in therapy. If training

programs (e.g., counseling psychology, clinical psychology, and counselor education, and rehabilitation counseling) are going to prepare their students to work effectively with clients who are religious, comprehensive guiding principles for their training are needed. Prest, Russel, and D' Souza (1999) reported that 92.2% of their graduate student participants reported that they had not received training in their clinical program to help them integrate religious issue into practice. Therefore, clinicians need to understand that their client's religious beliefs are just as important as their racial, ethnic, gender, or cultural background (Bergin, Payne, & Richards, 1996). Because the beginning stage of a clinicians' clinical training is critical, it would be important to explore how he/she makes clinical judgments with regard to clients who are religious. The following section will present empirical literature addressing the impact of specific biases (e.g., race and gender) on clinical judgment. This section will then conclude with empirical literature addressing the way in which various ideologies and religious values influence clinical judgment.

*Sex and Race Bias.* Hansen and Reekie (1990) explored sex bias through clinical judgment. More specifically, the researchers explored whether clinicians would judge a case differently if the patient were male or female. One hundred and three clinical social workers participated in the study. Each participant was given a one-page, randomly distributed vignette (sex and age) along with a questionnaire. The results suggested significant correlations for both sex of patient and sex of clinician. Female patients were seen as having a better prognosis ( $r=.23, p<.01$ ) and better psychosocial functioning ( $r=.19, p<.05$ ). Female clinicians recommended case management more than male clinicians ( $r=.32, p<.01$ ) and rated patients as having better psychosocial functioning than

did male clinicians ( $r=.22, p<.05$ ). Female clinicians also considered family of origin issues to be more salient than did male clinicians ( $r=.22, p<.05$ ). Overall, the results of the study suggested that there are some differences in terms of how clinicians judge cases based on sex.

Atkinson et al. (1996) also examined biases through clinical judgment. However, in contrast to the previous study, the researchers examined clinical judgments that African American and European American psychologists make regarding skin tone of African American clients. One hundred and ninety six psychologists participated in the study (91 African American and 106 European American). Participants were asked to complete a questionnaire after reading a case presentation of an African American woman dealing with depressive and interpersonal issues. Superimposed on the upper right hand corner of the case description was one of three photographs of an African American woman. Each photograph was identical with the exception of skin tone—light, medium, or dark. European American psychologists rated specific mental disorders (Major Depression, Dysthymia, and Borderline Personality Disorder;  $M=3.55, SD=1.13, n=106$ ) as a more appropriate diagnoses than did African American psychologists ( $M=3.23, SD=1.32, n=86$ ). The canonical correlations revealed that the two groups of psychologists differed most on their ratings of client physical attractiveness ( $r=.71$ ) and potential for academic success ( $r=.34$ ). The mean Physical Attractiveness and Ability to Achieve Academic Success ratings for African American participants (Physical Attractiveness:  $M=4.15, SD=.70, n=91$ ; academic success:  $M=3.79, SD=.64, n=91$ ) were found to be significantly higher than the mean ratings for European Americans (Physical Attractiveness:  $M=3.75, SD=.69, n=105$ ; academic success:  $M=3.59, SD=.78,$

n=106). In general, African American psychologists provided higher ratings for the client as compared to European American psychologists. Overall, the results of the study suggested that race-ethnicity of the psychologist influences judgments that he/she makes about an African American female client.

Rosenthal and Berven (1999) also explored the effects of client race (African American vs. White) on clinical judgment. The researchers hypothesized that more negative clinical impressions and estimates of future potential would be found when a client was portrayed as African American than when portrayed as White. Ninety-nine White, master's degree students in rehabilitation counseling participated in the study. Participants were asked to review case materials regarding a client served by a rehabilitation agency and to also rate the client. The results suggested that the client seemed to be viewed as having less potential when portrayed as African American ( $M_{z^{\wedge}} = -0.267$ ,  $SD_{z^{\wedge}} = 0.806$ ) than when portrayed as White ( $M_{z^{\wedge}} = 0.219$ ,  $SD_{z^{\wedge}} = 0.872$ ),  $\tau(89) = -2.74$ ,  $p = .004$ . After reviewing the initial client information, participants' mean ratings on the highest educational level that the client might eventually achieve were 2.66 when portrayed as African American and 3.16 when portrayed as White (3 rating represented 6 months to 1 year of technical school training or a 1-year diploma); after reviewing the subsequent information, participants' mean ratings were 3.85 and 4.22, respectively (4 rating represented 1 to 2 years of technical school training or a 2-year diploma). After reviewing initial client information, they rated the mean hourly wages of the three highest-level occupations that the client was viewed as potentially achieving as \$9.66 when portrayed as African American and \$11.24 when portrayed as White. After reviewing subsequent information, participants rated the

mean wages as \$12.01 and \$13.31, respectively. Overall, the results suggested that effects of client race were found on estimates of future potential, but not on clinical impressions.

Thus far, the above-mentioned studies have explored the way in which clinical judgment is influenced by specific biases related to sex and race. These variables are important to consider as they could impede the therapeutic process if they are not addressed (Hansen & Reekie, 1990; Atkinson et al., 1996). The following studies will address additional variables, ideology and religion, which also influence clinical judgment.

*Ideology and Religion.* Lewis and Lewis (1985) explored the effects of client and therapist religious affiliation on therapists' diagnostic and prognostic impressions. Seventy-seven psychologists participated in the present study. On the initial questionnaire, 40 therapists reported an affiliation with a particular denomination, whereas 33 reported no religious affiliation. Thirty of the nonreligious therapists held Ph.D.s, 2 held Ed.D.s, and 5 held M.A.s. Of the religious group, 30 held Ph.D.s, 4 held Ed.D.s, and 6 held M.A.s.

Participants were randomly assigned to one of two conditions. The conditions differed in regard to how the client described her symptoms. One tape included the client discussing her issues using religious terminology (e.g., loss of relationship with God and inability to pray), whereas the client in the other tape discussed similar content in nonreligious terminology. In both conditions, participants listened to an audiotaped clinical interview between a male psychiatrist and a 54-year-old woman with depression. The participants also completed seven measures. First, they were asked to report their

political attitudes on a 5-point scale (very liberal to very conservative). Second, they were asked to report their religious attitudes on a 5-point scale. Third, after completing the study, a questionnaire regarding the importance of religion in one's life was sent to the participants. Participants were asked to describe the client on a 4-point scale (very evident religious orientation to religious orientation not in evidence). Fourth, participants were also asked to report their perceptions of the client's sex role attitudes on a 5-point scale. Fifth, a modified form of the Therapist Personal Reaction Questionnaire (TPRQ), measuring therapist-perceived attractiveness, was administered. Sixth, an eight-question schedule adapted from Graham (1980) was used to measure therapists' prognostic expectations. Therapists also estimated the number of sessions required before the client was expected to make any progress in therapy. Lastly, participants were asked to give a diagnosis based on the DSM III.

A two-way ANOVA was performed on the TPRQ, and neither therapist,  $F(1, 73)=1.20$   $p<.05$ , nor client religion,  $F(1, 73)=2.01$ ,  $p<.05$ , affected therapist attraction to the client. A MANOVA was performed on the schedule adopted from Graham (1980), and therapists saw the religious client as requiring fewer therapy sessions as compared to the nonreligious client,  $F(1, 73)=3.96$ ,  $p<.05$ . Also, religious therapists were significantly more likely to select the clients in both of the taped interviews for their caseloads than were nonreligious therapists,  $F(1, 73)=4.55$ ,  $p<.03$ . In other words, religious therapists wanted the clients as part of their caseload. A 2x2 ANOVA was performed on therapists' ratings of the impact of religion on the client's current disorder. A significant main effect for tape was obtained,  $F(1, 73)=11.72$ ,  $p<.001$ . Thus, religion was seen as having a significantly larger impact on the problems of the religious client as compared to the



nonreligious client. Chi-square analysis indicated no effect for therapist or client religion. The analysis also indicated that neither therapists' religious affiliation nor client's religious orientation was related to the tendency to assign a particular diagnosis. Overall, this study did not suggest that therapist diagnoses were biased by their own and/or client's religions, however there appeared to be some biases. Moreover, according to the researchers, religion was viewed as having a significantly greater impact on the problems of the religious versus nonreligious patient.

Houts and Graham (1986) conducted a similar study, however they were more specific with regard to religious affiliation. They explored the influence of traditional Christian values of therapists and clients on clinical judgments. A letter was generated to invite therapists who were listed either in the yellow pages or local listings in the Directory of Psychologists and Psychological Examiners Licensed and Registered in Tennessee (Board of Examiners, 1983). Forty-eight therapists (24 religious/24 nonreligious) participated in the present study. They all completed a demographic questionnaire, including questions about their religious affiliation.

There were three experimental conditions. Participants read one of three videotapes that depicted an intake interview between a male client and a male therapist. All scripts were identical with the exception of religiosity. The distinctions were very religious, moderately religious, and nonreligious. Four weeks following initial contact, participants were randomly assigned to view one of the videotapes. The Clinical Judgment Scale (CJS) assessed participant's initial impressions. The clinician's perceptions of client psychopathology were assessed with the Health Sickness Rating Scale (HSRS). The HSRS presents a 100-point continuum of psychopathology

(Luborsky, 1962). Four questions about the therapists' attributions were included to assess the extent to which participants attributed clinical problems to external, circumstantial factors versus internal, and dispositional factors.

Based upon analyses of variance, the results suggested that client religious values influenced therapists' judgments irrespective of therapists religious values,  $F(2, 42)=4.82$ ,  $p<.05$ . Newman-Keuls follow-up tests ( $p<.05$ ) suggested that all therapists judged the moderately religious client as having a more pessimistic therapeutic prognosis as compared to the very religious or the nonreligious. The authors suggested that the moderately religious client was judged more pessimistically because of the level of doubt that was communicated by the client. The analysis of HSRS ratings yielded an effect for client religious values,  $F(2, 42)=3.64$ ,  $p<.05$ . Newman-Keuls tests ( $p<.05$ ) suggesting that both therapist groups saw the moderately religious client as more disturbed than the very religious client. The ANOVA on clinicians' attributions for the cause of the client's problem showed that attributions varied jointly as a function of the client and clinicians' religious values,  $F(2, 42)=5.18$ ,  $p<.01$ . Religious therapists made more internal attributions for the nonreligious client than did nonreligious therapists. Conversely, within the nonreligious group, the very religious client elicited more internal attributions than did the nonreligious client (Newman-Keuls,  $p<.05$ ). Overall, the results of the study suggested that a client's religious values influence the therapists' clinical judgments. The results also suggested that the therapist might view this client (e.g., a moderately religious client as previously illustrated) as more disturbed as compared to a very religious client. Furthermore, nonreligious therapists made more internal attributions to religious clients as compared to nonreligious clients.

Similar to the aforementioned study, Cannon (2002) examined the impact of specific religious values on clinical judgment. However, in addition to religious values, the researcher examined another variable, clinicians' training and supervision on clinical judgment. In general, the effects of client's fundamental-evangelical religious orientation, clinicians' religious orientation, and clinicians' training and supervision on clinical judgment were examined. There were 207 participants, all of whom had doctoral client and the other, a fundamental-evangelical highly religious Christian client), and a Clinical Judgments and Impressions scale). Overall, the results suggested that the interaction between client religious orientation and therapist religious orientation would significantly predict various clinical judgment variables. More specifically, for the criterion variable (overall clinical evaluation), the overall regression equation was significant ( $p = .003$ ) and predicated 9.5% of the variability in overall clinical evaluation. Client religious orientation was a significant predictor, revealing that the religious client received a less positive clinical evaluation than did the no-mention-of-religion client [or neutral client] (Cannon, 2002). No support was found for the training variable. Again, recognizing the potential biases around religious values seems important for the therapist.

Gartner et al. (1990) also conducted a study examining variables that influence clinical judgment. However, in contrast to the above-mentioned studies, the researchers did not focus on religious affiliation. Instead, the general influence of client and therapist ideology on clinical judgment was examined. Three hypotheses were explored in the present study. First, they hypothesized that therapists respond more negatively to ideological clients than to non-ideological clients. Second, they hypothesized that therapists respond more negatively to clients whose ideologies are on the opposite end of

the ideological spectrum from their own. Third, they hypothesized that therapists who themselves hold a more extreme ideological orientation respond more negatively than moderate therapists to clients whose ideologies are on the opposite end of the ideological spectrum from their own.

The present study included 363 clinical psychologists who were randomly selected from a list of clinical psychologists in the National Register of Mental Health Service Providers in psychology. Participants were asked to rate two written case history vignettes using the clinical judgment scale (CJS; Wallach & Strupp, 1960). One vignette described a client with an extreme political or religious group (Fundamentalist Christian—a right wing religious group, John Birch Society—a right-wing political group, Atheists International—a left-wing religious group, and American Socialist Party—a left-wing political group), whereas the other vignette described a client with no mention of ideology. Participants were also asked to complete a demographic questionnaire and to indicate their own religious and political ideology using a likert-type scale.

A multivariate analysis of variance for repeated measures tested the hypotheses. Hypothesis one was supported; clinicians were influenced by patient ideology. Seven percent of the non-ideological clients received obsessive-compulsive disorder as compared to twenty percent of the ideological clients. Sixty four percent of the non-ideological clients were diagnosed with generalized anxiety disorder as compared to forty-nine percent of the ideological clients. Hypothesis two was supported; clinicians rated clients more negatively if they held an ideology opposite of their own, but only when the client promoted empathy. Both liberal and conservative clinicians were more

likely to express a personal preference for patients of their own ideological type. Hypothesis three was supported for judgments of maturity. Clinicians who strongly identified themselves as liberal rated right-winged clients as less mature than left-wing clients. In contrast, clinicians who identified themselves as moderately liberal rated right-winged clients more positively than left-wing clients. Overall, the results suggested that the clients with an extreme ideology were rated more negatively. In addition, ideological clients were perceived as more disturbed than non-ideological clients.

