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Empirical Research on Religion and Psychotherapeutic Processes and Outcomes: A 10-Year Review and Research Prospectus

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A decade of research on religion and counseling, consisting of 148 empirical articles, was reviewed. Methodological sophistication, poor a decade ago, has approached current secular standards, except in outcome research. Religious people cannot be assumed to be mentally unhealthy. Nonreligious and religious counselors share most counseling-relevant values but differ in the value they place on religion. Those religious differences affect clinical judgment and behavior, especially with religious clients. Religious interventions have been techniques imported from formal religious traditions and used as adjuncts to counseling or traditional theories of counseling adapted to religious clients. The authors suggest a research agenda and speculate about future mental health practices.

With the virtual acceptance of multiculturalism as a "fourth force" in psychology (Cheatham, Ivey, Ivey, & Simek-Morgan, 1993), the role of religion in counseling and psychotherapy has become an acceptable topic for debate and discussion and has become an acceptable aspect of training.[1] Religious experience is not only part of multiculturalism but also consistent with the overall direction of postmodern culture. The acceptance of some role of religion in counseling has thus exploded into the mainstream of counseling and clinical psychology over the last decade.

In 1986, Worthington reviewed a decade (1974–early 1984) of empirical research on the role of religion in counseling, updating a review by Arnold and Schick (1979). Since 1986, interest in religion and counseling has boomed. Professional organizations have sprouted. One example is the American Association of Christian Counselors, which has grown from 2,000 to over 16,000 members between 1993 and early 1995. Many other professional associations have thrived (i.e., the Christian Association for Psychological Studies, Society for the Scientific Study of Religion, Religious Research Association, the Christian Medical and Dental Society, etc.). Conferences and workshops have been in high demand. For example, at the American Psychological Association's annual conventions, attendance at preconvention workshops and regular sessions concerning religion has been high in recent years. Religiously oriented doctoral training programs in clinical psychology have produced substantial numbers of religious therapists, who see religious as well as nonreligious clients. Pressures created in part by managed mental health care initiatives have led to making religious counseling centers into large entities that employ hosts of religious counselors and see many religious clients. As a consequence of the growing interest in religion and counseling, a plethora of theoretical, polemic, and conceptual works have been published. These include (among others) a recent appeal for rapprochement between science and religion by Jones (1994) in the *American Psychologist;* reviews of religion and mental health by Bergin in the *American Psychologist Integration* (Bergin, 1991), the *Journal of Psychotherapy Integration* (Payne, Bergin, & Loftus, 1992), and *Counseling and Values* (Bergin, 1985); reviews by Gorsuch of the psychology of religion in the *Annual Review of Psychology* (1988) and of measurement in religion in the *American Psychologist* (1984); conceptual, theoretical, and review articles by Worthington in the *Journal of Counseling Psychology* (1988), *The Counseling Psychologist* (1989), and the *Journal of Psychology and Christianity* (1991b); and a meta-analysis of intrinsic and extrinsic religion and mental health in the *Journal of Personality and Social Psychology* (Donahue, 1985). Some special issues of journals have addressed religious counseling (Sorenson, 1994; Watson, 1994; Worthington, 1991a, 1994). Additionally, major volumes have reported research on religious counseling (e.g., Benner, 1987a, 1987b; Burke & Miranti, 1995; Jones & Butman, 1991; Lovinger, 1990; Miller & Jackson, 1995; Miller & Martin, 1988; Stern, 1985a; Worthington, 1993). Empirical research on the role of religion in counseling has increased considerably. As one index of this growth, the number of journals reviewed for the present article was 36, whereas Worthington reviewed only 22 in 1986.

This amazing growth in interest in religious counseling

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[1] Throughout this article, the term *counseling* is used generically to refer to counseling, psychotherapy, or both. Similarly, *counselors* can refer to counselors, psychotherapists, or both.

among professionals is paralleled by an increasing interest in religion and spirituality among the general population and (less rapidly but still much growth) in religion and physical health (Hill & Butter, 1995; Levin & Vanderpool, 1991; Martin & Carlson, 1988; Rainwater, 1995; Sethi & Seligman, 1993). Numerous people are seeking professional counseling with therapists who are explicitly religious. In addition, managed mental health care is limiting clients' access to long-term counseling and is forcing therapists in general practices toward brief therapy (Koss & Shiang, 1994). As a consequence, many people are seeking help for mental health problems from pastors, who usually do not charge for counseling (Miller & Jackson, 1995). In summary, religious counseling by religious counselors of religious clients has recently assumed an increased prominence, which argues for an up-to-the-minute summary and analysis of what is known from research about religious counseling. This article surveys the empirical research on religion in counseling and psychotherapy that was published from 1984 through 1994. We attempt such a summary and analysis to inform professionals about what is known and to suggest new directions for researchers and scholars to direct future research to benefit a large number of people in the general population.

Method

Definitions

For the present review, *religious* applies to any organized religion. Religious beliefs are propositional statements (in agreement with some organized religion) that a person holds to be true concerning religion or religious spirituality. Religious values are generally considered, following Rokeach (1967), to be superordinate organizing statements of what a person considers important. For example, a person may hold several religious beliefs (i.e., belief in the existence of God) to be true but not value those religious beliefs as important in his or her life. Generally, a religious person is taken to be one who holds some religious beliefs and values religion to some degree. The degree of religiosity can vary across a wide spectrum. Highly religious people are considered to be those who score in the top 10% to 15% of religious people on measures of religious commitment, intensity, or salience—three related concepts that measure a person's internal motivation toward religious devotion. A religious counselor or a religious client is a counselor or client, respectively, who holds to the primary beliefs associated with organized religion and values religion.

Religious should be differentiated from *spiritual,* which generally is taken to mean believing in, valuing, or devoted to some higher power than what exists in the corporeal world. In this sense, a person may be spiritual but not religious (believing in and valuing, e.g., a universal human spirit or an *elan vital* without holding religious beliefs to be true) or both spiritual and religious (believing in and valuing a higher power that is acceptable to and consistent with some organized religion). The person could also be religious but not spiritual, holding to doctrines of a religious organization but not experiencing or expressing any devotion to a higher power (other than intellectual assent to its existence). The person could also be neither religious nor spiritual.

Defining a person as a religious counselor does not necessarily mean that the person does religious counseling. Religious counseling primarily involves personal issues that use the content associated with an organized religion (e.g., discussions of sin, guilt, confession, forgiveness, and repentance; attendance at religious services; and religious duties), explicit discussions of the impact of a person's actions on his or her religious beliefs or values or the impact of a person's religious beliefs and values on his or her actions, or counseling done in an explicitly religious context where consideration of religious issues might be normally expected to occur and do frequently occur. Religious counseling techniques are counseling interventions that take into account a religion's unique characteristics (i.e., a modified version of a cognitive–behavioral approach that takes into account Christian principles; Propst, Ostrum, Watkins, Dean, & Mashburn, 1992) or interventions that incorporate a religion's practices (i.e., prayer with or for a client). Thus, a religious counselor may hold religious beliefs to be true, value religion highly, and counsel a religious client, who also may subscribe to similar religious beliefs and value religion highly, but the counselor may not do religious counseling, which deals with those religious values and beliefs explicitly.

Secular is defined as nonreligious (either omitting religion from one's belief and value systems or disagreeing with religious beliefs), and secular counseling is defined as counseling not involving religious content or religious issues or not set in an explicitly religious context. Thus, secular counseling may occur between religious counselors and clients who do not deal with religious issues, and religious counseling may occur if a secular counselor sees a secular client about a religious concern.

Procedure of the Search

Journal articles focusing on religion and clients, religion and counselors, and religious counseling between 1984 and 1994 were reviewed. Psychology, mental health, and religious journals found in the libraries of three urban institutions of higher learning—a large state university, a church-supported private university, and a large Protestant seminary—were examined systematically. The journals considered in the present review are listed in Table 1. Articles were also obtained by consulting tables of contents of journals, databases (*PsycInfo, Social Science Citation Index,* and *Religious Index*) available through libraries, and references of published articles; by requesting reprints; and by receiving interlibrary loans of articles unavailable at the libraries. Because of the large number of articles on religion and counseling, the scope of this review was limited to published empirical studies and reviews of empirical research on religion and clients, religion and counselors, and religious counseling techniques. Limiting the scope of the study eliminated some promising areas of consideration. For example, many 12-step programs for treatment of alcohol or drug addiction or other recovery programs were not systematically reviewed because the treatments emphasized spiritual but not religious aspects.[2]

[2] Interested readers can consult Castaneda and Galanter (1987); E. Johnson (1993); N. P. Johnson and Chappel (1994); Jonas and Gold (1992); Khantzian and Mack (1994); Machell (1992); Project MATCH Research Group (1993); Rawson, Obert, McCann, and Castro (1991); Tuite and Luiten (1986); Van Wormer (1987); and White (1979) for summaries of research on 12-step programs.