The following section is two-fold, as it presents a more specific view of religious values through the examination of religious orientation. First, this section will present theoretical literature regarding religious orientation, the extrinsic, intrinsic, and quest dimensions of the Three Dimensional Religious Orientation Scale (3-D ROS) (Batson & Ventis, 1982). Second, empirical literature including these dimensions will be discussed.

### *Religious Orientation*

“Therapists generally are more religious than would be expected, even though they are not as traditional as the general public.” (Bergin, 1991, p. 396). According to a survey conducted by Bergin and Jensen (1990), of 425 therapists, 77% professionals (psychotherapists) agreed with the statement, “I try hard to live by my religious beliefs,” and 46% agreed with the statement, “My whole approach to life is based on my religion.” However, only 29% of professionals rated religious content as important in treatment with all or many clients (Bergin, 1991). Furthermore, there seems to be a spiritual/religious interest among clinicians that is unexpressed due to the secular framework of the profession. Bergin and Jensen (1990) suggested that the lack of expression regarding religious involvement is due to their being little consideration of

such expression in training, education, and practice. Therefore, it is important to recognize that although many clinicians work within secular settings, they may have religious beliefs that have an impact on the way in which they work with religious clients.

Because recognizing the impact of religious beliefs is critical, Gordon Allport examined the concept of being religious. Consequently, Allport's distinction between extrinsic (immature) and intrinsic (mature) religion is the most popular conception of being religious (Batson, Schoenrade, & Ventis, 1993) within psychology. In their quantitative study, Allport and Ross (1967) provided extensive, formal definitions of extrinsic and intrinsic orientations. The *extrinsic orientation* was defined as a person who uses religion for his/her own ends. It can be defined by the extent to which a value is placed upon social interactions, relationships, and acceptance. Extrinsic values are always instrumental and functional. Persons with this orientation may find religion useful in a variety of ways—to provide security and solace, sociability and distraction, status and self-justification. The person with an *intrinsic orientation* finds satisfaction within the religion. It is a pure form of religious orientation, guided by faith and recognition from God and not external satisfaction. Other needs, strong as they may be, are regarded as of less significance than the relationship with God. Having embraced a creed, the individual endeavors to internalize religion and follow dutifully.

*Examination of the ROS.* The Religious Orientation Scale (ROS) (Allport & Ross, 1967) is well known in research and designed to measure religious orientation (Maltby & Lewis, 1996). Though the original development of the ROS is still used today, it has not gone unchallenged. The ROS has generated a significant number of theoretical and empirical investigations, and researchers are still attempting to understand

the complexity of this scale (Genia, 1996; Trimble, 1997). Since the beginning of its conceptualization, the intrinsic and extrinsic dimensions have undergone several operational definition changes. For example, there was a distinction between individuals who accept religion unreflectively or uncritically and those who accept religion reflectively. Now the concepts extrinsic and intrinsic are used, respectively. During this developmental process, the extrinsic and intrinsic dimensions have been challenged through criticism for its lack of specificity and clarity in the literature (Batson, Schoenrade, Ventis, 1993; Gorsuch & Venable, 1983; Kirkpatrick, 1989; Trimble, 1997).

It is difficult to acquire a clear understanding of early investigations regarding the ROS, as researchers often reported insufficient details regarding their work. Consequently, other researchers (Hoge, 1972; Kirkpatrick, 1989; Gorsuch & Venable, 1983) have attempted to further investigate and improve the validity and reliability of the ROS. However, the investigations have only raised additional questions. For example, both Gorsuch and Venable (1983) and Kirkpatrick (1989) made significant contributions in refining the ROS. Gorsuch and Venable refined the ROS for age appropriateness while Kirkpatrick examined the psychometric properties. However, they excluded major contributors (e.g., Hoge, 1972,) who suggested previous revisions.

Furthermore, Batson et al. (1993) examined the ROS and suggested that the extrinsic and intrinsic dimensions do not actually measure two distinct types of religious orientation. Instead, the extrinsic and intrinsic dimensions seem to measure independent continuous dimensions. Therefore, dimensions could conceivably measure other unrelated dimensions. For example, an individual may be in denial about his/her need for achievement of personal and/or social gains through religion. Therefore, he/she may

score intrinsically when actually his/her motivation represents an extrinsic motivation. In Allport's early theoretical writings, he discussed the concept of mature religion, which included three characteristics that are now missing from the measure of intrinsic religion—encouraging the individual to face complex problems such as ethical responsibility and evil, a readiness to doubt and be self-critical, and an emphasis on incompleteness and tentativeness (Batson & Ventis, 1982). As a result, Batson (1976) and Batson and Ventis (1982) introduced their three-dimensional religious orientation scale (3-D ROS)—means (extrinsic), end (intrinsic), and quest (the degree to which an individual's religion involves an open-ended, responsive dialogue with existential questions raised by the contradictions of life; also includes open-mindedness and flexibility). Four additional scales—Internal, External, Interactional, and Doctrinal Orthodoxy were also added to the 3-D ROS. However, for the ease in administration, the additional scales will not be discussed nor will they be considered for the current study. Instead, an abbreviated form of the 3-D ROS, including extrinsic, intrinsic, and quest will be considered. Results from other studies utilizing the 3-D ROS have not only suggested that religious orientation affects life experiences, but that it also influences the way in which clinicians respond to their clients who are religious.

*The ROS and Empirical Research.* Lyons and Zingle (1990) used the 3-D ROS to examine client ratings of pastoral counselor responses. Specifically, the relationship between religious orientation and empathy in pastoral counselors was examined. The researchers hypothesized that in a client rating of pastoral counselor empathy, a significant difference between quest and end-oriented (intrinsic) counselors would not be



found. They also hypothesized that means-oriented (extrinsic) pastoral counselor would be perceived as significantly less empathic than quest or end-oriented counselors. There were 67 clergy and 124 clients, each of whom was involved in counseling with one member of the clergy. The 3-D ROS (Batson & Ventis, 1982) was administered to the clergy. The Truax-Carkhuff (1967) Relationship Questionnaire was also administered to the clients. This 47 true-false questionnaire included items that described a client's perceptions of his/her counselor. The results suggested that the mean ratings for the three counselor religious orientations were: means (extrinsic; 35.5), end (intrinsic; 38.5), and quest (39.2). The Duncan Multiple Range Test ( $\alpha=.05$ ) showed that clients rated end and quest-oriented clergy as significantly more empathic in the counseling setting than means-oriented clergy. There was no significant difference between quest and end-oriented (intrinsic) counselors.

Lyons and Zingle (1990) suggested that individuals with end and quest orientations function more effectively in counseling. Conversely, they suggested that means-oriented individuals seem to be less capable of demonstrating the same level of effectiveness or empathy. Lyons and Zingle also suggested that a means orientation leads one to attain nonreligious aims such as status or social relations. Furthermore, the researchers believe that a means oriented individual is more occupied with his/her own needs to be genuinely sensitive to someone else's needs. Overall, Lyons and Zingle's study suggested that an end or quest orientation is related to an empathic disposition. Though this study included clergy as opposed to laypersons, it still addressed the

importance of how religious orientation influences the way counselors or clinicians respond to clients.

The following section will build upon the current section by addressing the concerns that clients have about their therapist addressing religious issues. The clinician's views on religious issues may have an impact on clinical judgment, particularly when the therapist and the client have different ways of existing in the world.

#### *Client Concerns about Therapists' Treatment of Religious Content*

Ignoring religious issues within the context of therapy could have a serious impact on the development of the therapeutic alliance (Ross, 1994). For example, if clients feel ignored they might interpret this behavior as unempathic. According to Bergin and Jensen (1990), it is not uncommon for secular therapists to challenge or advise clients who are religious to give up their religious commitment for the purpose of "advancing" the progress of therapy. Worthington (1991) labeled a similar process as a "hit-and-run style," where the therapist only deals with the religious issues superficially because he/she views them as marginally important. Therapists might discourage their clients from religiousness, and claim that by doing so, more opportunity for therapeutic change may occur. Consequently, challenging the client to give up religiousness also ignores his/her sense of identity and integrity (Bergin & Jensen, 1990). The following empirical studies explored how challenging and/or ignoring a client's religious beliefs influences the perception of and trust for the therapist. In addition, these studies explicitly address Christian beliefs of the participants.

Morrow, Worthington, and McCullough (1993) used the analogue-to-counseling method to examine Christians with relatively high, conservative, evangelical beliefs as well as those with relatively low, conservative, evangelical beliefs. High versus low Christian beliefs were measured using The Shepherd Scale. However, this scale is not able to definitively categorize individuals into Christian versus non-Christian groups (Bassett, 1981). Therefore, the scale was used to categorize participants into high versus low conservative, evangelical beliefs based upon an extreme range of scores. The researchers hypothesized that participants endorsing highly religious beliefs would respond to religious issues differently than would participants with fewer such beliefs.

One hundred and two undergraduate psychology students participated in the study. Participants were randomly assigned to view one of three 10-minute videotapes (support, ignore, and challenge) of a counseling scenario. The counselor either supported the client by suggesting an exploration of Christian values, ignored the client by suggesting that the client's family influenced his/her religious values, or challenged the client by suggesting that the client was mature enough to question his/her religious upbringing. The first seven minutes of videotape consisted of a clinical psychologist with a female graduate student. The three videotapes differed only within the last three minutes. During this time period, the counselor responded differently to the client's religious beliefs. The participants completed five instruments for the study. These instruments included: 1) the Shepherd Scale, which included a measure of evangelical Christian beliefs and practices; 2) the Tape Rating Scale, which measured the participants' attraction and receptivity to the counselor; 3) the Persuasibility

Questionnaire, which measured the degree to which the counselor persuaded a participant; 4) participants ratings of expectation for client change, likelihood of referral, and likelihood of client and participant's return, using three 8-point items used by Worthington and Gascoyne (1985); and 5) social desirability was also measured by the MMPI—K scale (Minnesota Multiphasic Personality Inventory).

A 2x3 MANCOVA (Christian belief x counselor's treatment of client's religious values—support, ignore, challenge) was performed. The multivariate main effect for the counselor's treatment of the client's religious values, as measured by the Persuasibility Questionnaire), was significant, multivariate  $F(16,174)=2.35, p=.004$ . The main effects for both social desirability and level of Christian belief, however, were not significant. Follow-up ANCOVAs were also performed to determine the locus of the multivariate main effect for counselor's treatment of religious values. Significant results were found for the degree to which the participant was persuaded by the counselor  $F(2,95)=3.96, p=.02$ , predicted change of the client  $F(2,95)=3.96, p=.04$ , and likelihood that the participant would have returned for the next session  $F(2,95)=4.18, p=.02$ . A post hoc analysis suggested that participants were more persuaded by the counselor who ignored the client's religious values than they were by the counselor who supported the client's religious values. Participants who viewed the challenging counselor rated themselves less likely to return for the next session had they been the client ( $M=4.3, SD=2.3$ ) than did participants who viewed the other two conditions (Support,  $M=5.5, SD=2.2$ ; Ignore,  $M=5.7, SD=2.1$ ). Overall, the results of the study suggested that most college students

expect counselors to support a client's religious beliefs rather than challenge a client's religious beliefs.

McCullough and Worthington (1995) partially replicated and extended the aforementioned study using the analogue-to-counseling method. They stated that the Shepherd Scale, which was used in Morrow et al. (1993), measured content of religious beliefs rather than content of religious values. The measures of religious values might assess a participants' perception of a counselor's response to religious issues (McCullough & Worthington, 1995). Therefore, the researchers hypothesized that participants, based upon high or low religious values as opposed to religious beliefs, would respond differently to counselors who support or challenge the client's religious values. One hundred and forty-eight undergraduate psychology students participated in the study. Two 10-minute videotapes of a counseling scenario were shown to the participants. The first seven minutes of videotape consisted of a clinical psychologist with a female graduate student. The two videotapes differed only within the last three minutes. During this time period, the counselor either supported the client's religious values by encouraging the client to hold on to her Christian values or challenged the client by suggesting that she question her religious upbringing. The participants completed six instruments: 1) the Shepherd Scale, which included a measure of evangelical Christian beliefs and practices; 2) the Measure of Christian orthodoxy, which included Glock and Stark's (1965) subscale of the Orthodox Christian Belief Scale; 3) the Religiosity Self-Rating, which is a measure of religious beliefs based upon Kelly's (1990) taxonomy of religious commitment; 4) the Religious Values Scale (RVS), which

is a measure of religious commitment and authority afforded sacred writings and tolerance for those holding different views for scriptures as examples.; 5) the Tape Rating Scale was administered; and 6) a questionnaire, which assessed the likelihood of referral and the likelihood of client and participant's return, was also administered.

Post hoc univariate ANOVAs revealed a significant univariate interaction for likelihood of referring a Christian friend  $F(5, 135) = 3.98, p < .05$  and a non-Christian friend  $F(5, 135) = 4.09, p < .05$ . Participants with the highest level of religious commitment, as measured by the Religiosity Rating Scale were more likely to refer a Christian friend to the supportive counselor than to the challenging counselor. Participants with low religious commitment, as measured by the Religiosity Rating Scale, were more likely to refer a non-Christian friend to the challenging counselor than to the supportive counselor. Post hoc univariate ANOVAs revealed significant univariate interactions for observers' attraction to the counselor  $F(1, 117) = 9.97, p < .05$ ; receptivity to the counselor  $F(1, 117) = 14.22, p < .05$ ; and likelihood of observer return  $F(1, 117) = 4.92, p < .05$ . Participants who afforded low authority to religious group identification, as measured by the Religious Values scale, were more attracted to the challenging counselor than to the supportive counselor. Post hoc comparisons revealed that observers with low tolerance for different religious groups, as measured by the Religious Scale, were more attracted to the challenging counselor than to the supportive counselor. Participants with high tolerance for different religious groups were more receptive to the supportive counselor than to the challenging counselor. Overall, the results of the study suggested

that people with strong religious values perceive counseling differently than people with weaker religious values.