Table 1
Journals Publishing Reviews and Empirical Studies of Religious Counseling

Journal	Description
	Nonreligious psychology and counseling journals
American Journal of Family Therapy	Theoretical and empirical articles on family and family therapy
American Journal of Psychiatry	Theoretical articles and empirical studies of general interest to psychiatrists
American Psychologist	Theoretical articles and position articles of general interest to psychologists
Cognitive Therapy and Research	Research and some theoretical articles concerning cognitive therapy
Counselor Education and Supervision	Research and theoretical articles concerning cognitive therapy
Families in Society	Research and theoretical articles on family
Family Therapy	Theoretical articles on family therapy
Hillside Journal of Clinical Psychiatry	Theoretical and research articles
Hospital and Community Psychiatry	Research and theoretical articles on community psychiatry
Journal of Consulting and Clinical Psychology	Mostly research on treating clinically disturbed clients and occasional theoretical or review articles
Journal of Counseling and Development	Theoretical and some research articles on topics of interest to counselors and other human service professionals
Journal of Gay and Lesbian Psychotherapy	Research and practice articles on psychotherapy with gay and lesbian clients
Journal of Social and Clinical Psychology	Mostly empirical studies that integrate social, psychological, and clinical concerns
Journal of Transpersonal Psychology	Mostly theoretical articles and idea articles on Jungian therapy
Professional Psychology: Research and Practice	Research articles of interest to applied psychologists
Psychological Bulletin	Reviews of empirical research
Psychotherapy	Mostly theoretical articles with some research and reviews on individual, group, couple, and family therapy
	Pastoral counseling journals
Journal of Pastoral Care	Research, review, and theoretical articles about pastoral counseling
Journal of Pastoral Counseling	Mostly theoretical and practical (case study or technique description) articles about pastoral counseling, little research
Journal of Pastoral Practice	Theoretical, practical, and scriptural review of issues related to Christian (especially nouthetic) counseling (nouthetic counseling is Bible-based contributive pastoral counseling)
Pastoral Psychology	Theoretical articles on pastoral counseling
	General religion and science journals
Cultic Studies Journal	
Journal of the American Scientific Affiliation	Theoretical articles about science and Christianity, occasionally articles about psychology, little or no research
Journal of the Evangelical Theological Society	
Journal of Humanistic Psychology	
Journal of Psychical Research	
Journal of Psychology and Christianity	Theoretical, empirical, and idea articles that integrate psychology and Christianity
Journal of Psychology and Judaism	Articles involving clinical and philosophical issues relating Judaism to psychology
Journal of Psychology and Theology	Mostly research and theoretical articles about the integration of Christianity and psychology
Journal of Religion and Health	Mostly theoretical articles on religion
Journal of the Scientific Study of Religion	Research on religion in general, a few apply to counseling
Journal of Supervision and Training in Ministry	Theoretical articles of practical significance to ministers
Review of Religious Research	Mostly research on religion in general and reviews, little concerning religious counseling
	Psychological journals with religious (or values) orientation
Counseling and Values	Mostly theoretical articles about secular values, fewer research articles, little on religious values (cf. one special issue on Christian counseling)
Dialogue: A Journal of Mormon Thought	Variety of articles dealing with various aspects of Mormonism
Journal of Religion and the Applied Behavioral Sciences	Articles about the new-age religion and behavioral sciences, no research apparent yet

Religion and Clients

Status in 1984

In the previous decade, there was little evidence of systematic research on religious clients. Worthington (1986) identified only two replications and found few people who had published more than two articles. Studies varied in quality and methodological rigor. No studies were theory driven. In general, Worthington found that conservative religious people generally differed from less religious and nonreligious people. Potential clients who were religious (a) feared that their values would be undermined in counseling or that they would be misunderstood

or misdiagnosed, (b) preferred counselors who shared their religious values, and (c) changed their beliefs and values through successful counseling to be more similar to their counselors.

Survey of Current Status of Methodology

The research in the area has generally focused on *potential,* not actual, clients. That is, few studies have investigated the role of religion in clients' lives during their counseling. Instead, most researchers have examined religion in mental health, in coping with stress, or in highly religious versus less religious people who were not receiving counseling at the time of the research. In other cases, people not in counseling have been asked about their expectations of counseling. In the coming decade, research on religion and clients must be more precise if psychologists are to be able to generalize from research. Research on actual clients should be a priority.

The sophistication of research investigating religion in potential clients has vastly improved. Programs of empirical research are clearly evident headed by scholars such as Bergin, Hood, Koenig, Larson, Malony, Morris, Pargament, Rayburn, P. S. Richards, Watson, Witztum, Worthington, and others. Theories have been articulated (e.g., by Pargament, 1990, and Worthington, 1988), and empirical tests have been made of the theoretical propositions of those and existing theories (e.g., Allport, 1951).

Larson and his colleagues have systematically examined the nature and amount of empirical research in a variety of fields (Gartner, Larson, & Vachar-Mayberry, 1990; Larson, Donahue, Lyons, & Benson, 1989; Larson, Sherrill, Lyons, & Craigie, 1992). Larson, Donahue, Lyons, and Benson (1989) studied research in psychiatric journals, where they found that relative to population demographics, Protestants and unaffiliated religious people were underrepresented but Jews were overrepresented. Most researchers on religion and mental health have sampled Protestants, but researchers of several studies have investigated Mormons (notably research programs by Bergin and P. S. Richards) and Jews (Bilu, Witztum, & Van der Hart, 1990; Rahav, Goodman, Popper, & Lin, 1986; Witztum, Greenberg, & Buchbinder, 1990; Witztum, Greenberg, & Dasberg, 1990).

Empirical research on religious people is summarized in Table 2. Research is grouped under five rubrics: (a) religion and mental health, (b) religion and coping with stress, (c) religious people's views of the world, (d) preferences and expectations about religion and counseling, and (e) religious clients' responses to counseling.

Religion and Mental Health

Ellis (1981) suggests that religion is associated with irrationality, which he expects to lead to poor mental health. That challenge energized scholars who vigorously investigated Ellis's hypothesis. Bergin fired an opening salvo in his 1983 meta-analytic review of 24 empirical articles that measured both religion and quality of mental health. In 1991, Bergin summarized the results of his investigations (i.e., Bergin, 1983; Bergin, Masters, & Richards, 1987; Bergin, Reynolds, & Sullivan, 1991; Bergin, Stinchfield, Gaskins, Masters, & Sullivan, 1988; Payne, Bergin, Bielema, & Jenkins, 1991). A veritable army of other researchers has also addressed the issue (Chau, Johnson, Bowers, Darvill, & Danko, 1990; C. G. Ellison, 1991; Fitz, 1990; Galanter, 1986; Gartner, Larson, & Allen, 1991; Hood, Morris, & Watson, 1991; Kroll & Sheehan, 1989; Kurklen & Kassinove, 1991; Larson, Koenig, et al., 1989; Larson, Sherrill, Lyons, & Craigie, 1992; Levin & Vanderpool, 1991; Myers, 1992; Pressman, Lyons, Larson, & Strain, 1990; D. G. Richards, 1991; P. S. Richards, Smith, & Davis, 1989; Sazar & Kassinove, 1991; Sharkey & Malony, 1986; Strayhorn, Weidman, & Larson, 1990; Watson, Folbrecht, Morris, & Hood, 1990; Watson, Hood, Morris, & Hall, 1984, 1985; Watson, Morris, Hood, & Biderman, 1990; Watson, Morris, Hood, & Folbrecht, 1990).

Results have been generally consistent. Religion does not affect mental health negatively. In fact, there appears to be a positive relationship overall. However, most intrinsically religious people (religion as an end in itself) derive substantial positive mental health benefit from their religion, whereas extrinsically religious people (religion as a means to achieving other ends) do not derive benefit or perhaps experience negative consequences (Donahue, 1985).

One important, yet unclear, issue is the definition of mental health. In most research, *mental health* has been taken to be either the absence of psychological problems or the presence of prosocial behavior (or both). A main finding from such investigations is that the concept of mental health is complex and its relation to religion depends on the definitions of mental health and religion used. Bergin has tended to equate positive mental health with internal locus of control, intrinsic motivational traits, sociability, sense of well-being, responsibility, self-control, tolerance, wanting to make a good impression, achievement by conformity, and intellectual efficiency. Those qualities of positive mental health seem to be agreed on by most mental health professionals, regardless of orientation (Jensen & Bergin, 1988). Bergin (1991) found intrinsic religiosity to be related to those characteristics. If one defined *mental health* as freedom from guilt, freedom from societal constraints, pursuit of autonomy, or open mindedness to all ideas, then one might arrive at different conclusions from Bergin and others who have investigated the topic.

Intrinsically and extrinsically religious people experience life differently. For example, they talk differently about their lives, which has implications for counseling. Hood, Morris, and Watson (1990) isolated students in an immersion chamber—that is, students were immersed in water to provide a constant sensory experience. Students were given either a religious or nonreligious mental set. Hood et al. reasoned that such an unusual experience might evoke personally relevant explanations of experience. People seemed to experience similar things phenomenologically. Intrinsically religious students described their experience in religious terms whether prompted or not. Indiscriminantly proreligious students, those high on both intrinsic and extrinsic religious motivations, described their experience in religious terms if prompted but otherwise omitted mention of religion. Extrinsically religious students did not describe their experience as religious even when prompted. Hood et al. suggest that a religious counselor might easily label an extrinsically religious client as *nonreligious* if the client did not use religious terminology, even when prompted. Prompts that inquire

(*text continues on page 457*)

Table 2
Summary of Empirical Research on Clients and Religion

Study	Participants (age)	Design	Measures	Major findings
		Survey of current status of methodology		
Bilu et al. (1990)	Psychiatric patient in Jerusalem (35)	Case study	Inventories	Client resolved his emotional conflict in spite of a culture gap between the therapist and the patient
Larson, Donahue, et al. (1989)	Patients in research samples in psychiatric journals during 1978–1982	Correlational questionnaire research	Questionnaire	Relative to population demographics, Protestant and the unaffiliated religious were underrepresented, but Jews were overrepresented
Rahav et al. (1986)	1,446 residents of Jewish Jerusalem who were inpatients at a psychiatric facility	Multivariate statistical analysis	Psychiatrist report	Ashkenazim Jews had a comparatively high rate of illness in the very religious Jewish neighborhoods
Witztum, Greenberg, & Buchbinder (1990)	19 patients in a Jerusalem community mental health center who were members of a small Hasidic sect	Survey research	Therapist report	Participants were diagnosed with paranoid schizophrenia, schizoaffective disorder, and personality disorders
Witztum, Greenberg, & Dasberg (1990)	71 (20–48) BTs (those who have undergone change to Orthodox Judaism) and 490 (16–61) non-BTs as new referrals to a community mental health center in Israel	Survey research	Therapist report	BTs tended to have schizophrenia or severe personality disorders and were less likely than other referrals to have anxiety, depressive, or adjustment disorders; however, most BTs had psychiatric problems before becoming religious
		Religion and mental health		
Bergin et al. (1987)	119 religious undergraduate students, 32 former missionaries	Correlational questionnaire research	ROS, CPI, TMAS, SCS, BDI, IBT	Religiosity is related to "normality" and is not indicative of emotional disturbances
Bergin et al. (1988)	60 undergraduate religious students	Survey research	Interviews, MMPI, EPI, CPI, TSCS, ROS	There was no evidence in the group as a whole for an overall negative or positive correlation between religiousness and mental health
Chau et al. (1990)	76 male and 117 female university students from Hawaii and Missouri	Correlational questionnaire research	Measures of intrinsic and extrinsic religiosity, sensitivity of conscience (guilt and shame), personality (EPI); and altruism (giving help, receiving help, and importance of helping)	Results indicate that the distinction between dimensions of religiosity is real and of social relevance
C. G. Ellison (1991)	997 respondents to a national survey	Survey research	General survey of social functioning	Individuals with strong religious faith reported higher levels of life satisfaction, greater personal happiness, and fewer negative psychosocial consequences of traumatic life events
Frenz & Carey (1989)	175 undergraduate students	Correlational questionnaire research	Health-related questionnaires that included STAI	There is no evidence for a relationship between religiousness and trait anxiety
Galanter (1986)	305 previously engaged members of the Unification Church	Correlational questionnaire research	Social Cohesive Scale, REL, Spouse Traits Scale, SWS, Work and Marital Adjustment Scales, and Marital Life Events	Participants scores of well-being remained below those of the general population, but religious affiliation counteracted the distress caused by the unusual marriage situation of the sect
Hood et al. (1990)	73 undergraduate students	3 × 2 factorial design	Mysticism Scale with a phenomenological experience factor and a religious interpretation factor	Intrinsically religious participants described the experimental condition in religious terms, whereas indiscriminately proreligious participants did so when prompted and extrinsically religious participants did not

Table 2 (*continued*)

Study	Participants (age)	Design	Measures	Major findings
		Religion and mental health (cont'd)		
Hood et al. (1991)	71 non-Catholic men, selected for religious commitment	Correlational questionnaire research	PBI	A measure of early maternal care and protection, assumed indicative of repression, best predicted selecting both a suffering Christ and an erotic or nurturing Virgin Mary
Kroll & Sheehan (1989)	52 psychiatric patients	Correlational questionnaire research	BDI, religious beliefs, practices, and personal experiences	Patients' religious beliefs were similar with the results of a national and a Minnesota poll on religious beliefs; patients with depressive and anxiety disorders scored lower on some religious indexes than patients with other diagnoses
Kurklen & Kassinove (1991)	96 undergraduate students who attended a 20-min mental health lecture	2 × 2 × 3 factorial design	Counselor Rating Form–S	A significant effect for profanity and a nonsignificant effect for touch, religiosity, and their interactions were found; profanity had a negative effect on compliance
Larson, Koenig, et al. (1989)	401 White men free from hypertension or cardiovascular disease	Repeated measure	Blood pressure readings	Church attendance and religious importance was related to lower diastolic blood pressure
Larson et al. (1992)		Meta-analysis	Religious commitment in 139 studies	In about $^2/_3$ of the measures, the studies either made no hypotheses or reported no results in describing the relationship between religious commitment and mental health status
Masters et al. (1991)	60 undergraduate religious students	Survey research	Interviews, MMPI, EPI, CPI, TSCS, ROS	There was no evidence of a link between orthodox religiosity and pathology
O'Connor & Vallerand (1990)	176 French–Canadian older people (M = 82)	Correlational questionnaire research	Motivation questionnaires	Four types of religious motivation (intrinsic, SDE, non-SDE, and amotivation) was reliably measured and occurred in a pattern similar to patterns described by Deci and Ryan (1985)
Pargament et al. (1987)	147 members of four conservative churches, 157 members of four "mainline" churches	Correlational questionnaire research	Organizational and psychological measures	Conservatives and "mainliners" did not vary in their tolerance for individual differences or active problem-solving skills
Pressman et al. (1990)	30 older female patients	Correlational questionnaire research	GDS, Index of Religousness	Religious belief was correlated with lower levels of depressive symptoms and a higher ability to walk as assessed by physical therapists
Quackenbos et al. (1985)	37 men, 49 women	Survey research	Questionnaire regarding the relationship between religion and psychotherapy	79% thought that religious values were important in therapy, and 53% said that they would seek counseling at a pastoral center if available
P. S. Richards (1991)	268 undergraduate students	2 × 2 between-subjects	ROS	Did not support Ellis's (1981) hypothesis that religiously devout and orthodox people are more emotionally disturbed than less religious persons
P. S. Richards, Smith, & Davis (1989)	36 women and 13 men (19–57) MPCs and 30 women and 21 men (21–64) MNCs	ANCOVA	ROS, DIT	MPCs scored higher on shame and lower on existential well-being; female MNCs scored higher on guilt, whereas female MPCs scored higher on shame; all preferred Stage 4 moral reasoning
Robinson (1990)	194 undergraduates	Correlational questionnaire research	ROS, extraversion measures from EPI	Results support the contention that impulsivity may underlie the relationship of extraversion and religiosity
Sazar & Kassinove (1991)	120 undergraduate students	3 × 2 × 2 factorial design	REL	Use of profanity had a negative impact on acquisition of content and on initial compliance
Sharkey & Malony (1986)	28 very religious, 34 artheist, 33 religiously neutral individuals soliciting consultation	Survey research	Self-report	Religious affiliation had no affect on mental health

(*table continues*)