McCullough, Worthington, Maxey, and Rachal (1997) expanded the work of both Morrow et al. (1993) and McCullough and Worthington (1995) by considering the role of gender in the analogue-to-counseling protocol. Three hypotheses were generated. First, the researchers speculated that the counselor's gender would influence how participants responded to his/her interventions that either challenged or supported a client's religious values. Second, the effects of a counselor's gender on participants' responses to the interventions would at least be partially influenced by participants' perceptions of the counselor's religiousness. Third, the researchers expected to replicate previous studies (e.g., Keating & Fretz, 1990; McCullough & Worthington, 1995) that demonstrated that participants' responses to religious interventions are influenced by the interaction of the clients' religious commitment and qualities of the counselor or the religious interventions themselves. In general, McCullough et al. (1997) expected that religious commitment would be positively related to participants' ratings of the counselor in the supportive intervention and negatively related to participants' ratings of the counselor in the challenging intervention.

Two hundred and thirty-nine individuals from an introductory psychology course participated in the study. They all identified as Christian. The Religious Commitment Scale (RCI), which included the Worthington, Hsu, Gowda, and Bleach's (1988) RCI (measures motivational and behavioral commitment to a religious value system); perception of counselor religiousness, which measured the participants' perceptions of

the videotaped counselors' religiousness; and the Tape Rating Scale-Revised, which measured participants' attitudes toward the counselors were all included in the study. One of sixteen 10-minute videotapes was shown. Within the total number of videotapes, there were four counselors (two male and two female) and four clients (two male and two female). Each of the four counselors was involved in two videos with a female client (one supporting the client's religious values and one challenging the client's values) and two videos with a male client (one supporting and one challenging).

A 2 (participant gender) x 2 (counselor gender) x 2 (client gender) x 2 (religious intervention—challenging versus supportive) ANOVA was performed. In the supportive condition, the simple effect of counselor gender was not significant  $t(103) = -.70$ , indicating that participants viewed both female and male counselors equally favorably. However, in the challenging condition, the effect for counselor gender was significant  $t(102) = -4.77$ ,  $p < .001$ , indicating that female therapists were viewed more favorably than male therapists. Further, the interaction of religious commitment and condition was significant  $F(1, 169) = 9.21$ ,  $p = .01$ . For participants who viewed the supportive intervention, religious commitment was positively correlated with scores on the TRS-R ( $p < .001$ ). Conversely, for participants who viewed the challenging condition, religious commitment was negatively correlated with scores on the TRS-R ( $p < .05$ ). The main effect of counselor gender was also significant ( $p < .0001$ ). In general, participants rated the sessions with female counselors more favorably than the sessions with male counselors.



In general, it appeared as though participants rated female counselors more positively than they rated male counselors. McCullough et al. (1997) suggested that religious commitment was positively related to perceptions of counselors who performed the supportive intervention but negatively related to perceptions of counselors who performed the challenging intervention. Lastly, the results also suggested that gender influenced participants' ratings of the counselor who challenged the clients' religious beliefs. In other words, the perception was that female counselors seemed to be "more Christian" than the male counselors.

Collectively, the following above-mentioned studies suggest that a therapist may have power to persuade his/her Christian client, especially when the therapist is challenging the client. A Christian client who has strongly committed to his/her Christian beliefs might be more likely to refer other Christians to a therapist who is supportive rather than challenging. Furthermore, the decision to refer other Christian clients further speaks to the therapeutic experience of the client. Gender may also play a significant role in how Christian clients perceive therapists, particularly during a therapeutic process that appears to be threatening or challenging. However, gender has not been the focus of many studies exploring a therapist's treatment of Christian religious issues. It seems critical for therapists to have an awareness of how they are responding to Christian clients in therapy. Therapists can never be certain of when they might be called to help clients integrate religious beliefs and coping skills (Ross, 1994). Furthermore, helping clients with this integration can be accomplished if therapists are willing to confront their attitudes and behaviors regarding religion.

### *Conclusion*

The literature in this chapter has highlighted a number of critical issues that are important to consider when clinicians make clinical judgments. Clinical judgments are influenced by a number of variables—race, ethnicity, gender, and religious orientation. Issues regarding race and ethnicity influence clinical judgment, as it is important for clinicians to be aware of how their biases could lead to nontherapeutic outcomes. Clients may be assigned inappropriate diagnoses based upon the clinicians' comfort level in working with someone from a different racial or ethnic background. Gender also influences clinical judgment, as female clients may be perceived as having more psychological difficulty than males. However, there are times when female clients may be viewed more positively as a result of guilty feelings or overcompensation by the clinician. Religious orientation also influences the way in which clinicians respond to their clients. This may be true, especially when the clinician and the client have different religious orientations. The clinician may not be able to relate to religious content if he/she does not identify with or lacks knowledge about them (Genia, 1994). This lack of identification or lack of knowledge could also have an impact on the clinicians' expectations or goals for therapy. As a result, the therapist may approach therapy with his/her own agenda or need while ignoring what is best for the client (Marrow, Worthington, & McCullough, 1993).

### *Purpose of Study*

There are a number of studies that have generally explored clinical judgments that clinicians make regarding their clients (Gartner et al., 1990; Kelly & Strupp, 1992;

Kivley, 1986). However, there are only a few studies that have directly explored clinical judgment in relation to clients who are religious (Houts & Graham, 1986; Lewis & Lewis, 1985). Furthermore, the majority of the studies that have included a religious dimension are dated. Third, none of these studies have exclusively explored clinicians in training. Instead, professionals within the field of psychology and psychiatry have participated in these studies. The participants who have been involved in these studies have appeared to be mixed, convenience samples. Furthermore, this study is being conducted to examine the extent to which differences in clinicians' clinical judgments (as measured by the Therapist Personal Reaction Questionnaire—TRPQ) for clients of varying religious orientations (extrinsic, intrinsic, and quest) attributed to clinicians' background factors (age, sex, race, field of study, highest degree earned, and number of years conducting psychotherapy), social desirability scale values, and religious orientation.

### *Research Questions*

1. To what extent are differences in clinicians' clinical judgments (as measured by the TPRQ) for clients of varying religious orientations attributed to clinicians' background factors (age, sex, race, field of study, highest degree earned, and number of years conducting psychotherapy)?
2. To what extent are differences in clinicians' clinical judgments (as measured by the TPRQ) for clients of varying religious orientations attributed to clinicians' social desirability scale values?

3. To what extent are differences in clinicians' clinical judgments (as measured by the TPRQ) for clients of varying religious orientations attributed to clinicians' religious orientation, after accounting for the variance attributable to both background factors and social desirability?

## Chapter Three

### Method

This chapter describes the participants and their recruitment for this study. Information regarding the instruments, data analysis procedures, and hypotheses is also provided

#### *Participants*

A total of 307 individuals responded to the survey. Of the total number of participants, 272 completed the survey. The remaining 35 participants did not complete the survey, and 17 participants were excluded from the analyses, as they did not meet the criteria for this study. These participants reported already completing a Ph.D. Two additional participants were excluded because they reported being enrolled in programs other than counseling or clinical psychology. Finally, 67 participants reported their highest degree either as a B.A. or B.S. with no indication of pursuing an M.A. or Ph.D. in Counseling or Clinical Psychology. Thus, a total of 186 participants were used in the final data analyses.

The participants in the study were male and female clinicians-in-training at either the master's or doctoral-level enrolled in an APA-approved graduate program in Clinical Psychology or Counseling Psychology. The age of participants ranged from 22 to 56 years old (mean=30.48,  $SD=7.11$ ). More women than men ( $n=147$  and  $n=39$ , respectively) participated in the survey. The sample was primarily White ( $n=162$ ). Other racial groups included Latinos ( $n=10$ ), Asian Americans ( $n=8$ ), African Americans ( $n=4$ ), and "Other" ( $n=12$ ). The majority of the sample was enrolled in either a Clinical

Psychology program ( $n=119$ ) or Counseling Psychology program ( $n=66$ ). There was one participant who identified “Other” for the field of study. This participant indicated “clinic,” for field of study. Most of the participants had completed a master’s degree ( $n=184$ ) or “other” ( $n=2$ ). Two participants had completed a B.S. The sample was composed mainly of those who had been doing therapy for 1-3 years ( $n=82$ ), followed by those who had provided therapy between 4-6 years ( $n=62$ ), and lastly, more than 7 years ( $n=14$ ). The percentage of caseload concerns related to religious issues was slightly over 10% (mean=10.53%,  $SD=11.07\%$ , range 0%-60%).

### *Recruitment*

In an effort to increase the likelihood of obtaining the desired number of participants, two recruitment strategies were implemented for the present study. First, participants were recruited via APA. In accordance with APA policy, a copy of this proposal was submitted to the APA Research Office for review and approval to recruit APA members. Upon approval, a recruitment notice (Appendix A) was posted to specific listservs within APAGS (American Psychological Association of Graduate Students), including APAEMGS (concerning ethnic minority students), APAGSINTERNSHIP (students currently on internship), APAGSWOMEN (issues related to women), CLINAPAGS (students studying clinical psychology), and PSYCGRAD (graduate students of psychology). In addition, the recruitment notice was also sent to listservs affiliated with Division 12 (Society of Clinical Psychology) and Division 17 (Society of Counseling Psychology).

Second, listserv managers of two training councils were also contacted. The

Executive Board Members of the Council of Counseling Psychology Training Programs (CCPTP) agreed to forward my recruitment notice to training directors within this organization. I also obtained permission to contact directors of training individually through the Council of University Directors of Clinical Psychology (CUDCP).

Therefore, training directors were contacted individually, and subsequently a recruitment notice was forwarded to those training directors.

### *Procedure*

All instruments were posted to a web site coordinated by [www.psychdata.com](http://www.psychdata.com). Participants read the recruitment notice (Appendix A) for the present study and an informed consent (Appendix B). Only those members who indicated acknowledgement of the informed consent were allowed to continue with the study. An incentive to enter into one of four random drawings for \$25.00 was included in all the notices.

Upon completion of the informed consent, participants completed one demographic and background questionnaire (Appendix C). They were then prompted to read one of three randomly assigned vignettes (Religious Mary, Nonreligious Mary, and Spiritual Mary—Appendices D, E, and F), and complete three measures (The Three-Dimensional Religious Orientation Scale [3-D ROS], the Therapist Personal Reaction Questionnaire, and the Social Desirability Scale)—Appendices G, H, and I). The measures were submitted in the same order to all participants. Participants were not asked to submit their names during the procedure.

A pilot study involving 29 people was conducted for the purpose of receiving feedback about the survey, including formatting; ensuring that the measures within the

survey as well as the procedures were clear; and to evaluate the length of time it took to complete the entire survey. Once the pilot study participants completed the survey, they provided feedback by completing a 9-question survey about their experience. Overall, the feedback seemed to be minimal and similar among participants. As a result of the feedback, the content was formatted to facilitate ease of navigation and instructions/response sets were clarified for some items. On average, participants reported that it took them approximately 20 minutes to complete the survey, and I updated the informed consent for the study so that future participants had an accurate assessment of the time commitment. Multiple comments were received via email during both the pilot and the actual study from participants who expressed concern about items, particularly those on the 3-D ROS. Participants generally expressed that the items were too personal, too vague, and too confusing. Participants stated that the items did not apply to their personal beliefs. For example, the beginning of the Likert scale for the 3-D ROS provided a response of “Strongly Disagree,” which seemingly led some participants to believe that they were still subscribing to some type of religious belief despite the option to “strongly disagree.” This information was noted but no changes were made to the study as a result of this feedback as most of the comments centered around particular items and instructional sets. I did not feel that I could change these aspects of the measures without risking invalidation of the psychometric properties of these instruments.



### *Measures*

*Demographic and Background Questionnaire (Appendix C).* This form requested the following demographic information: age, sex, race, field of study, highest degree obtained, and number of years conducting psychotherapy related to clients and religious issues.

*Clinical Vignettes (Appendices, D, E, and F).* The vignettes used in the study were named Religious Mary, Nonreligious Mary, and Spiritual Mary. Each vignette depicted the same female client who was religious, spiritual, or nonreligious. Two of the three vignettes (religious and nonreligious female) were originally used in Hillowe's (1985) study that explored the effect of interactions between the therapists' and patients' religiosity. The same vignettes were also used in studies conducted by Shafranske and Malony (1990) and Feeser (1997). Shafranske and Malony (1990) used the vignettes to examine the presence or absence of bias toward clients holding a religious perspective. In addition to using the same vignettes, Feeser (1997) developed an additional vignette, depicting a spiritual female client. Her study examined the effects of counseling psychologists' beliefs on perceived attractiveness and overall prognosis of a religious, spiritual, or nonreligious client.

*The Three-Dimensional Religious Orientation Scale (3-D ROS) (Appendix G).*

The Three-Dimensional Religious Orientation Scale (3-D ROS; Batson & Ventis, 1982) was developed to categorize individuals according to their means (intrinsic), end (extrinsic), or quest orientation to religion. The development of the means (intrinsic) and end (extrinsic) dimensions were inspired by Allport and Ross's (1967) Religious

Orientation Scale (ROS), which consists of extrinsic and intrinsic scales. The *extrinsic orientation* is defined as a person who uses religion for his/her own ends. Individuals with this orientation may find religion useful in a variety of ways—to provide security and solace, sociability and distraction, status and self-justification. The person with an *intrinsic orientation* finds satisfaction within the religion. Other needs, strong as they may be, are regarded as of less ultimate significance, and they are, so far as possible, brought into harmony with the religious beliefs. Thus, the person lives his or her religion (Allport & Ross, 1967).