Table 2 (*continued*)

Study	Participants (age)	Design	Measures	Major findings
		Religion and mental health (cont'd)		
Sheehan & Kroll (1990)	52 psychiatric patients	Correlational questionnaire research	Questionnaire	The role of guilt in depression appears to have been overestimated; patients with depression do not appear to be preoccupied with sin and morality issues
Strayhorn et al. (1990)	199 families with 201 Head Start children	Correlational questionnaire research	Measure of religion	Parents with high religious scores correlated with good mental health, greater social support from friends, more favorable parenting practices, higher SES, and lower hostility; parents' religious scores were not related to child behavior or parents' verbal ability
Wallace (1985)	7 therapists with religious clients	Interview	Therapist report	Religious clients are no different from "regular"; but because of their unique lifestyles, their manifestations and resolutions may differ
Watson, Folbrecht, et al. (1990)	86 undergradutes from a Presbyterian college, 122 undergraduates from a state university	2 × 4 ANCOVA	IBT, ROS, value profile	Religious participants were not more irrational than nonreligious participants
Watson et al. (1984)	180 undergraduate students	Correlational questionnaire research	ROS, SDS	There was a direct relationship between an intrinsically religious orientation and empathy versus an inverse relationship with an extrinsic religious orientation
Watson et al. (1985)	421 undergraduates	Correlational questionnaire research	Rosenberg's (1965) Self-Esteem Scale, SEI, Shostrom Self-Acceptance subscale of the Personal Orientation Inventory, ROS, Batson et al.'s (1993) internal, external, and interactional indices of religiosity, sin, grace, and forgiveness items	Sensitivity to the humanistic language of the self-esteem measures and to the guilt dimensions of orthodox views were useful in demonstrating positive associations between self-esteem and a number of the religiosity measures, including those relating to sin
Watson, Morris, Hood, & Biderman (1990)	850 undergraduate students	Correlational questionnaire research	ROS	Intrinsically religious participants were lower on clearly pathological forms of narcissistic exploitativeness
Watson, Morris, Hood, & Folbrecht (1990)	280 undergraduate students from a state university	Correlational questionnaire research	IBT, Mach IV scale of Machiavellianism, Interpersonal Reactivity Index, Social Responsibility Scale	Dependency as a religious rationality was related to increased social responsibility and emotional empathy, and lower levels of depression, manipulation, and alienation
		Religion and coping with stress		
Harbaugh & Rogers (1984)	144 seminarians	Correlational questionnaire research	Holmes–Rahe (1967) Stress Scale, other state and trait anxiety measures	Participants were more stressed than the population average
Hathaway & Pargament (1990)	108 church attenders	Correlational questionnaire research	Questionnaire	Intrinsic religiousness on psychosocial competence was inconsistently mediated and thus suppressed by religious coping styles
Pargament et al. (1990)	586 members of Christian churches who use religious coping strategies	Correlational questionnaire research	Measures of negative events, religious and nonreligious coping activities and outcomes	Both religious and nonreligious coping activities are involved and interrelated in the coping process
Pargament et al. (1988)	197 church members	Correlational questionnaire research	Measures of problem-solving styles	Religion plays a diverse role in problem-solving styles which affects level of competence
Pargament et al. (1992)	538 mainstream Christian church members	Correlational questionnaire research	Religious orientation measures and measures of religious and nonreligious coping	Intrinsic, extrinsic, and quest orientations lead to specific coping behaviors

Table 2 (*continued*)

Study	Participants (age)	Design	Measures	Major findings
		Religion and coping with stress (cont'd)		
Rayburn (1991)	51 Roman Catholic nuns, 45 FRRs, 32 female Episcopalian priests, 45 United Methodist clergywomen, 45 Presbyterian clergywomen, 36 female seminarians (24–75)	Correlational questionnaire research	Occupational Environment Scale, the Personal Strain Questionnaire, the Personal Resources Questionnaire	Nuns had less stress, strain, and depression, as well as better coping resources, than clergywomen had; FRRs experienced the most stress, strain, and depression and had the lowest coping resources
Rosik (1989)	139 widows, 20 widowers	Correlational questionnaire research	Measures on grief, depression, and intrinsic–extrisic religiousness	Higher extrinsic religiousness was found with higher levels of distress across gender, suggesting that an extrinsic orientation may set the stage for poorer adjustment; widowers tending to be more indiscriminately proreligious also showed higher distress levels
Schafer & King (1990)	195 undergraduates	Correlational questionnaire research	Measures of religious preference, attendance at religious services, importance of religion	No relationships were found between the measures of religiousness and perceived stress
Williams et al. (1991)	720 adults	Longitudinal study	Questionnaire	Religious affiliation was unrelated to mental health status; religious attendance buffered the deleterious effects of stress on mental health
		Religious people's views of the world		
S. Lau (1989)	1,475 college student believers (Protestants and Catholics) and nonbelievers (those indicating no religious faith)	Correlational questionnaire research	Measure of values	Believers showed greater preference for and possession of the moral and relational values, and lesser on the personal–extrinsic, competency, and egoistic values; no difference was found on the social and intellectual types of values, which are basically schema irrelevant
Lupfer et al. (1992)	183 people who varied in their commitment to conservative Christianity	Survey research	Christian Orthodoxy Scale, Nearness to God Scale, Church Involvement, Devotionalism, Orthodoxy of Church Affiliation	Moderately and nonreligious people relied more heavily on nonreligious attributions for explaining the cause of behavior, but highly committed conservative Christians made more attributions to God and satan
McCullough & Worthington (1995a)	148 undergraduate students	2 × 2 factorial design	Orthodoxy Measure, Shepherd Scale, Religious Values Scale, E. W. Kelly's (1990) Religious Typology	Measures of religious commitment or value, but not belief, separated religious people's responses to different ways that a counselor deals with religious issues from the responses of less religious people
Morrow et al. (1993)	102 undergraduate students	2 × 3 factorial design	Shepherd Scale, SDS	Participants' religious beliefs did not affect participants' ratings of counselor, but most expected counselors to support clients' religious beliefs or attend to psychological beliefs rather than to challenge a client's religious beliefs
Wikler (1989)	20 Orthodox Jewish clients (20–47)	Semistructured interview schedule	Questionnaire assessing therapists religious identity	45% preferred orthodox therapists, 40% preferred Jewish therapists, 15% expressed no preference
		Preferences for religious counselors and expectations of religion counseling		
Bassett et al. (1989)	200 Christian therapists, 12 undergraduate students	Survey research	Surveys and journal entries	Investigated ways to differentiate between righteous anger and sinful anger
Chesner & Baumeister (1985)	78 male college students—30 Jewish and 48 Christian	Correlational questionnaire research	Questionnaire	Participants were less intimate in disclosing when therapists disclosed their religious beliefs than with the nondisclosing therapists

(*table continues*)

Table 2 (*continued*)

Study	Participants (age)	Design	Measures	Major findings
		Preferences for religious counselors and expectations of religion counseling (cont'd)		
Godwin & Crouch (1989)	96 undergraduates	4 IV quasi experiments	Profile ratings	Christians had more favorable EC in which social desirability does not play a factor; neither participants' gender nor the counselors' religious orientation were as important in forming ECs as previously suggested
Keating & Fretz (1990)	College student and adult participants	Correlational questionnaire research	Religiosity scale, negative anticipations measure	Participants with higher scores on the religiosity scale had strongest negative anticipations about secular counselors, less negative ones about secular but spiritually empathetic counselors, and least negative ones about Christian counselors
Larson, Donahue, et al. (1989)	Patients in research samples in psychiatric journals during 1978–1982	Correlational questionnaire research	Questionnaire	Religious affiliation may have an effect on the use of mental health services
Lewis & Epperson (1991)	360 undergraduates (17–47)	2 × 2 factorial design	Participant feedback	Results indicate that the provision of information about a counselor's values, goals, and techniques enhances a potential client's ability to make informed choices regarding a counseling relationship
Lewis et al. (1989)	172 women seeking treatment at a large psychiatric hosital and outpatient clinic	2 × 2 factorial design	Participant feedback	Consistent with previous research, a simple label was not adequate in triggering a set of accurate beliefs, impressions, and expeditions about the counselor
McMinn (1991)	115 returning students (22–60)	Correlational questionnaire research	Questionnaire	Participants found therapists who valued religious commitment to be more favorable than therapists emphasizing clinical skills; participants with less religious commitment preferred the clinical-skill emphasis
Pecnik & Epperson (1985)	84 Christian and 83 non-Christian undergraduates	2 × 2 between-subjects	Modified version of the Expectations About Counseling—Brief Form	No significant interaction was found between participants' and counselors' religious orientation
P. S. Richards & Davison (1989)	49 Mormon clients, 51 Mormon church leaders	Correlational questionnaire research	ROS, DIT, SDS, scales of shame, guilt, spiritual well-being, and trust of therapist	Participants' views (orthodox vs. unorthodox) affected their trust
Sell & Goldsmith (1988)	279 adults	Survey research	Measure of Christian orthodoxy	Although Christian orthodoxy did not influence the seeking of counseling, participants consulted with friends and family, then doctors and clergy, before seeing counselors
Wikler (1989)	20 Orthodox Jewish clients (20–47)	Semistructured interview schedule	Questionnaire assessing therapists religious identity	45% preferred orthodox therapists, 40% preferred Jewish therapists, 15% expressed no preference
Worthington & Gascoyne (1985)	55 non-Christians, 197 Christians	Correlational questionnaire research	Questionnaire	Participants preferred counselors who shared similar beliefs to themselves; views concerning Christianity did not affect expected counselor style and performance ratings
Wyatt & Johnson (1990)	125 male and 125 female undergraduates	2 × 5 between-subjects	Religious Attitude Inventory, other dependent measures	Positive relationships were found between participants' religiosity and the dependent measures for the religious counselor and between male participants' religiosity and confidence in and willingness to see the Christian counselor

Table 2 (*continued*)

Study	Participants (age)	Design	Measures	Major findings
		Religious clients' responses to counseling		
Kelly & Strupp (1992)	36 clients who presented a marked impairment in interpersonal functioning, had a minimum *T* score of 40 on the SCL–90–R Global Severity Index, and had no evidence of drug abuse, psychosis, gross self-destructive tendencies, or psychotropic medication use	Longitudinal study	Rokeach Value Survey (1967)	Client–therapist dyads whose values were moderately similar showed the most improvement, indicating that an intermediate range of values similarity may function as a predictor of positive outcome
Martinez (1991)	30 clients and their therapists	Correlational questionnaire research	Study of Values—Religious Values Scale (Allport & Ross, 1967), Omnibus Personality—Religious Orientation Scale (Heist et al., 1968)	Clients perceived more improvements when the therapists' initial religious values were dissimilar; therapists perceived improvements when clients' initial religious beliefs were less conservative than themselves; convergence did not correlate significantly with clients' self-improvement ratings

Note. ANCOVA = analysis of covariance; BDI = Beck Depression Inventory (Beck, 1978); BT = "baalei teshuva"; CPI = California Personality Inventory (Gough, 1975); DIT = Defining Issues Test (Rest, 1979); EC = expectations of counseling; EPI = Eysenck Personality Inventory (Eysenck & Eysenck, 1968); FRRs = female reform rabbis; GDS = Geriatric Depression Scale (J. S. Lyons, Strain, Hammer, Ackerman, & Fulop, 1989); IBT = Irrational Belief Test (Jones, 1994); MMPI = Minnesota Multiphasic Personality Inventory; MPCs = Mormon psychotherapy clients; MNCs = Mormon nonclients; PBI = Parental Bonding Instrument (Parker, Tupling, & Brown, 1979); REL = Religiosity Scale (Rohrbaugh & Jessor, 1975); ROS = Religious Orientation Scale (Allport & Ross, 1967); SCS = Self-Control Schedule (M. Rosenbaum, 1980); SDE = self-determined extrinsic; SDS = Social Desirability Scale (Crowne & Marlowe, 1960); SEI = Coopersmith Self-Esteem Inventories (Coopersmith, 1967); SES = socioeconomic status; STAI = State–Trait Anxiety Inventory (Speilberger, Gorsuch, & Lushene, 1970); SWS = Spiritual Well-Being Scale (C. W. Ellison & Paloutzian, 1978); TSCS = Tennessee Self-Concept Scale (Fitts, 1965); TMAS = Taylor Manifest Anxiety Scale (Taylor, 1953).

about religion do not help the religious counselor differentiate the intrinsically religious from the indiscriminantly proreligious client. The nonreligious counselor might be discomfited, however, if an intrinsically religious person persistently describes himself or herself or his or her experiences in religious terms, which is likely to happen. The counselor might think the intrinsically religious person more personally rigid and the indiscriminantly proreligious person as more flexible. Generally, though, intrinsically religious people—as has been shown by a large amount of research—are more likely to be mentally healthy and may actually be *more open to change* than extrinsic or indiscriminantly proreligious people (Bergin, 1991). Contrary to popular stereotypes, this openness to change may be especially true of religiously conservative people relative to people in mainline religions (Pargament et al., 1987).

Bergin (1991) summarized his longitudinal research on 60 Mormon college students by observing that students tend to take different paths to mental health and mental disorder. Mentally healthy college students were likely to have parents who were benevolent, nonconflictual childhoods, smooth or continuous religious-development histories, and mild religious experiences. Those students usually had little turbulence in adolescence and reported real (but not dramatic) religious sentiments. In contrast, students with more troubled lives—including troublesome mental health problems and troubling religious experiences—had conflict-laden childhoods, discontinuous religious commitment, and subcultural involvement that involved violation of social norms. Many experienced depression, anxiety, rigid perfectionism, and other disturbances. In some of those students, religious experiences in their college years alleviated their distress, provided happiness, and helped them adjust better to social norms.

During the next decade, researchers need to determine *why* religion sometimes has positive effects. There are some tentative answers. Religion may (a) produce a sense of meaning (something worth living and dying for; Spilka, Shaver, & Kirkpatrick, 1985); (b) stimulate hope (Scheier & Carver, 1987) and optimism (Seligman, 1991); (c) give religious people a sense of control by a beneficent God, which compensates for reduced personal control (Pargament et al., 1987); (d) prescribe a healthier lifestyle that yields positive health and mental health outcomes; (e) set positive social norms that elicit approval, nurturance, and acceptance from others; (f) provide a social support network; or (g) give the person a sense of the supernatural that is certainly a psychological boost but may also be a spiritual boost that cannot be measured phenomenologically (Bergin & Payne, 1993).

Religion and Coping With Stress

A stressful occurrence is an event, series of events, or life condition that demands adjustment. A stress reaction is a reaction to one's perception of the stressful occurrence. Stress is the complex of stimuli, perceptions, and reactions that indicate that

internal and external demands are taxing the organism's adaptive resources (Monat & Lazarus, 1985). Religious and nonreligious people tend to experience equal amounts of stress (Schafer & King, 1990), but religion may help people deal better with negative life events and the attendant stress.

Pargament (1990) adapted Lazarus' cognitive model of stress and coping (Lazarus & Folkman, 1984) to include religious cognition and behavior. In Pargament's model, people appraise stress-producing events using primary appraisal (Is the event potentially harmful?) and secondary appraisal (Can I cope with it?). A stress reaction may ensue, depending on various mediators such as social support, personal hardiness, problem-solving style, and the like. For example, Anson, Carmel, Bonneh, Levenson, and Maoz (1990) examined social support as a mediator between stress and negative life events in 230 members of a kibbutzim. Belonging to a religious community reduced stress, whereas personal religious beliefs did not (see similar findings from a longitudinal study of 720 adults by Williams, Larson, Buckler, & Heckman, 1991). In the last aspect of Pargament's model, people cope with stress through many strategies, some religious and others not. Pargament's model of stress and coping is recursive, not linear. People make appraisals after considering coping efforts and stress reactions, which are in turn considered by other appraisals.

In a series of studies of college students and members of religious or secular communities, Pargament and his colleagues tested various aspects of his model (e.g., Pargament, Ensing, Falgout, & Olsen, 1990; Pargament et al., 1988, 1992). The major tenets of Pargament's (1990) model have also received support. Several beliefs help people cope ("God is a just and benevolent God," "God is one's partner through suffering," "religious rituals provide a sense of security," and "religion provides support;" Pargament et al., 1990). Different problem-solving styles were differentially related to outcomes (Pargament et al., 1988). For example, a collaborative style, involving an active interchange with God, was related to a sense of competence and personal efficacy. A deferring style, in which the person waits for God to solve the problem, was related to lower levels of competence and to an external locus of control. A self-directing style, which emphasizes God-given freedom to direct one's own life, is part of a general well-functioning way of dealing with stress but is weakly related to religion. Note that Pargament has generally investigated people who have not presented themselves to a religious (or secular) counselor. The extent to which Pargament's findings are generalizable to a clinical sample is thus far undetermined.