Batson and Ventis (1982) modified the extrinsic and intrinsic scales to identify three previously mentioned dimensions: religion as a means, religion as an end, and religion as a quest (Lyons & Zingle, 1990). The quest dimension involves honestly facing existential questions in all their complexity, while at the same time resisting clear-cut, pat answers. An individual who approaches religion in this way recognizes that he or she does not know, and probably never will know, the final truth about such matters. Still, the questions are deemed important, and however tentative and subject to change, answers are sought. There may or may not be a clear belief in a transcendent reality, but there is a transcendent, religious aspect to the individual's life (Batson & Ventis, 1982). The means, end, and quest dimensions were not intended to type one as having either one orientation or another. Instead, each dimension was intended to be independent and orthogonal (Batson & Schoenrade, 1991). The 3-D ROS includes three religious orientation scales—extrinsic (means), intrinsic (end), and quest, as described earlier.

The scale contains 32 items. Participants responded to items using a four-point, Likert-type scale (strongly disagree to strongly agree). Participants received a score on all three dimensions (Batson & Ventis, 1993). Batson and Schoenrade (1991) reported a test-retest reliability coefficient of .73 for the complete scale. Batson and Schoenrade (1991) replaced a former version of the Quest scale by proposing a 12-item Quest scale. The new version has Cronbach's alphas in the .75 to .82 range, which generally corresponds to the internal consistency of the Extrinsic (.65 to .75) and Intrinsic (.75 to .85) scales.

*Therapist Personal Reaction Questionnaire (Appendix H):* The original Therapist Personal Reaction Questionnaire (TPRQ) was developed by Ashby, Ford, Guerney, Guerney, and Synder (1957). Test-retest correlations were computed using original data from the researchers study. They were obtained by correlating a score obtained at the fourth interview with a score obtained at the eighth interview. The development of the TPRQ is briefly summarized here. The TPRQ was originally comprised of two scales containing 35-items that measure counselor-perceived client attractiveness. One scale reflected negative reactions (e.g., hostility, resentment) to therapy with the client. The other scale reflected positive reactions (e.g., progress, achievement) to therapy with the client. Test-retest correlations were obtained by correlating a score obtained at the fourth interview with a score obtained at the eighth interview. The negative scale had a test-retest correlation of .85, while the positive scale had a test-retest correlation of .81. Goldstein (1971) modified the TPRQ, which resulted in a score ranging from 40 to 200,

and this was the counseling attraction score for the client. The higher the score, the more attractive the client was considered to be to the counselor.

The TPRQ was modified further to include 15 items by Davis, Cook, Jennings, and Heck (1977), and this version was used for the present study. The participants responded to 15 items along a five-point scale, yielding a total attraction score for each participant such that the higher the TPRQ score, the greater the attraction to the patient. The five-point scale is verbally anchored at each pole by the phrases *not characteristic of my present feelings (1)* and *highly characteristic of my present feelings (5)*. There are nine positive subjective items (range = 9 to 45) and six negative subjective items (range = 6 to -30). Adding the positive and negative scale totals will result in a possible range of -21 to 39, and result in each participant's attraction score. Higher attractiveness scores generally have been associated with desirable client behaviors (Tryon, 1989).

Davis, Cook, and Heck (1977) conducted a study using the modified TPRQ, and added a factor of 10 to each participant's composite score in order to simplify calculations. Furthermore, adding this factor ensured that all attraction scores resulted in a final possible range of -11 to 49, with a median of 19. The present study used the composite score in all analyses and also added a factor of 10 to simplify calculations.

Tryon (1989) cluster analyzed the 15 TPRQ items to explore what the instrument measures and how useful it is in assessing counselor attitudes as they relate to certain aspects of the counseling process. Cluster one has seven items assessing the attractiveness of the client as a psychotherapy candidate. The items are related to counselor feelings toward the client, and seem to assess an initial "gut reaction" to the

client after the first session. For example, one item on this cluster is “I like this client more than most.” Cluster two has eight items assessing how well the session went (Tryon, 1992). The items are related to a well-studied counseling phenomenon—premature termination. An item example for this cluster is “I was seldom in doubt about what the client was trying to say.” Adequate internal consistency was established as evidenced by a Chronbach alpha of .89 for cluster one and of .82 for cluster two.

*Social Desirability Scale (Reynolds, 1982) (Appendix I).* The short form of the Social Desirability Scale is a 13-item form (Reynolds, 1982) of the well-known Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) which contains 33 true-false items. The original Crowne and Marlowe scale has been used in a number of religious/spiritual studies (Batson, Naifeh, & Pate, 1978; Genia, 1996; Richards, Smith, & Davis, 1989). According to Paulhus (1991), social desirable responding (SDR) occurs when the respondent gives answers that make him/her look good. Therefore, the Social Desirability Scale was administered to explore how participants responded to questions in the survey packet. Reynold’s shortened form of the scale assesses the degree to which participants respond in a socially desirable manner. Participants replied to true-false items (e.g., “I have never been irked when people expressed ideas very different from my own.”). Higher scores indicate more socially desirable responses. The short form of the Marlow-Crowne Social Desirability Scale offers a brief, easy-to-administer measure (Zook & Sipps, 1985). Reynolds reported that the short form correlated .93 with the standard 33-item form. KR-20 coefficients ranged from .63 to .82 with an overall

coefficient of .74, and a six-week test-retest correlation of .74 was obtained (Zook & Sipps, 1985).

### *Research Questions*

1. To what extent are differences in clinicians' clinical judgments (as measured by the TPRQ) for clients of varying religious orientations attributed to clinicians' background factors (age, sex, race, field of study, highest degree earned, and number of years conducting psychotherapy)?
2. To what extent are differences in clinicians' clinical judgments (as measured by the TPRQ) for clients of varying religious orientations attributed to clinicians' social desirability scale values?
3. To what extent are differences in clinicians' clinical judgments (as measured by the TPRQ) for clients of varying religious orientations attributed to clinicians' religious orientation, after accounting for the variance attributable to both background factors and social desirability?

### *Analysis*

The data analysis procedure involved a combination of descriptive statistics and inferential statistics. Prior to conducting the data analysis, the data were entered into an SPSS (Statistical Package for the Social Sciences; version 13.0) data file. The data were inspected for possible coding errors or invalid entries using the missing value analysis (MVA) program in SPSS and frequencies procedures. Variables that were treated as representing interval scale of measurement data were examined for normality using skewness values and Q-Q plots. The Q-Q plots statistically determined whether or not

the sample of values followed a normal distribution. As background preparation for data analysis, the researcher also examined the relationships between the variables.

A sequential regression analysis was conducted to determine if Religious Orientation Scale scores of therapists improved prediction of Therapist Personal Reaction Questionnaire scores above and beyond what was predicted by the demographic variables (age, race, sex, field of study, highest degree completed, and years doing therapy) and social desirability scores of the therapists. Three separate sequential regression equations were performed – one for each of the three vignettes (Religious Mary, Non-religious Mary, and Spiritual Mary). SPSS REGRESSION, SPSS EXPLORE, and Q-Q plot were used in order to evaluate the assumptions for regression analysis. The statistical significance level was set a priori at  $\alpha \leq .05$ .

## Chapter Four

### Results

#### *Pre-analysis*

The data were screened prior to conducting any statistical analyses. This screening included an inspection of univariate descriptive statistics for accuracy of input, evaluating the amount and distribution of missing data, testing for heteroscedasticity, and identifying and dealing with nonnormal variables (Tabachnick & Fidell, 2001).

First, the variables were checked for univariate outliers using stem-and-leaf and box plots. There were no outliers in the data once all the participants with missing data were excluded.

Second, I evaluated the amount and distribution of missing data. Missing data were examined with regard to the scales (excluding the demographics) as outlined by Tabachnick and Fidell (2001). A total of 307 participants responded to the survey. Of the total number of participants, 272 completed the survey. The remaining 35 participants did not complete the survey, and therefore these participants were removed from the study. In addition, 17 participants who completed the survey were excluded from the analyses, as they reported already completing a Ph.D. Two additional participants were excluded because they reported being enrolled in programs other than Counseling or Clinical Psychology. Finally, 67 participants reported their highest degree either as a B.A. or B.S with no indication of pursuing an M.A. or Ph.D. in Counseling Psychology or Clinical Psychology. These participants were not part of the population



Tabachnick and Fidell (2001), “Heteroscedasticity, the failure of homoscedasticity, is caused either by nonnormality of one of the variables or by the fact that one variable is related to some transformation of the other. Homoscedasticity is related to the assumption of normality because when the assumption of multivariate normality is met, the relationships between variables are homoscedastic (p. 79).” In general, the values of the plots for each variable did not appear to show any problems. Thus, homoscedasticity was assumed.

Fourth, data variables were examined to assess if their distribution approximated normality by way of skewness and kurtosis values and Q-Q plots. When a distribution is perfectly normal, the values of skewness and kurtosis are zero (Tabachnick & Fidell, 2001). All the variables seemed to have very little kurtosis, except age, and therefore reflect a fairly normal distribution (Field, 2005). Similarly for skewness, the values were near 0, and therefore the variables were judged to satisfy the normality assumption. Please see Table 1 for skewness and kurtosis values. The standard error is based on the sample size only, and therefore it is the same for all variables. The standard errors for skewness and kurtosis are .18 and .36 respectively. The distribution of three variables was inspected more closely (i.e., the Short Form of the Marlowe-Crowne Social Desirability Scale, 3-DROS-intrinsic, and age) because the kurtosis and skewness values for their variables indicated there may be a slight problem. First, the Marlowe-Crowne Social Desirability scores were slightly skewed according to the confidence interval of the skewness values. However, when plotted using a Q-Q plot, visual inspection revealed that the variable did not appear to be skewed. Thus, it was decided to use the original

variable. Second, the non-normality of age was expected, given the population sampled. Third, there was a very small amount of kurtosis for the 3DROS-intrinsic variable. The confidence interval (CI) of the kurtosis statistic indicated that the 3-DROS intrinsic variable evidenced a small amount of kurtosis. The confidence interval (CI) should cross 0 if there is no kurtosis, and the CI was -1.6656 to -.2544. To make sure that kurtosis was not an issue, a log transformation was attempted. The log transformation did not make the CI interval of the kurtosis values cross 0, and it made the Q-Q plot of the scores deviate more from normal than the original scores. Thus, the 3-DROS intrinsic variable was not transformed.

Three independent variables based on religious orientation (extrinsic, intrinsic, and quest) were established. Demographic variables (i.e., age, sex, race, highest degree earned, and number of year conducting psychotherapy) and social desirability were additional independent variables. The dependent variable for this study was therapist reaction. Religious orientation, therapist reaction, social desirability, age, highest degree earned (e.g., M.A. or Ph.D.), and years conducting therapy were interval scaled variables whereas sex and race represented nominal data.

### *Descriptive Analyses*

Descriptive statistics including means, standard deviations, and Cronbach alpha values for the variables in the study were computed (Table 3). The possible range for Therapist Personal Reaction Questionnaire (TPRQ) was -21 to 39 with a mean score of 16.08 and a median score of 9. The TPRQ measures counselor-perceived client attractiveness. Generally, based on visual inspection of the data, the 186 final

participants had high attractiveness scores. The possible range for Social Desirability was 13 – 26 with a mean score of 17.35. On average, the sample was quite low on social desirability. The possible range for the extrinsic scale was 11 – 99 with a median score of 55 and a mean score of 38.89, which was below the median. The possible range for the intrinsic scale was 9 – 81 with a median score of 45. The mean value was 44.05 and was close to the median. The possible range for the quest scale was 12 – 108 with a median score of 60. The mean value was 63.02, which was slightly higher than the median.

Table 4 summarizes means and standard deviations of religious orientation within type of vignette. Figure 1 shows a bar chart of the religious orientation means. Across conditions, the means of the three types of religious orientation are the same. Therefore, random sampling appeared to work. The mean scores for extrinsic orientation, intrinsic orientation, and quest orientation within the Religious Mary vignette were 38.00, 45.06, and 62.74 respectively. The mean scores for extrinsic orientation, intrinsic orientation, and quest orientation within the Non-Religious Mary vignette were 39.70, 42.51, and 63.83 respectively. The mean scores for extrinsic orientation, intrinsic orientation, and quest orientation within the Spiritual Mary vignette were 39.11, 45.47, and 62.83 respectively.

I also examined the relationships between the variables (Table 2). As is evident in the correlation matrix, the variables for the most part were not significantly correlated. There was, however, a significant correlation between extrinsic orientation and intrinsic orientation ( $r = .15, p < .05$ ), TPRQ and intrinsic orientation ( $r = .16, p < .05$ ), as well as age

and the intrinsic orientation ( $r = .17, p < .05$ ). The strongest relationships were gender and field ( $\Phi = .20, p < .01$ ), gender and race ( $\Phi = .24, p < .01$ ), as well as external orientation and quest orientation ( $r = .27, p < .01$ ). Statistically significant negative correlations were found between age and the extrinsic orientation ( $r = -.16, p < .05$ ), age and field (point biserial =  $-.16, p < .05$ ), as well as quest orientation and field (point biserial =  $-.16, p < .05$ ). Though these correlations were significant, they were at best modest and accounted for a relatively small amount of the variance.

### *Primary Analysis*

Three research questions guided the analysis for this study.

1. To what extent are differences in clinicians' clinical judgments (as measured by the TPRQ) for clients of varying religious orientations attributed to clinicians' background factors (age, sex, race, field of study, highest degree earned, and number of years conducting psychotherapy)?
2. To what extent are differences in clinicians' clinical judgments (as measured by the TPRQ) for clients of varying religious orientations attributed to clinicians' social desirability scale values?
3. To what extent are differences in clinicians' clinical judgments (as measured by the TPRQ) for clients of varying religious orientations attributed to clinicians' religious orientation, after accounting for the variance attributable to both background factors and social desirability?

A sequential regression analysis was conducted to determine if Religious Orientation Scale scores of therapists improved prediction/explanation of Therapist

Personal Reaction Questionnaire scores above and beyond what was predicted/explained by the demographic variables (age, race, sex, field of study, highest degree completed, and years doing therapy) and social desirability scores of the therapists. Three separate sequential regression equations were performed – one for each of the three vignettes (Religious Mary, Non-religious Mary, and Spiritual Mary). SPSS REGRESSION, SPSS EXPLORE, and Q-Q plots were used in order to evaluate the assumptions for a regression analysis. As described earlier, after examining the data for skewness and kurtosis, potential outliers, violations of linearity, and any problems with homoscedasticity, it was decided that the analysis could be conducted without transforming any predictor variables. The significance was set at  $\alpha \leq .05$ .

Tables 5, 6, and 7 each show the  $R^2$  and statistical significance of the regression models at each step of the regression analysis. Table 5 summarizes the results for the Religious Mary vignette. Table 6 summarizes the results for the Non-religious Mary vignette and Table 7 summarizes the results for the Spiritual Mary vignette. All the aforementioned tables report the slope estimates and the p-values for each independent variable within each step of the sequential regression procedure.

#### *Demographic Variables Model Results*

Six demographic variables were entered in step one of the regression analysis. For all the vignettes the overall regression models were not statistically significant ( $p > .05$ ; Tables 5, 6, 7). Collectively the demographic variables do not explain a significant amount of variance in the therapist's personal reaction to the client when measuring the therapist's reaction using the TPRQ.

### *Demographic and Social Desirability Model Results*

The social desirability score as measured using the Marlowe-Crowne scale was included with the demographic variables to assess whether any change occurred in the therapist's personal reaction values. Regression results summarized in Table 5 through 7 reveal no statistically significant results (model  $p > .05$ ) were found. The combination of demographic variables and social desirability scores did not explain a significant amount of variance in therapist's personal reactions to clients.

### *Demographic, Social Desirability, and Orientation Model Results*

The addition of the 3-Dimensional Religious Orientation Scale scores increased the variance accounted for by each model somewhat for the Religious, Non-religious, and Spiritual vignettes. However,  $R^2$  values are generally inflated when addition of predictors are introduced into a model (Kutner, Nachtsheim, Neter, & Li, 2005). None of the models were significant for the p-values corresponding to the overall F-test for each vignette; Religious, Non-religious, and Spiritual Mary. This indicated that the 3-D ROS scores did not contribute a significant amount of additional predictive power. It is interesting to note that for the Religious Mary vignette, the only predictor (out of ten total predictors) that was significant was the intrinsic orientation ( $p < .003$ ).

## Chapter Five

### Discussion

This chapter includes a summary of the results presented in Chapter 4. Limitations of the study are discussed, as well as implications for practice and future research.

#### *Clinicians' Clinical Judgments for Clients of Varying Religious Orientations*

In this study, I sought to explore the extent to which differences in clinical judgments of clients of varying religious orientations in a sample of clinicians-in-training could be attributed to participants' demographic variables, social desirability, or religious orientations. Neither demographic variables nor social desirability accounted for significant variation in clinical judgment, regardless of the religious orientation of the client. Neither extrinsic or quest religious orientation of the participant accounted for significant variation in clinical judgment of the client. Intrinsic orientation of the participant was a significant predictor of clinical judgment for the Religious Mary vignette. Thus, participants with high scores on a measure of intrinsic religious orientation tended to perceive the client in the Religious vignette (i.e., Religious Mary) as attractive.

#### *Research Question One*

The first research question sought to explore the extent to which differences in clinicians' clinical judgments (as measured by the Therapist Personal Reaction Questionnaire—TPRQ) for clients of varying religious orientations (as assessed by the Religious, Non-religious, and Spiritual vignettes) could be attributed to clinicians'

background factors (i.e., age, sex, race, field of study, highest degree earned, and number of years conducting psychotherapy). This study is the first to explore the extent to which differences in clinicians'-in-training clinical judgments for clients of varying religious orientations can be attributed to clinicians' background factors. I decided to explore background demographic variables as it seemed important to try to explain clinical judgment based on contextual variables prior to drawing conclusions about how participants' religious orientation might influence attraction (i.e., clinical judgment) to a client.

In the sequential regression analysis to explain variation in therapists' reactions to vignettes featuring clients representing three religious orientations, demographic variables were entered as a block at the first step. When only the demographic variables were entered as predictors into the regression equation, the block of demographic predictors failed to reach statistical significance. Therefore, the researcher concluded that demographic factors were not reliable predictors of TPRQ scores. Other studies, however, have explored how background factors (e.g., race, sex, and age) are related to clinical judgment. For example, Rosenthal (2004) explored the effects of client race on the clinical judgment of practicing European American vocational rehabilitation counselors. The results suggested that European American counselors judged African American clients more negatively than European American clients. Rahimi, Rosenthal, and Chan (2003) explored whether or not African American students hold bias against African American clients and judge them as having less potential than European American clients. The results suggested that African American students rated the African



American client as having higher educational potential than the European American client. Teasdale and Hill (2006) explored preferences of therapists-in-training for client characteristics. Preferences for similar versus dissimilar gender and race-ethnicity were not strong on the forced-choice questionnaire. Therapists did however, prefer to work with clients who were of a similar age rather than older clients. The researchers speculated that therapists thought that they would have a difficult time identifying with older clients or felt that older clients would perceive them as less competent because they were younger.

Based on the above-mentioned studies, it appears as though background factors could have an impact on clinical judgment. These mixed findings may suggest the need to continue to consider the role of contextual factors. For example, as indicated above, clinicians may have a difficult time identifying with clients who are older, as it may raise concerns regarding competency. In the current study, lack of variability regarding race/ethnicity may have influenced statistical significance. The sample was primarily White ( $n=162$ ). Other racial groups included Latinos ( $n=10$ ), Asian Americans ( $n=8$ ), African Americans ( $n=4$ ), and "Other" ( $n=12$ ). One might assume the same for sex as well, as there were significantly more women participants ( $n=147$ ) as compared to men ( $n=39$ ). Age may have been similarly restricted. Though there was a broad range of ages (i.e., 22 to 56 years old), the mean age of respondents was 30.48 and the SD was 7.11. The median and the mode age of the respondents was 28 and 26, respectively.

*Research Question Two*

The second research question sought to explore the extent to which differences in clinicians'-in-training clinical judgments (as measured by the TPRQ) for clients of varying religious orientations (as measured by the Religious, Non-religious, and Spiritual vignettes) could be attributed to clinicians' social desirability (as measured by the Short Form of the Marlowe-Crowne Social Desirability Scale) after accounting for background variables. The purpose of this question was to explore whether or not participants would attempt to project themselves in a socially positive light. To date, there are no studies that explore the extent to which differences in clinicians' clinical judgments for clients of varying religious orientations can be attributed to clinicians' social desirability values. Religion and psychology have long had a complicated relationship (Hage, 2006). Despite this ongoing tension, the alienation between mental health professionals and religion for most of the 20<sup>th</sup> century seems to be ending (Richards & Bergin, 2000). In earlier decades, there were theorists who argued that therapy needed to be value-free. However, few clinicians have found this position to be tenable (Gelso & Fretz, 1992). Though an increased interest and acceptance of religion by many clinicians has been expressed, very few clinicians feel competent to address religion in therapy (Aten & Hernandez, 2004). It is plausible, then, to assess the extent to which clinicians'-in-training desire to be perceived positively, and how this might account for variations in clinical judgment.

A sequential regression analysis was conducted to determine if social desirability of therapists'-in-training improved prediction of Therapist Personal Reaction Questionnaire scores above and beyond what was predicted by demographic variables.

Since the p-values were not significant, the researcher concluded that the social desirability scores were not reliable predictors of the TPRQ scores.

Numerous studies have administered the Marlowe-Crowne Social Desirability Scale (MCSD) to explore whether or not participants would attempt to project themselves in a socially positive light. In their study, Krous and Nauta (2005) assessed the degree to which values, motivations, and learning experiences were associated with a desire to work with underserved populations (UPs) among future professionals who were majoring in helping fields in college. Given the highly face-valid nature of the UPs items, the researchers were concerned that high scores on the measure might reflect socially desirable responding. Therefore, they administered a version of the Marlowe-Crowne Social Desirability Scale—Short Form (MCSD-SF; Reynolds, 1982) to participants. The bivariate correlation between MCSD-SF scores and the desire to work with UPs total score was not significant. Thus, the measure of desire to work with underserved populations did not simply represent socially desirable responding. Lastly, Loo (2001) examined attitudes toward persons with disabilities of management undergraduates who would be the next generation of professionals and managers hiring and working with employees or clients with disabilities. The researcher found a statistically significant correlation between the Interaction with Disabled Persons Scale (IDP) and the MCSD scores, and it accounted for only about 4% of the variance in the relationship between the two variables. Loo concluded that social desirability would not be considered a serious response bias problem.

The results of the above-mentioned studies are consistent with the findings of this study, and suggest that socially desirable responding was not a problem. I was not surprised to find that socially desirable responding in the current study was not a problem as my experience suggests that clinicians-in-training seem to be openly vocal about their views. Further, the methodology of the study may have encouraged respondents to respond honestly, as participants were assured of anonymity. I am also not surprised, however, that one of the studies described previously found modest statistical significance for social desirability, as some participants may not feel comfortable fully disclosing such views given the nature of the topic.

### *Research Question Three*

This research question sought to explore the extent to which differences in clinicians' -in-training clinical judgments (as measured by the TPRQ) for clients of varying religious orientations (as measured by the Religious, Non-religious, and Spiritual vignettes) could be attributed to clinicians' religious orientation after accounting for the variance attributable to both background factors and social desirability. To date, there are no studies that explore the extent to which differences in clinicians' clinical judgments for clients of varying religious orientations attribute to a clinicians' religious orientation. With one exception, my results indicated that religious orientation of clinicians' -in-training was not found to be associated with clinical judgment. When the three religious orientations (i.e., extrinsic, intrinsic, and quest) were entered as a block, the change in  $R^2$  was not significant. However, within the religious orientation block an intrinsic religious orientation was significant ( $p < .003$ ) for the Religious Mary vignette. These results

suggest that participants with an intrinsic orientation perceived the client in the Religious Mary vignette as attractive. In my discussion of these results, I focus on why participants who scored highly on intrinsic religious orientation might be attracted to the client portrayed in the Religious Mary vignette. I conclude with a discussion of why, for the most part, religious orientation does not seem to influence attraction towards clients.

Participants who scored highly on intrinsic religious orientation might be attracted to the client portrayed in the Religious Mary vignette because there is a focus on God and not external satisfaction. Hence, there is a direct connection between the counselor and the client. According to Allport and Ross (1967), persons with this orientation find their master motive in religion, and therefore the individual lives his/her religion. The author provides examples of intrinsic type statements, as identified on the Religious Orientation Scale, “If I were to join a church group I would prefer to join a Bible study group rather than a social fellowship” and “My religious beliefs were what really lie behind my whole approach to life.” The language used in the Religious Mary vignette is similar. Specifically, the vignette states “Mary says that she has always felt a sense of trust and security that comes from a belief in her intellectual worth and academic accomplishments and from a belief in God and from a feeling that things happen according to God's plan. Her few social contacts are with other members of the religious congregation to which she belongs...” Overall, there seems to be a direct connection between intrinsic religious orientation and those encounters that encompass a similar internalized sense of well-being as it relates to God.

Though the following research is not directly related to the current study, the results of the research seem to provide useful information for understanding the results. Jonas and Fischer (2006) conducted three separate studies with 78 patrons of a students' coffee shop-pub in Munich (Germany). Overall, the researchers hypothesized that religious beliefs play a protective role in managing terror of death. Study 1 showed that after a naturally occurring reminder of mortality, people who scored high on intrinsic religiousness did not react with worldview defense (in relation to terror management, people are motivated to defend their individual cultural world views and not general conservative beliefs), whereas people low on intrinsic religiousness did. The researchers ran correlations between intrinsic religiousness and the responses to some questions. The results revealed that the higher the participants' intrinsic religious orientation, the more often they reported that in response to the terrorist attacks they had said additional prayers that there be no more terrorist attacks. Study 2 specified that intrinsic religious belief mitigated worldview defense only if participants had the opportunity to affirm their religious beliefs. Study 3 illustrated that affirmation of religious belief decreased death-thought accessibility following mortality salience only for those participants who scored high on the intrinsic religiousness scale. Taken as a whole, these results suggest that only those people who are intrinsically vested in their religion derive terror management benefits from religious beliefs. The same observation of intrinsically vested people in this research may also be observed in the current study with Religious Mary, "...she has always felt a sense of trust and security that comes from a belief in her intellectual worth and academic accomplishments and from a belief in God and from a feeling that things

happen according to God's plan.” Therapists-in-training might be particularly drawn to working with clients who share their worldview as they may feel better able to conceptualize concerns and interventions.

Rose, Westefeld, and Ansley (2001) explored psychotherapy clients’ beliefs about the appropriateness of discussing religious and spiritual concerns in counseling, clients’ preferences for such discussion, and identified explanatory variables for beliefs about appropriateness and preferences for discussing religious and spiritual concerns. Clients appeared to believe that discussing religious concerns in counseling was appropriate and demonstrated a preference for discussing both religious and spiritual issues. The researchers also suggested that the results were consistent with previous research in that level of religiosity is positively related to preferences for pastoral rather than secular counseling, and for religion to have a more important role in therapy. Based on the above-mentioned research findings, it seems valid that religious clients would prefer to engage in therapy with someone whose beliefs are more closely related to their own in an effort to feel safe and understood in therapy. While these results apply to client preferences, my results suggest that the converse might also be true: counselors may have a preference for working with someone whose beliefs are closely related to their own. This is similar to the current study, as participants who scored high on intrinsic orientation were more attracted to the Religious Mary Vignette, which indicated similar views.