Religious People's Views of the World

Worthington (1988) suggests that highly committed religious people—usually those who score in the top 10–15% of religious people on measures of religious commitment, intensity, or salience—view the world differently than do less religiously committed, nonreligious, or antireligious people. Highly religious people were hypothesized to evaluate others on three primary value dimensions—importance ascribed to Scripture or sacred writings, religious leaders, and one's primary religious group—whereas moderately and nonreligious people do not often make such evaluations. Furthermore, he suggests that people have "zones of toleration," ranges within which they can accept the values of another. An interaction between people's religious values and their perceptions of counselors was predicted. Although the predictions applied to all highly religious people, an exaggerated effect was predicted for clients.

Primary to Worthington's (1988) theory is that highly religious people use more religious schema (i.e., cognitive constructs) to perceive the world than do less religious people. Two studies have supported that proposition. Lupfer, Brock, and DePaola (1992) studied 183 participants who varied in their commitment to conservative Christianity. Lupfer et al. solicited attributions for everyday behavior. Moderately and nonreligious people relied more heavily on nonreligious attributions for explaining the cause of behavior, but highly committed conservative Christians made more attributions to God and to Satan than did less committed believers. S. Lau (1989) compared the belief systems of 1,475 Protestant and Catholic students according to how schematic or aschematic they were with respect to religion. The highly religious showed more religious differentiation than did the nonreligious.

Worthington (1988) suggests that highly religious clients would prefer therapists of similar religious values to themselves, but moderately or nonreligious clients would not distinguish as much between counselors similar or dissimilar to them on religious values. Two studies have supported that proposition. Wikler (1989) examined 20 Orthodox Jewish clients through a semistructured interview. Most clients held strong preferences about type of counselor. Of the 20 clients, 45% preferred orthodox counselors, 40% preferred Jewish therapists, and 15% had no preference. Keating and Fretz (1990) tested 301 Protestant Christian college students who expressed a similar pattern of preferences for counselors.

Religious values affect highly religious people's preferences for counseling, but religious beliefs do not. Morrow, Worthington, and McCullough (1993) had students observe videotape excerpts of counselors supporting, challenging, or ignoring a client's religious values. Students generally preferred the supportive counselor. Students were classified according to whether they were high, medium, or low on conservative Protestant beliefs. No interaction between religious beliefs and perceptions of the counselors was found, which replicated Pecnik and Epperson (1985) who also did not find a Protestant belief by perception interaction. McCullough and Worthington (1995a) replicated that finding, using two measures of religious beliefs; however, they found expected interactions when they classified students according to religious values, namely, religious commitment and values suggested by Worthington (1988)—authority of Scripture, authority of religious leaders, and authority given to religious identification (see also Keating & Fretz, 1990, who classified students according to the same three values and found an interaction). Regardless of the students' religious values, the students preferred counselors who did not directly challenge the client's religious values. Most secular counselors are reluctant to challenge even erroneous religious beliefs of their clients (Holden, Watts, & Brookshire, 1991); when they do, people with high religious values may react quite negatively (Morrow, Worthington, & McCullough, 1993).

Preferences for Religious Counselors and Expectations of Religious Counseling

In 1986, Worthington reviewed six analogue studies that provided religious and nonreligious people information about

counseling and then measured their preferences for religious counselors. Generally, religious people prefer religious counselors, but any exposure to actual counseling made religious or nonreligious counselors who behave the same equally attractive. On the basis of that evidence, Worthington dismissed the importance of the effect of pretherapy information regarding similarity of client–counselor religious values on clients' preferences for and expectations of counseling because actual counseling had not been found to affect the clients' preferences and expectations. That dismissal may have been premature.

Nine studies since 1984 have shown that pretherapy information that discloses the counselor's religious values can affect clients' preferences for different types of counselors and expectations about processes and outcomes of different types of counseling (Chesner & Baumeister, 1985; Godwin & Crouch, 1989; Keating & Fretz, 1990; Lewis & Epperson, 1991; Lewis & Lewis, 1985; Pecnik & Epperson, 1985; P. S. Richards & Davison, 1989; Worthington & Gascoyne, 1985; Wyatt & Johnson, 1990). Usually, researchers presented students or actual clients with a brief written description of the counselor that described his or her approach, training, expertise, or specialty with a label either as a *Christian* (e.g.) or with no label concerning religion. Chesner and Baumeister (1985) used visible symbols of religion—a *yarmulke* or cross—to convey counselor religiosity. Research participants' religious orientations were generally measured by standardized inventories. Outcome measures have generally been nonstandardized measures of (a) preferences among types of counselors, (b) expectations about what might or might not occur in various types of counseling, and (c) expectations about likely outcomes of different types of counseling. Revealing a counselor's religious values has produced several effects:

1. Highly religious Jews, Mormons, Protestants, and Roman Catholics usually prefer counseling with religiously similar counselors.
2. Non-Christians do not usually differ in preferring Christian or non-Christian counseling, especially if the counselor is accepting of spiritual experience (Keating & Fretz, 1990), or if they do prefer one type, they usually mildly prefer Christian counselors (Keating & Fretz, 1990; Worthington & Gascoyne, 1985).
3. Christians tend to rate all counselors—labeled *Christian* or *not*—more favorably than do non-Christians (Godwin & Crouch, 1989; Pecnik & Epperson, 1985).
4. Highly religious people may use religion as the litmus test for their reaction to a counselor. Less religious clients react to counselors more on the basis of disclosure of other values. P. S. Richards and Davison (1989) studied 49 Mormon clients at an explicitly Mormon counseling clinic and 51 Mormon religious leaders within the Minneapolis, MN, metropolitan area. Richards and Davison concluded that the reactions of clients with high religious and moral traditionality to therapist self-disclosure of their values generally could be accurately predicted on the basis of similarity to the clients' values. Other people's reactions to therapist self-disclosure depended more on specifically what the therapist self-disclosed.
5. If a client knows a counselor's religious identification, the client may change his or her self-disclosure to the counselor. For example, all participants chose more intimate topics when they expected to talk with the person who was not wearing a religious emblem (see also Wyatt & Johnson, 1990) than when they expected to talk to an explicitly religious counselor. However, highly religious Christians chose more intimate topics when they expected to talk with the counselor wearing the cross, and highly religious Jews chose more intimate topics when they expected to talk with the counselor wearing the yarmulke (again, similar to Wyatt & Johnson, 1990).
6. Most clients do not want counselors to focus centrally on religion. Wyatt and Johnson (1990) found that all their participants except the most highly committed religious people preferred a traditional (no mention of religion) counselor or religious counselor who said that he or she did not think religious issues were at the core of counseling. The least preferred counselors were the explicitly agnostic counselor, the explicitly Christian counselor who believed that religious values were at the core of counseling, and the explicitly Christian counselor who used biblical Scripture in counseling. For highly committed Christians, though, the most preferred counselors were the two Christian counselors who (a) believed that religious values were at the core of counseling and (b) used Scripture in counseling.
7. Christians who describe themselves as "born again" expect more religious behavior (praying, quoting the Bible, etc.) from Christian counselors than from secular counselors (Worthington & Gascoyne, 1985).
8. The type and amount of pretherapy information is important. Lewis and Epperson (1991) extended the work of Lewis, Epperson, and Foley (1989) about the optimal amount of description of counselors with feminist views. In contrast to Lewis et al. (1989), who found that less information about therapists with feminist views produced more positive expectations, Lewis and Epperson found that more information about Christian counselors resulted in more positive expectations about counseling outcomes (see Wyatt & Johnson, 1990, for a replication).
9. Clients may rate a counselor labeled *Christian* as less expert than if the label was not known, regardless of whether the participants are Christian (Pecnik & Epperson, 1985).
10. Adding information about how much counseling experience the counselor has can elevate ratings of religious counselors' expected competence (Godwin & Crouch, 1989). People may hold a stereotype that religious counselors are less trained or experienced than are secular counselors.
11. Christians usually anticipate negative outcomes in counseling if they attend counseling with either secular counselors or nonreligious counselors who believe that problems might have a "spiritual cause" (Keating & Fretz, 1990). This is important because a minority of counselors are traditionally religious; many are spiritual but not religious (Bergin & Jensen, 1990; Jensen & Bergin, 1988; Shafranske & Gorsuch, 1984; Shafranske & Malony, 1990b). Spiritual (but not traditionally religious) counselors may assume that their stance toward spirituality may be acceptable for highly religious clients, but this is not necessarily true with highly committed Jews (Wikler, 1989) and Christians (Keating & Fretz, 1990).