In general, as suggested by the remainder of the results in the current study, religious orientation does not seem to influence attraction towards clients. Perhaps this is

true due to the way in which religious orientation is measured. People seem to have a difficult time articulating their religious affiliation or lack thereof, as religion can be viewed as multifaceted. As a result, varied responses by participants may not be accurate representations of how people are religiously. For example, according to Jonas and Fischer (2006), “part of what defines intrinsic religiousness is that it is more central and internalized. Thus, it appears that intrinsically religious people are also more religious in a quantitative sense (e.g., they pray more often) than extrinsic religious people (p. 564).”

### *Study Limitations*

This study had a number of limitations. The first limitation is how the study’s sample size was established. Though the sample size was adequate, there were a number of participants who were deleted from the study. A total of 307 individuals responded to the survey. Of the total number of participants, 272 completed the survey. The remaining 35 participants did not complete the survey. An additional seventeen participants were excluded from the analyses, as they reported already completing a Ph.D. and this study was designed to look at trainees in psychology programs. Two additional participants were excluded because they reported being enrolled in programs other than counseling or clinical psychology. Finally, 67 participants reported their highest degree either as a B.A. or B.S. with no indication of pursuing an M.A. or Ph.D. in counseling or clinical psychology; given that we could not be certain these individuals met the inclusion sample for the study, they were also excluded. A total of 186 participants were used in the final analyses. The high number of participants excluded from participating in this study is unusual, and it is reasonable to question whether the



sample obtained adequately reflects the population of the interest. Different recruitment strategies could have been implemented to prevent the deletion of such a large number of participants. For example, the recruitment letter could have emphasized the exclusionary criteria for participation. Perhaps it would have been helpful when contacting directors of training to emphasize who was eligible to participate in the study. In addition, the question, “What is your field of study?” could have eliminated the option “Other” to prevent confusion regarding inclusion criteria (Counseling Psychology and Clinical Psychology).

Second, the participants seemed to have questions and concerns regarding the nature of the 3-D ROS items. This researcher received multiple comments via email during both the pilot and the main study (but primarily during the main study) from participants who expressed concern about these items. Participants generally expressed that the items were too personal, too vague, and too confusing. Participants stated that the items did not apply to their personal beliefs. For example, the beginning of the Likert scale provided a response of “Strong Disagree,” which seemingly led some participants to believe that they were still subscribing to some type of religious belief despite the option to “strongly disagree.” Therefore, it may have been helpful to include a sentence that further clarified the directions for this scale. For example, “the response (Strongly Disagree) also applies if you do not identify as a religious person.” In general, the above-mentioned comments were received from participants who did not complete the survey as well as those who chose to complete it. It seemed, however, as though the majority of the concerns were expressed by those who did not complete the survey, as

indicated in the comments, and this of course heighten concerns about sample bias. Overall, the comments were either constructive as discussed above or positive. For example, participants expressed that it was enjoyable to participate, that they thought more deeply about their own beliefs, and appreciation for this study being conducted. There was only one comment that seemed harshly negative. As mentioned previously, the literature is also limited regarding measures that examine clinical judgments, as they are either dated or lack sufficient reliability and validity information. For example, the Clinical Judgment Scale (Houts & Galante, 1985) is the only scale to date that specifically measures clinical judgment. It is dated, however, and few studies have utilized this scale because of its limited specificity and clarity. Also, other scales, like the TPRQ, seem to address clinical judgment indirectly. The TPRQ measured attraction toward a patient or client and it is reasonable to wonder whether a measure that was more specific would have proven to be more fruitful.

The third limitation is related to the vignettes not specifying race of the client. However, other background factors were either stated or at least implied (i.e., age, sex, field of study, degree, and religious/spiritual beliefs). It is important to consider all background factors, including race. Clinicians with biases based on client characteristics may hinder the formulation of an assessment (Rosenthal, 2004).

Fourth, though two of the three vignettes indicated the existence of spiritual or religious beliefs, religious concerns did not seem to be a focus. Religious concerns would have been an important dimension, as the study focused on clinicians' clinical judgments for clients of varying religious orientations. Highlighting this variable within

the vignette could have provided additional data to help clinicians to become more aware of potential biases related to religion.

The fifth limitation is related to the nature of the measures. There are a limited number of valid measures that assess religious orientation and clinical judgment. As the literature has shown, the ROS has a longstanding history of modifications and criticisms. For example, during the development process, the extrinsic and intrinsic dimensions have been criticized for their lack of specificity and clarity and a wide range of researchers (Batson, Schoenrade, Ventis, 1993; Gorsuch & Venable, 1983; Kirkpatrick, 1989; Trimble, 1997). Researchers (Hoge, 1972; Kirkpatrick, 1989; Gorsuch & Venable, 1983) have attempted to improve the validity and reliability of the ROS. These investigations, however only raised additional questions. Batson et al. (1993) examined the ROS and suggested that the extrinsic and intrinsic dimensions do not actually measure two distinct types of religious orientation. Instead, the extrinsic and intrinsic dimensions seem to measure independent continuous dimensions. Furthermore, regarding the nature of the measures, they were not designed to measure those who were not religious at all. Perhaps revisions to the 3-D ROS would allow those who are non-religious to feel more comfortable responding to the measure. For example, an option of “Not Applicable” could be a useful modification.

Therefore, dimensions could conceivably measure other unrelated dimensions. In general, concerns about reliability for the extrinsic, intrinsic, and quest dimensions were raised in this study as well. Cronbach alpha coefficients for the extrinsic, intrinsic, and quest dimensions were .60, .89, and .76 respectively. These are considered to be good,

with the exception of the coefficient alpha for the extrinsic dimension. The coefficient alpha for this dimension is quite low and only marginally acceptable.

Based on the aforementioned limitations of the study, it was not surprising to find that the results of the study did not match my experiences related to issues and therapy. Therefore, the implications for future research are important to consider. This consideration would increase the likelihood of a match between the clinicians' experiences and the research outcomes.

### *Implications for Research*

In future research studies, addressing some of the study's limitations while expanding the scope of the study would be helpful. Use of precise recruitment strategies, including a follow-up letter or a follow-up with the person (e.g., director of the academic program) who is responsible for distributing the recruitment notice, would be important. Follow-up would increase the likelihood that the individuals participating in the study are actually eligible. Follow-up would also decrease the need to remove a significant number of participants from the data. Additional follow-up during a pilot study would possibly rule out any confusion about what the questions are asking. For example, the question regarding highest degree could have been close-ended to prevent confusion about what degree was being pursued. Also, exploring other options for reliable and valid measures that assess the constructs in this study under investigation is recommended. For example, the TPRQ measured attraction toward a patient or client instead of measuring clinical judgment directly and identifying an alternative way to assessing clinical judgment would

have allowed specific examination of how religious orientation influenced clinicians' judgments.

Another way to enhance the study would be to conduct a qualitative study. If the data were gathered carefully, the researcher would save a significant amount of time from speculating (Bogdan & Biklen, 1992). Furthermore, transcripts from taped interviews would provide detailed and descriptive data. The development of analytical questions would avoid the use of measures such as the 3-D ROS, which generated significant negative feedback given the lack of clarity and nature of the questions. For example, there were participants who found it difficult to answer certain questions because they could not relate to them. This was especially true for participants who did not identify as spiritual or religious. A qualitative approach would allow the researcher to ask more open-ended questions and to follow-up more carefully on how the client made meaning of the constructs under scrutiny.

Finally, future research could specifically compare different populations—non-spiritual/religious, spiritual, and religious instead of sampling from one mixed population of clinicians in training regardless of spiritual or religious affiliation. Furthermore, sampling from various spiritual/religious groups (e.g., Muslim, Buddhist, and Jewish) that differ with regard to spiritual/religious expression or lifestyle as indicated in the current study's vignettes might prove to be informative. Whether the clinician subscribes to a particular spiritual/religious belief or not, having a client with religious concerns may prompt different reactions to the client. For example, it would be important for the client to be aware of any lack of knowledge related to religious content (Genia, 1994). If

clinicians do subscribe to particular beliefs, matching them with clients based on religious orientation versus customs/traditions might be worth exploring.

### *Implications for Practice*

The current study only had one finding; intrinsic orientation was significantly associated with the Religious Mary vignette. This finding suggests that clinicians who either identify religiously or are at least comfortable with religious content, may judge religious clients more optimistically. In other words, clinicians who identify with an intrinsic orientation seem to be more attracted to clients who are religious. Examples of intrinsic type statements, as identified on the Religious Orientation Scale (Allport & Ross, 1967), include, “If I were to join a church group I would prefer to join a Bible study group rather than a social fellowship” and “My religious beliefs are what really lie behind my whole approach to life.” These results were similar to a study by Gerson et al. (2000) that suggested that therapists with strong religious beliefs were most optimistic for the religious patient.

In the current study, participants had a range of negative reactions to the 3-D ROS, which was used to identify individuals on three major dimensions of religious experience: Religion as Means (Intrinsic), Religion as End (Extrinsic), and Religion as Quest. Some participants identified specific concerns. For example, “The questionnaire does assume religious affiliation and/or belief, so it is impossible to answer the questions clearly if you don't have one—particularly since many of the statements are compound statements, where the second part assumes that the first is true/relevant (e.g., “I don't allow my religious beliefs to influence...” assumes that you have religious beliefs).

Another example included, "...I just wanted to point out that it is very difficult to answer the ?s as a person who does not identify as "religious." I tried to answer based on my beliefs about morality instead, substituting it for religion (except for the questions that specifically talked about "organized religion")." If the 3D-ROS can generate such strong reactions among participants, who are clinicians in training, it is easy to imagine how such reactions might manifest in a therapeutic or training setting. Strong reactions may be related to clinicians not feeling adequately trained and supervised on religious issues in therapy. The feeling of not feeling competent to handle religious issues if they emerge is shared among clinicians in the field (Gerson et al., 2000).

Overall, I have learned that the above-mentioned has important implications for training programs. First, open dialogue in the classroom may allow for ongoing peer-educated learning and translate to openness with clients. Further, as spiritual/religious clients continue to express concerns with regard to pursuing therapy with a secular clinician, it is crucial that researchers continue to work on understanding and exploring ways to integrate instruction related to spirituality and religion in training programs. Lastly, I have learned that being mindful of exclusionary criteria is critical. Not only was it important with regard to measures in this study, but it was also important with regard to the use of language. The topic of clinical judgments for clients of varying religious orientations is important. Therefore, if I, other clinicians, and researchers desire to increase the awareness of others within the field, we must do so in a way that is sensitive, yet informative.

Table 1  
 Summary of Normality Measures for Interval Data Variables (n = 186)

	Skewness	SE of Skewness	SE of Kurtosis	Kurtosis
MC	.46	.18	-.49	.36
Age	1.69	.18	2.57	.36
Int. Orient	-.24	.18	-.98	.36
Ext. Orient	.15	.18	-.14	.36
Quest Orient	-.27	.18	-.35	.36
TPRQ	-.12	.18	.56	.36

Note: MC = Short Form of the Marlowe-Crowne Social Desirability Scale; Ext. Orient. = Extrinsic Orientation; Int. Orient. = Intrinsic Orientation; Quest Orient. = Quest Orientation; TPRQ = Therapist Personal Reaction Questionnaire. Race, sex, field of study, degree, and years conducting psychotherapy were not included, as they were treated as nominal variables.



Table 2

Zero-order Correlations for Variables Included in the Regression Analysis (n = 186).

	TPRQ	MC Total Score	Age	Ext. Orient.	Int. Orient.	Quest Orient.	Gender	Race	Field	Degree
TPRQ	--	.02	.05	.05	.16*	.11	-.05	-.04	.02	-.02
MC		--	.05	.01	.06	-.06	.11	-.01	.14	.08
Age			--	-.16*	.17*	.00	-.07	.02	-.16*	.03
Ext. Orient.				--	.15*	.27**	.00	-.13	.09	.11
Int. Orient.					--	.05	.06	-.08	-.03	-.00
Quest Orient.						--	-.04	.05	-.16*	.09
Gender							--	.24**	.20**	.02
Race								--	.18	.11
Field									--	.06
										--

**Note.** Sex: 0 = male, 1 = female; Race: 0 = person of color, 1 = White; Field: 0 = clinical, 1 = counseling; Degree 1 = masters, 0 = other; Gender = MC=Short Form of the Marlowe-Crowne Social Desirability Scale; Ext. Orient=Extrinsic Orientation; Int. Orient=Intrinsic Orientation; Quest Orient=Quest Orientation; TPRQ = Therapist Personal Reaction Questionnaire

\*  $p < 0.05$ , 2-tailed. \*\*  $p < 0.01$ , 2-tailed.

Table 3

Summary Descriptive Statistics Internal Consistency Values. (n = 186)

Variable	Mean	Standard Deviation	Cronbach	
			Alpha	Range
TPRQ	16.08	6.60	.74	- 21 - 39
MC	17.35	2.62	.67	13 - 26
Age	30.51	7.12		22 - 56
Ext. Orient.	38.89	10.05	.60	11 - 99
Int. Orient	44.05	18.87	.89	9 - 81
Quest Orient.	63.02	15.42	.76	12 - 108

Note. TPRQ = Therapist Personal Reaction Questionnaire; MC= Short Form of the Marlowe-Crowne Social Desirability Scale; Ext. Orient. = Extrinsic Orientation; Int. Orient. = Intrinsic Orientation; Quest Orient. = Quest Orientation.

Table 4

Means and Standard Deviations by Vignette for Three Orientation Dimensions. (n = 186)

Vignette	Ext. Orient	Int. Orient.	Quest Orient.
Religious Mary			
<u>M</u>	38.00	45.06	62.74
<u>SD</u>	11.87	19.23	17.95
Non-religious Mary			
<u>M</u>	39.70	42.51	63.83
<u>SD</u>	10.94	20.21	13.84
Spiritual Mary			
<u>M</u>	39.11	45.47	62.83
<u>SD</u>	10.34	17.03	14.48

Note. Ext. Orient. = Extrinsic Orientation; Int. Orient. = Intrinsic Orientation; Quest Orient. = Quest Orientation.

Table 5

Sequential Regression Results for Therapist Personal Reaction Regressed on Selected Variables for the Religious Mary Vignette. ( n = 186)

Variable	<u>Step 1</u>			<u>Step 2</u>			<u>Step 3</u>		
	<i>b</i>	Beta	<i>p</i>	<i>b</i>	Beta	<i>p</i>	<i>b</i>	Beta	<i>p</i>
Sex	-.884	-.058	.700	-1.114	-.073	.636	-2.322	-.153	.299
Age	.114	.130	.384	.117	.135	.374	.066	.075	.593
Race	-1.285	-.057	.724	-.927	-.041	.804	.925	.041	.800
Field	.236	.019	.901	-.071	-.006	.072	.114	.009	.954
Degree	-2.674	-.078	.616	-2.928	-.085	.588	-.399	-.012	.937
Years	1.145	.131	.387	1.097	.126	.412	.934	.107	.448
MC				.291	.081	.600	.174	.049	.739
Ext. Orient							.061	.109	.533
Int. Orient							.156	.454	.003
Quest Orient							.043	.116	.523
(Constant)	13.453		.063	8.368		.488	-2.911		.818
Model F and (p)	.478 (.821)			.443 (.870)			1.491 (.177)		
Total R <sup>2</sup>	.059			.064			.262		
Adjusted R <sup>2</sup>	-.064			-.081			.086		

R <sup>2</sup> Change	.059	.005	.198
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Note: Sex: 0 = male, 1 = female; Race: 0 = person of color, 1 = White; Field: 0 = clinical, 1 = counseling; Degree: 1 = masters, 0 = other; Years: 1 = less than 1 year, 2 = 1-3 years, 3 = 4-6 years, 4 = greater than 7 years; MC=Short Form of the Marlowe-Crowne Social Desirability Scale; Ext. Orient=Extrinsic Orientation; Int. Orient=Intrinsic Orientation; Quest Orient=Quest Orientation

Table 6

Sequential Regression Results for Therapist Personal Reaction Regressed on Selected Variables for the Non-religious Mary Vignette. ( n = 186)

Variable	<u>Step 1</u>			<u>Step 2</u>			<u>Step 3</u>		
	<i>b</i>	Beta	<i>p</i>	<i>b</i>	Beta	<i>p</i>	<i>b</i>	Beta	<i>p</i>
Sex	20.111	.092	.537	1.509	.105	.487	1.331	.092	.551
Age	.088	.099	.459	.088	.100	.460	.094	.106	.453
Race	-3.894	-.191	.183	-3.719	-.182	.205	-4.229	-.207	.178
Field	-.235	-.020	.889	-.219	-.019	.897	-.150	-.013	.934
Degree	-2.473	-.072	.600	-3.235	-.095	.503	-3.155	-.092	.554
Years	-.172	-.023	.865	.039	.005	.970	-.045	-.006	.967
MC				-.370	-.115	.410	-.447	-.139	.351
Ext. Orient							-.065	-.118	.428
Int. Orient							-.016	-.052	.720
Quest Orient							8.14E-005	.000	.999
(Constant)	20.111		.005	27.184		.016	32.305		.015
Model F and (p)	.452 (.841)			.484 (.842)			.398 (.942)		

Total R <sup>2</sup>	.046	.058	.071
Adjusted R <sup>2</sup>	-.056	-.062	-.108
R <sup>2</sup> Change	.046	.012	.013

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Note: Sex: 0 = male, 1 = female; Race: 0 = person of color, 1 = White; Field: 0 = clinical, 1 = counseling; Degree 1 = masters, 0 = other; Years: 1 = less than 1 year, 2 = 1-3 years, 3 = 4-6 years, 4 = greater than 7 years; MC=Short Form of the Marlowe-Crowne Social Desirability Scale; Ext. Orient=Extrinsic Orientation; Int. Orient=Intrinsic Orientation; Quest Orient=Quest Orientation

Table 7

Sequential Regression Results for Therapist Personal Reaction Regressed on Selected Variables for the Spiritual Mary Vignette. (n = 186)

Variable	Step 1			Step 2			Step 3		
	<i>b</i>	Beta	<i>p</i>	<i>b</i>	Beta	<i>p</i>	<i>b</i>	Beta	<i>p</i>
Sex	-1.414	-.080	.550	-1.344	-.076	.573	-1.408	-.079	.566
Age	-.074	-.075	.616	-.074	-.075	.619	-.050	-.051	.746
Race	-.122	-.007	.959	-.265	-.014	.911	.281	.015	.908
Field	-.395	-.027	.847	-.268	-.018	.897	-.205	-.014	.922
Degree	-1.753	-.042	.751	-1.402	-.034	.802	-1.175	-.028	.839
Years	.113	.014	.923	.144	.018	.902	.001	.000	.999
MC				-.251	-.070	.589	-.246	-.069	.600
Ext. Orient							.050	.075	.599
Int. Orient							.062	.153	.261
Quest Orient							.078	.162	.216
(Constant)	21.539		.013	25.846		.030	14.928		.271
Model F and (p)	.113 (.995)			.138 (.995)			.401 (.941)		



Total R <sup>2</sup>	.011	.015	.064
Adjusted R <sup>2</sup>	-.084	-.096	-.095
R <sup>2</sup> Change	.011	.004	.049

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Note: Sex: 0 = male, 1 = female; Race: 0 = person of color, 1 = White; Field: 0 = clinical, 1 = counseling; Degree 1 = masters, 0 = other; Years: 1 = less than 1 year, 2 = 1-3 years, 3 = 4-6 years, 4 = greater than 7 years; MC=Short Form of the Marlowe-Crowne Social Desirability Scale; Ext. Orient=Extrinsic Orientation; Int. Orient=Intrinsic Orientation; Quest Orient=Quest Orientation

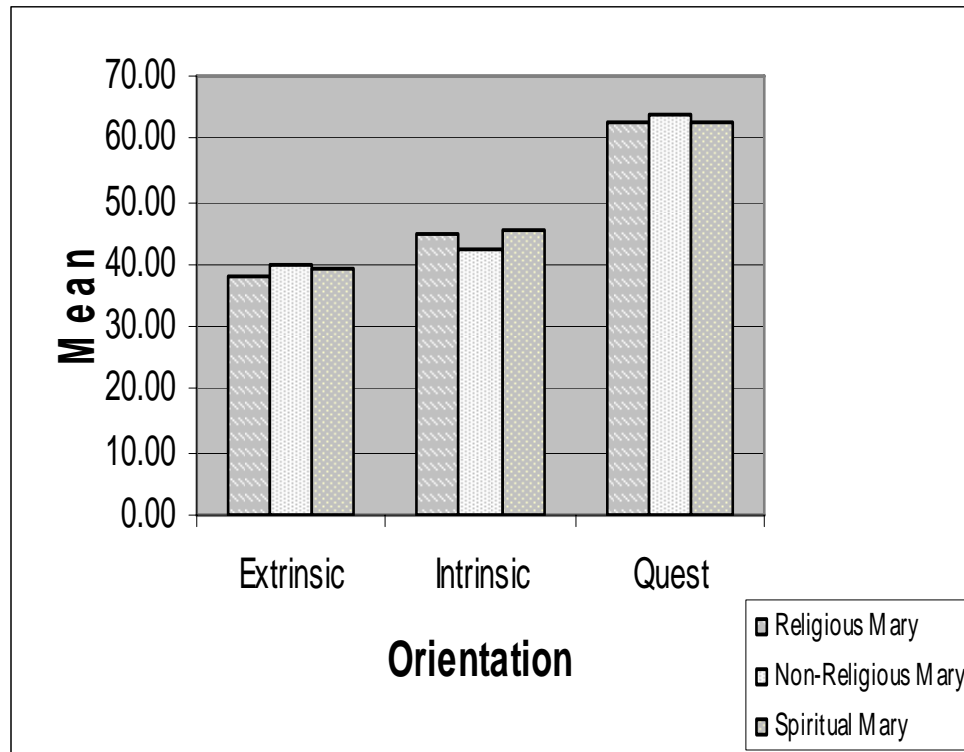


Figure 1. The mean scores for extrinsic, intrinsic, and quest orientations by condition.

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## Appendix A

### Recruitment Notice

I am a counseling psychology doctoral student at The Pennsylvania State University (PSU). Since the beginning of my studies, I have been interested in the relationship between religion and psychotherapy. I am particularly interested in how religious orientation influences the therapeutic interaction. I hope you will consider participating in my dissertation study.

If you are a master's or doctoral-level student enrolled in a clinical or counseling psychology program, please participate in my study by sharing your clinical knowledge. In return for your participation, there will be an option for your name to be entered into one of four random drawings for \$25.00. If you win, a message will be sent to you either by email or snail mail with this notification. Your participation in this study will provide general insights and information that could lead to greater understanding and awareness related to the influence of religious orientation on the therapeutic interaction. If you choose to participate, go to [www.psychdata.com/surveys.asp?SID=8241](http://www.psychdata.com/surveys.asp?SID=8241). The survey will take approximately 20 minutes. Confidentiality will be maintained to the degree permitted by the technology used. As the data transmits, it will be encrypted and stored on a secure server. The survey does not ask for any information that would identify to whom responses belong.

This study is a project of the Pennsylvania State University. It is voluntary and is for research purposes only. This project has received IRB approval (#19499). If you have any questions or concerns, please feel free to contact me, Michele Henry via email at [MLh243@psu.edu](mailto:MLh243@psu.edu), 4352 W. Ogden, Chicago, IL 60608, 708-288-5653. My dissertation co-advisors, Drs. Keith B. Wilson at [Kbw4@psu.edu](mailto:Kbw4@psu.edu), 327 CEDAR Bldg, University Park, PA 16802, 814-863-2413 and Kathleen Bieschke at [Kbieschke@psu.edu](mailto:Kbieschke@psu.edu), 306 CEDAR Bldg, University Park, PA 16802, 814-865-3296 may also be contacted.

## Appendix B

## INFORMED CONSENT FORM

## Clinical Judgments for Clients of Varying Religious Orientations (#19499)

The purpose of this study is to examine the extent to which differences in clinicians' clinical judgments for clients of varying religious orientations are attributed to specific factors. In order to participate, you must be a master's or doctoral-level student and enrolled in a Clinical or Counseling Psychology program. The information you provide will remain confidential.

There are no risks in participating in this research beyond those experienced in everyday life. Some of the questions are personal and may cause some discomfort. This study will require that you spend approximately 20 minutes to read one short vignette and three measures. In return for your participation, there will be an option for your name to be entered into one of four random drawings for \$25.00. If you win, a message will be sent to you either by email or snail mail with this notification. If you win, an email message will be sent to you with this notification.

The benefit to you includes learning more about yourself by participating in this study. You may gain a better understanding of your own clinical judgments in relation to clients of varying religious orientations. Furthermore, your participation could help improve training programs that exclude or offer limited education and clinical training related to spirituality and/or religion.

Confidentiality will be kept to the degree permitted by the technology used. No guarantees can be made regarding the interception of data sent via the Internet by any third parties. Data is encrypted as soon as it is sent and stored on a secure server. The survey will not ask for any information that would identify who the responses belong to. The Office for Research Protections and the Social Science Institutional Review Board may review records related to this project. In the event of any publication or presentation resulting from the research, no personally identifiable information will be shared because this information will not be linked to your responses.

If you have any questions about your rights in filling out this survey, contact The Pennsylvania State Office for Research Protection about IRB# 19499 at 814-865-1775. You can contact Michele Henry, who is conducting this research at [MIh243@psu.edu](mailto:MIh243@psu.edu), 4352 W. Odgen, Chicago, IL 60608, 708-288-5653. Her dissertation co-advisors, Drs. Keith B. Wilson at [Kbw4@psu.edu](mailto:Kbw4@psu.edu), 327 CEDAR Bldg, University Park, PA 16802, 814-863-2413 and Kathleen Bieschke at [Kbieschke@psu.edu](mailto:Kbieschke@psu.edu), 306 CEDAR Bldg, University Park, PA 16802, 814-865-3296 may also be contacted.

Your decision to participate in this research is voluntary. You can stop at any time. You do not have to answer any questions you do not want to answer. You must be 18 years of age or older to participate in this study.

This informed consent form was reviewed and approved by the Social Science Institutional Review Board at The Pennsylvania State University on **October 26, 2004**. It will expire on **September 27, 2005**.

If you have read and understand the above statements, please click on the "Submit" button below to indicate your consent to participate in this study. If you choose to continue and complete the packet, please print a copy of the consent form for your records.