In summary, highly religious people may prefer religious counselors and explicitly religious counseling, even though they

may rate the counselors as less qualified than they may rate secular counterparts. Despite preferring religious counselors, people do not want their counseling to focus mainly on religion. When counselors disclose their religious beliefs or values, their disclosure will likely affect both the client's behavior and expectations about counseling process and outcome. Disclosing a counselor's religious beliefs and values can facilitate counseling if the counselor and client are quite similar in beliefs and values and if the counseling does not focus mainly on religion. However, disclosing a counselor's religious beliefs can likely inhibit counseling if (a) the counselor differs substantially from the client in religious beliefs and values, (b) the client is prone to censor self-disclosure to a religious professional, (c) the client holds strong negative stereotypes about religious people or religious counseling, (d) counseling sessions become too focused on religion, or (e) the counselor is spiritual but not religious and is counseling highly religious Jews or Christians.

With health care reform and pressures for accountability in treatments, it is conceivable that more pretherapy information will be used, including information about the counselor, preparatory information about how to use counseling effectively, and even summaries of the content of the counselor's theory of therapy. That information may also be provided in a variety of formats, including brochures, other written material, videotapes, audiotapes, or compact discs. Questions about format and the amount of information clients—highly religious and otherwise—receive before therapy and the timing of information as therapy progresses need to be answered, for all counselors, not merely religious counselors.

Religious Clients' Responses to Counseling

Throughout the 1970s and 1980s, much ink was spilled concerning value convergence in counseling (for reviews, see Atkinson & Schein, 1986; Beutler, 1981; Beutler & Bergan, 1991; Beutler, Clarkin, Crago, & Bergan, 1991; T. A. Kelly, 1990; and Tjeltveit, 1986). Generally, all reviews have concluded the same thing: In successful counseling, clients tend to adopt the values of their counselors, especially personal and mental health values (Kelly & Strupp, 1992).

Initial therapist–client value similarity is related to the degree to which clients adopt the values of their counselors. T. A. Kelly (1990) reviewed the six most methodologically sound studies and concluded that value convergence predicts therapist ratings of client improvement but not client or observer ratings. Beutler, Machado, and Neufeldt (1994), who examined recent reviews, concluded that therapist–client initial similarity in religious values may engage clients in counseling but that usually clients' religious values do not change in therapy (see also T. A. Kelly & Strupp, 1992; Worthington, 1991b). In recent years, new empirical research has slowed but not stopped (T. A. Kelly & Strupp, 1992; Martinez, 1991). Kelly and Strupp's study was particularly informative. In this article, we do not review the few individual studies that have been published because previous reviewers have addressed the topic (Beutler et al., 1994).

Summary

Religious clients cannot reliably be labeled as having poor mental health. In fact, many may draw on their religion to cope with stress (Pargament, 1990). Most highly religious clients understand the world through more religious schema (Worthington, 1988) and consequently view counseling differently than do less- or nonreligious clients. In fact, the highly religious strongly prefer religiously similar counselors, not merely counselors who value general spirituality; however, highly religious clients do not want counseling to focus on religion. Even when religious clients attend counseling with nonreligious counselors, the clients' religious values are quite resistant to modification (T. A. Kelly & Strupp, 1992).

Religion and Counselors

Status in 1984

In 1984, existing research on religion and counselors was almost solely about clergy who counseled. Generally, counseling loads of clergy depended on the size of their congregation and their theology. More liberal theology was associated with more counseling. No research studied lay counseling or professionals who explicitly labeled themselves religious counselors. A few studies addressed the religious values of mental health professionals—most of whom did not highly value religion.

Worthington (1986) recommended more research and theorizing by women (because few women had written in the area up to that time) and more investigations of lay counselors, professionals who considered themselves to be religious counselors, and actual behavior during counseling (not just questionnaires). Because marriage and family are highly valued in most religious traditions, he also called for increased attention to research in marital and family counseling.

Topics Reviewed

Since 1984, research on religion and counselors has mushroomed. As a consequence, large literatures have addressed some topics that were unclear in 1984, and the breadth of research has expanded. Sophistication of published research has increased dramatically since 1984, probably because of the increased research activity that has provided more high-quality articles from which journals can choose. Many studies on religion and counseling have been published in mainline referred journals, indicating that more articles are conforming to the quality of experimental and statistical control normally expected in psychology. Furthermore, most journals that specialize in research on religious topics (see Table 1) have increased their standards of acceptance for published empirical research.

In this review, we summarize empirical research on (a) religion within the mental health professions, (b) several varieties of religious counselors and problems brought to each, (c) whether counselors' religious values and beliefs affect their clinical judgment, and (d) whether counselors' religious values and beliefs affect their clinical behavior. The studies reviewed are summarized in Table 3.

Religion Within the Mental Health Professions

Within the last 10 years, scholars have investigated the religious, spiritual, and general mental health values of mental

(*text continues on page 464*)

Table 3
Summary of Empirical Research on Counselors and Religion

Study	Participants (age)	Design	Measures	Major findings
		Religion within the mental health professions		
Bergin & Jensen (1990)	425 marriage and family therapists, clinical social workers, psychiatrists, and clinical psychologists	Correlational questionnaire research	Questionnaires about religious preference and church attendance, ROS	230 participants were classified as religious
Eckhardt et al. (1992)	147 members and fellows of the American Psychological Association	Correlational questionnaire research	37-item questionnaire examining religiosity, religious ideology, scientific thinking, and self-perceived conflict	Participants reported mild to moderate levels of religious involvement, which were much lower than those of the general public; they were also skeptical of complete dependence on science
Galanter et al. (1991)	193 psychiatrists who were members of an evangelical Christian medical society	Correlational questionnaire research	Questionnaire	Participants were more religious than Americans overall, would encourage religious morals, and used Bible and prayer in treatment of religious patients
Gartner (1986)	356 professors of clinical psychology	Quasi experiment	Acceptance or rejection into graduate school	Participants were more likely to admit a candidate who did not mention religious beliefs than an identically qualified candidate who did mention religious beliefs
Jensen & Bergin (1988)	425 marriage and family therapists, clinical social workers, psychiatrists, and clinical psychologists	Survey research	Survey	There was a strong relationship between participants view of a value's importance for a positive, mentally healthy life-style and its usefulness in guiding psychotherapy
Jones et al. (1992)	640 graduates of Christian graduate training programs	Survey research	Survey	Master's alumni were typically more morally and religiously conservative than were doctoral alumni; alumni reported themselves as envangelicals and reported a high frequency of religious behaviors; however, use of religious interventions was low; training had a positive impact on personal faith and promoted moderate satisfaction on integration issues
Joseph (1988)	53 social work practitioners	Correlational questionnaire research	Questionnaire	Participants identified religious and spiritual issues that emerged in social work practice as salient factors during various life stages
Shafranske & Gorsuch (1984)	272 clinical psychologists (M = 49)	Correlational questionnaire research	Questionnaire	Participants who perceived spirituality as relevant in their own lives were more likely to value spirituality in their clinical work
Shafranske & Malony (1990a)	47 randomly selected clinical psychologists from California	Survey research	Assessment of ideology, attitudes toward religion, religious affiliation, dimensions of religiosity, and use of clinical interventions of a religious nature	Majority of participants were found to address religious and spiritual issues in their personal lives, to respect the function religion serves in people's lives, to address religious and spiritual issues in professional practice, and to use interventions of a religious nature
Shafranske & Malony (1990b)	107 female and 299 male clinical psychologists (29–88)	Correlational questionnaire research	Questionnaire	Psychologists' religious and spiritual orientations affect attitudes and therapeutic interventions
		Varieties of explicitly religious counselors		
Lay and paraprofessional counseling				
Boan & Owens (1985)	27 paraprofessional lay counselors, 215 clients	Correlational questionnaire research	Questionnaires	Peer ratings of counselor skill can be useful in predicting client satisfaction

(*table continues*)

Table 3 (*continued*)