## Appendix C

## Demographic and Background Information

1. Your age \_\_\_\_\_
2. Sex:
  - a. Female
  - b. Male
3. Are you Hispanic/Latino?
  - a. Yes
  - b. No
4. What is your Race?
  - a. Asian/Asian American
  - b. Black/African American
  - c. Native American/Alaskan
  - d. White/European American
  - e. Other (Please Specify)
5. What is your field of study?
  - a. Counseling Psychology
  - b. Clinical Psychology
  - c. Other (Please Specify)
6. Which is the highest degree you have obtained?
  - a. Master's degree
  - b. Doctoral degree
  - c. Other (Please Specify)
7. How many years have you been doing therapy?
  - a. Less than 1 year
  - b. 1-3 years
  - c. 4-6 years
  - d. Greater than 7 years
8. Over the course of your training, what percentage of your caseload concerns has been related to religious issues? \_\_\_\_\_

## Appendix D

## CLINICAL VIGNETTE: RELIGIOUS MARY

Mary is a 26-year-old doctoral candidate and instructor in mathematics. She is self-referred. She was mildly apprehensive during the initial interview and seemed embarrassed about her problems. Her presenting complaint is that she is having difficulty reading, studying, and concentrating because she has become increasingly preoccupied with thoughts that she cannot dispel. She now spends hours each night rehashing the day's events, especially interactions with her professors and exchanges with students in an undergraduate course she teaches. She says that she endlessly tries to correct in her mind any mistakes she might have made. She runs over every event, asking herself if she had behaved properly or said the right thing. She would do this at her desk when she was supposed to be reading, preparing for a class or working on her dissertation. It was not unusual for her to look at the clock after such a period of rumination and find, to her surprise, that two or three hours had elapsed.

Mary is single, has never had a steady boyfriend and accepts dates rarely, anticipating that men will find fault with her and drop her. She has few friends and says she has felt awkward and shy around people since childhood. She speaks of herself as having been a fearful, quiet girl. While she very much wanted to be accepted and make friends, she says that she was "unpopular" and was sure most of her childhood schoolmates disliked her because she was "too smart." She has always been an "A" student and recognized as gifted in mathematics. She recently had a paper published in a prestigious journal. Her parents, whom she describes as "doting" on her and as having high expectations of her, are both high school teachers. She is an only child.

Mary says that she has always felt a sense of trust and security that comes from a belief in her intellectual worth and academic accomplishments and from a belief in God and from a feeling that things happen according to God's plan. Her few social contacts are with other members of the religious congregation to which she belongs. Her two "good friends," whom she sees occasionally, are members of her Bible study group. She avoids other social contacts because she feels that she has "nothing to offer" and would be rejected anyway.

## Appendix E

## CLINICAL VIGNETTE: NONRELIGIOUS MARY

Mary is a 26-year-old doctoral candidate and instructor in mathematics. She is self-referred. She was mildly apprehensive during the initial interview and seemed embarrassed about her problems. Her presenting complaint is that she is having difficulty reading, studying, and concentrating because she has become increasingly preoccupied with thoughts that she cannot dispel. She now spends hours each night rehashing the day's events, especially interactions with her professors and exchanges with students in an undergraduate course she teaches. She says that she endlessly tries to correct in her mind any mistakes she might have made. She runs over every event, asking herself if she had behaved properly or said the right thing. She would do this at her desk when she was supposed to be reading, preparing for a class, or working on her dissertation. It was not unusual for her to look at the clock after such a period of rumination and find, to her surprise, that two or three hours had elapsed.

Mary is single, has never had a steady boyfriend and accepts dates rarely, anticipating that men will find fault with her and drop her. She has few friends and says she has felt awkward and shy around people since childhood. She speaks of herself as having been a fearful, quiet girl. While she very much wanted to be accepted and make friends, she says that she was "unpopular" and was sure most of her childhood schoolmates disliked her because she was "too smart." She has always been an "A" student and recognized as gifted in mathematics. She recently had a paper published in a prestigious journal. Her parents, whom she describes as "doting" on her and as having high expectations of her, are both high school teachers. She is an only child.

Mary says that she has always felt a sense of trust and security that comes from a belief in her intellectual worth and academic accomplishments and from a feeling that "things happen for the best". Her few social contacts are with other members of the mathematics department. Her two "good friends," whom she sees occasionally, are members of her university's Mathematics Club. She avoids other social contacts because she feels that she has "nothing to offer" and would be rejected anyway.

## Appendix F

## CLINICAL VIGNETTE: SPIRITUAL MARY

Mary is a 26-year-old doctoral candidate and instructor in mathematics. She is self-referred. She was mildly apprehensive during the initial interview and seemed embarrassed about her problems. Her presenting complaint is that she is having difficulty reading, studying and concentrating because she has become increasingly preoccupied with thoughts that she cannot dispel. She now spends hours each night rehashing the day's events, especially interactions with her professors and exchanges with students in an undergraduate course she teaches. She says that she endlessly tries to correct in her mind any mistakes she might have made. She runs over every event, asking herself if she had behaved properly or said the right thing. She would do this at her desk when she was supposed to be reading, preparing for a class or working on her dissertation. It was not unusual for her to look at the clock after such a period of rumination and find, to her surprise, that two or three hours had elapsed.

Mary is single, has never had a steady boyfriend and accepts dates rarely, anticipating that men will find fault with her and drop her. She has few friends and says she has felt awkward and shy around people since childhood. She speaks of herself as having been a fearful, quiet girl. While she very much wanted to be accepted and make friends, she says that she was "unpopular" and was sure most of her childhood schoolmates disliked her because she was "too smart." She has always been an "A" student and recognized as gifted in mathematics. She recently had a paper published in a prestigious journal. Her parents, whom she describes as "doting" on her and as having high expectations of her, are both high school teachers. She is an only child.

Mary says that she has always felt a sense of trust and security that comes from a belief in her intellectual worth and academic accomplishments and from a feeling that "the universe provides". Her few social contacts are with other members of a group which considers issues of personal spirituality as they relate to daily life. Her two "good friends" whom she sees occasionally, participate in her meditation and yoga class. She avoids other social contacts because she feels that she has "nothing to offer" and would be rejected anyway.

## Appendix G

## THREE-DIMENSIONAL RELIGIOUS ORIENTATION SCALE

The following statements concern your religious development and the prevalence of various types of religious ideas and practices. There is no consensus about right or wrong answers; some people will agree and others will disagree with each of the statements.

The following statements concern your religious development and the prevalence of various types of religious ideas and practices. There is no consensus about right or wrong answers; some people will agree and others will disagree with each of the statements.

Strongly(SD)	Disagree(D)	Agree(A)	Strongly(SA)
Disagree			Agree
1	2	3	4
		5	6
			7
			8
			9

1. Although I believe in my religion, I feel there are many more important things in my life.
2. It is important for me to spend periods of time in private religious thought and meditation.
3. I was not very interested in religion until I began to ask questions about the meaning and purpose of my life.
4. Worldly events cannot affect the eternal truths of my religion.
5. It doesn't matter so much what I believe so long as I lead a moral life.
6. On religious issues, I find the opinions of others irrelevant.
7. If not prevented by unavoidable circumstances, I attend my religious institution.
8. I have been driven to ask religious questions out of a growing awareness of the tensions in the world and in my relation to the world.
9. The primary purpose of prayer is to gain relief and protection.



10. I try hard to carry my religion over into *all* my other dealings in life.
11. My life experiences have led me to rethink my religious convictions.
12. I find my everyday experiences severely test my religious convictions.
13. A religious institution is most important as a place to formulate good social relationships.
14. What religion offers me most is comfort when sorrows and misfortune strike.
15. The prayers I say when I am alone carry as much meaning and personal emotion as those said by me during religious services.
16. God wasn't very important to me until I began to ask questions about the meaning of my own life.
17. I pray chiefly because I have been taught to pray.
18. Quite often I have been keenly aware of the presence of God or the Divine Being.
19. It might be said that I value my religious doubts and uncertainties.
20. Although I am a religious person I refuse to let religious considerations influence my everyday affairs.
21. My religion is a personal matter, independent of the influence of organized religion.
22. For me, doubting is an important part of what it means to be religious.
23. I read literature about my faith (or religious institution).
24. A primary reason for my interest in religion is that my religious institution is a congenial social activity.

25. I find religious doubts upsetting.
26. If I were to join a religious group I would prefer to join a study group rather than a social fellowship.
27. Questions are far more central to my religious experience than are answers.
28. Occasionally I find it necessary to compromise my religious beliefs in order to protect my social and economic well being.
29. It is important for me to learn about religion from those who know more about it than I do.
30. As I grow and change, I expect my religion also to grow and change.
31. My religious beliefs are what really lie behind my whole approach to life.
32. One reason for my belonging to a religious institution is that such membership helps to establish a person in the community.
33. I am constantly questioning my religious beliefs.
34. The “me” of a few years back would be surprised at my present religious stance.
35. Religion is especially important to me because it answers many questions about the meaning of life.
36. I do not expect my religious convictions to change in the next few years.
37. The purpose of prayer is to secure a happy and peaceful life.
38. There are many religious issues on which my views are still changing

## Appendix H

## THERAPIST PERSONAL REACTION QUESTIONNAIRE (TPRQ)

During treatment, clinicians have many different feelings and reactions. These reactions are sometimes negative, sometimes positive and sometimes mixed. Therapists seem to agree that having varied feelings and reactions toward clients is not undesirable as long as the therapist recognizes and understands them. This scale is designed to assess your present feelings concerning the client described.

There are five possible answers to each of the items:

- 1 Not characteristic of my present feelings
- 2 Slightly characteristic of my present feelings
- 3 Moderately characteristic of my present feelings
- 4 Quite characteristic of my present feelings
- 5 Highly characteristic of my present feelings

Put a circle around the answers most representative of your present feelings with respect to the case study you just read. Be sure to put a circle around one answer for each item. Do not spend too much time on any item.

- |   |           |
|---|-----------|
| 1. I like this client more than most  | 1 2 3 4 5 |
| 2. I have a warm, friendly reaction to this client.                         | 1 2 3 4 5 |
| 3. I was seldom in doubt about what the client was trying to say            | 1 2 3 4 5 |
| 4. In general, I couldn't ask for a better client.                          | 1 2 3 4 5 |
| 5. I usually found significant things to respond to in what the client said | 1 2 3 4 5 |
| 6. I would feel pretty ineffective with this client.*                       | 1 2 3 4 5 |
| 7. I think I would do a pretty competent job with this client.              | 1 2 3 4 5 |
| 8. I disagree with this client about some basic matters.*                   | 1 2 3 4 5 |

9. I think this client is trying harder to solve her problems than most others. 1 2 3 4 5
10. It would be hard to know how to respond to this client in a helpful way. 1 2 3 4 5
11. It's easier for me to see exactly how this client would feel in the situation she describes than it is with other clients. 1 2 3 4 5
12. I am more confident this client will work out her problems than I am with other clients. 1 2 3 4 5
13. In comparison with other clients, I found it hard to get involved with this client's problems.\* 1 2 3 4 5
14. I would have liked to have been able to feel more warmth toward this client than I did.\* 1 2 3 4 5
15. Sometimes I resented the client's attitude.\* 1 2 3 4 5

\* These items are scored negatively (i.e., -1 to -5 for each).

## Appendix I

Marlowe-Crowne Social Desirability Scale  
(Short Form)

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide how it pertains to you.

Please respond either **TRUE** or **FALSE** to each item.

1. It is sometimes hard for me to go on with my work if I am not encouraged.
2. I sometimes feel resentful when I don't get my way.
3. On a few occasions, I have given up doing something because I thought too little of my ability.
4. There have been times when I felt like rebelling against people in authority even though I knew they were right.
5. No matter who I'm talking to, I'm always a good listener.
6. There have been occasions when I took advantage of someone.
7. I'm always willing to admit to it when I make a mistake.
8. I sometimes try to get even rather than forgive and forget.
9. I am always courteous, even to people who are disagreeable.
10. I have never been irked when people expressed ideas very different from my own.
11. There have been times when I was quite jealous of the good fortune of others.
12. I am sometimes irritated by people who ask favors of me.
13. I have never deliberately said something that hurt someone's feelings.

## VITA

**MICHELE L. HENRY**

### EDUCATIONAL EXPERIENCE

**Doctoral Candidate**, Counseling Psychology, The Pennsylvania State University, University Park, Pennsylvania. Dissertation proposal defended on June 2003.  
Degree expected: May, 2007

**Master of Arts**, Community Counseling, Loyola University Chicago, Chicago, Illinois, January, 1999

**Master of Arts**, African American Studies, The Ohio State University, Columbus, Ohio, August, 1995

**Bachelor of Arts**, Psychology, Northern Illinois University, DeKalb, Illinois, August, 1994

### CLINICAL EXPERIENCE

Mount Sinai Psychiatry and Behavioral Health September, 2003-Present

*Chicago, Illinois*

**Psych Triage Manager**

The Bobby E. Wright Comprehensive Behavioral Health Center August, 2002-September, 2003

*Chicago, Illinois*

**Clinical Therapist**

The Bobby E. Wright Comprehensive Behavioral Health Center August, 2002-September 2003

*Chicago, Illinois*

**Co-facilitated a Child Empowerment Group.**

*The Pennsylvania State University*

*August, 1999-May, 2001*

**Co-facilitated an African American Women's Group, an Eating Disorders Group, an Effective Personal and Career Decision Making Group, and a Process-Oriented Training Group**

### TEACHING EXPERIENCE

*Counselor Education, Counseling Psychology, and  
Rehabilitation Services, The Pennsylvania State University*

*August, 1997-January, 1999*

**Teaching Assistant**

**Co-Instructor**

### ASSESSMENT SKILLS/CERTIFICATION

Strong Interest Inventory (SII), Myers-Briggs Type Indicator (MBTI), DISCOVER, Student Interactive Guidance and Information System (SIGI-PLUS), Self-Directed Search (SDS), Adult Career Concerns Inventory, The Values Scale, The Career Decision Scale, and Behavior and Symptom Identification Scale (BASIS-32). Standard First Aid/Adult, Child & Infant CPR, and Crisis Prevention Institute, Inc. (CPI).