Study	Participants (age)	Design	Measures	Major findings
		Varieties of explicitly religious counselors (cont'd)		
Harris (1985)	44 clients	Four factor between-subjects	Questionnaire	A professional pastoral counselor and a volunteer lay helper combination results in a more favorable increase in client self-esteem than professional work only
Walters (1987)	98 clients of a lay counseling resource center	Survey research	Self-report data	Some clients indicated satisfaction although no progress was made, whereas clients who had progressed indicated dissatisfaction; clients with depression were dissatisfied
Spiritual direction				
Ganje-Fling & McCarthy (1991)	68 spiritual directors, 50 psychotherapists	Survey research	Self-report	Spiritual directors were more likely than psychotherapists to incorporate the other discipline's methods and topics into their practice
Chaplains				
Barger et al. (1984)	186 chaplains	Correlational questionnaire research	Questionnaire	Participants see themselves as counselors and professionals, and then religious functionaries
Clergy				
Chalfant et al. (1990)	806 respondents residing in the El Paso standard metropolitan statistical area	Face-to-face interviews with a structured interview schedule	Interview schedule	Clergy are by far the most popular source of help for a personal problem, not because of religious affiliation but because of ethnicity, church attendance, and SES
Domino (1990)	23 clinical psychologists, 75 clinical and counseling graduate students, 279 undergraduate students, 41 Catholic priests, 27 Jewish rabbis, 36 Protestant ministers, 23 Eastern religious leaders, 30 in nontraditional ministeries	Correlational questionnaire research	120-item multiple-choice test assessing knowledge of psychopathology based on material taught in abnormal psychology classes	Clergy scored lowest of all groups
Eaton et al. (1984)	ECA survey	Critique of implementation	Standards of measurement	Overview of the ECA survey
Larson et al. (1988)	18,495 clients	Four factor between-subjects	Client records	Participants receiving services from both clergy and mental health specialists were more likely to have major affective and panic disorders than participants who sought services from clergy or mental health specialists only or neither; participants in the care of mental health specialists were more likely to have substance abuse disorders, whereas participants in the care of only clergy were as likely as participants seeing only mental health specialists to have serious mental disorders
G. K. Lau & Steele (1990)	231 Methodist clergy	Hierarchical multiple regression	Self-report	Church membership status and type of presenting problems were the most significant predictors of if clergy would counsel, refer, or consult
Mertens et al. (1986)	240 clergy, 80 teachers, 160 employees of the United Methodist Church and March of Dimes Birth Defects Foundation	Correlational questionnaire research	Questionnaire	Clergy training needs to focus on genetic/bioethic education (and other current topics) to better serve their congregations
Regier et al. (1984)	ECA survey	Critique of implementation	Standards of measurement	Overview of the ECA survey
R. Rosenbaum (1994)	58 clients at an outpatient clinic	Two factor designs	Client response	58% of the clients thought a single psychotherapeutic session was sufficient

Table 3 (*continued*)

Study	Participants (age)	Design	Measures	Major findings
		Varieties of explicitly religious counselors (cont'd)		
Royse (1985)	174 clergy	Correlational questionnaire research	Questionnaire	People frequently report their near-death experiences to clergy and tend to become more religious while their fear of dying lessens
Wright (1984)	173 Protestant and Roman Catholic pastors in Canada	Correlational questionnaire research	7-page questionnaire	Years of education, positive attitudes toward community mental health, and workshop attendance significantly correlated with the clergy's involvement in mental health
		Does religion affect counselors' clinical judgment?		
Gartner, Harmatz, Hohmann, Larson, & Gartner (1990) *and* Gartner, Harmatz, Hohmann, & Larson (1990)	363 clinical psychologists	Repeated measures	Clinical judgment	Patient ideology, therapist ideology, and their interaction had affected clinical judgment
Hochstein (1986)	190 pastoral counselors	Correlational questionnaire research	38-item subscale of the Broverman Sex-Role Stereotype Questionnaire (Broverman et al., 1970), Index of Attitudes Toward Homosexuals	Pastoral counselors do not rate lesbian and gay male clients as significantly different from heterosexual clients
Houts & Graham (1986)	24 religious and 24 nonreligious clinicians	2 × 3 between-subjects	Videotape ratings	Moderately religious clients were viewed as having a more pessimistic prognosis and greater psychopathology; religious therapists made more internal attributions for nonreligious clients, whereas nonreligious therapists did the same for religious clients
Kivley (1986)	56 therapists	Correlational questionnaire research	Questionnaire	Participants did not believe religious beliefs were a neurosis; participants' self-perceived religiosity was significantly related to attitudes toward dealing with religious issues
Lewis & Lewis (1985)	77 psychologists in Iowa	2 × 2 between-subjects	Manipulation checks, a modified form of the Therapist Personal Reaction Questionnaire, a 9-question schedule, *DSM–III*	Religious commitment of both therapists and patients had no effect on therapists' attraction to or diagnosis of a patient
Reed (1992)	230 psychologists (30–76)	1 × 2 between-subjects	Questionnaire	Religiousness and stability of belief were not influences on clinicians' judgments on whether adoption should occur, recommendation of therapy, or estimates of adaptive functioning
		Does religion affect counselors' clinical behavior?		
Referral to and from clergy				
B. K. Lau & Steele (1990)	231 Methodist clergy	Hierarchical multiple regression	Self-report	Church membership status and type of presenting problems were the most significant predictors of if clergy would counsel, refer, or consult
Lowe (1986)	67 Church of Christ ministers in Southern California	Correlational questionnaire research	4-page questionnaire	Ministers rarely make referrals to mental health professionals and receive referrals from these professionals even less often

(*table continues*)

Table 3 (*continued*)

Study	Participants (age)	Design	Measures	Major findings
Does religion affect counselors' clinical behavior? (cont'd)				
Lyles (1992)	17 African American pastors	Correlational questionnaire research	Questionnaire	Barriers to psychiatric referral included religious and racial concerns, skepticism about psychiatric efficacy, and financial concerns
Meylink (1988)	54 graduate students in clinical psychology at Fuller Theological Seminary	Pretest–posttest	Questionnaire	An educational intervention significantly increased willingness to work together with clergy in conjoint–concurrent treatment situations
O'Malley et al. (1984)	65 clergy and mental health professionals	Correlational questionnaire research	Questionnaire	Therapist values were a more important aspect of the therapeutic process for religious counselors
Wright (1984)	173 Protestant and Roman Catholic pastors in Canada	Correlational questionnaire research	7-page questionnaire	Years of education, positive attitude toward community mental health, and workshop attendance significantly correlated with the clergy's involvement in mental health
Counseling behaviors: Empathy, confrontation, and perceptions of therapy				
Gibson & Herron (1990)	103 religious and nonreligious therapists	Correlational questionnaire research	Vanderbilt Psychotherapy Process Scale, scales measuring involvement in church or synagogue activities and traditional theistic beliefs	Participants did not differ in their perception of the therapy process
Holden et al. (1991)	150 national certified counselors, 150 clergy	Correlational questionnaire research	Questionnaire	Both counselors and clergy feel that depressed religious clients' ideation was a misinterpretation of Judeo–Christian principles, but only those with religious training believed that they could effectively challenge clients' seemingly erroneous religious ideation
P. Lyons & Zingle (1990)	46 pastoral counselors, 96 clients	Correlational questionnaire research	Three-dimensional religious orientation scale (clergy), empathy scale (clients)	End-oriented and quest-oriented counselors were perceived to be significantly more empathic than means-oriented counselors

Note. *DSM–III* = *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.); ECA = Epidemiologic Catchment Area (Eaton et al., 1984); ROS = Religion Orientation Scale (Allport & Ross, 1967); SES = socioeconomic status.

health professionals. In 1984, no investigations of such values had been published. Bergin and Jensen (1990) surveyed 414 therapists (118 marital and family therapists, 106 clinical social workers, 71 psychiatrists, and 119 clinical psychologists). They found that the percentage of counselors who regularly attended religious services varied from 32% (psychiatrists) to 50% (marital and family therapists); however, most therapists agreed that they tried to live by their religious or spiritual beliefs (85%, marital and family therapists; 83%, clinical social workers; 74%, psychiatrists; and 65%, clinical psychologists). This suggests that there might be substantial interest in spirituality when broadly defined, including substantial participation in traditional religious beliefs and practices.

Jensen and Bergin (1988) found that 10 themes characterized the values of 425 mental health professionals (generally the same sample as above). They reported a general consensus on 8 of those themes, which characterized elements of positive mental health: mature self-regulating values that give purpose to life, forgiveness, commitment to others, individual responsibility and freedom, coping with stress and work, self-awareness, health and fitness, and perception and expression of feelings. Whereas those 8 themes garnered about 90% support among therapists, 2 themes were supported by fewer therapists. Only half of the two thirds of the therapists advocated (a) regulated sexual fulfillment and (b) spirituality or religion.

Shafranske and Gorsuch (1984) analyzed the data collected in a survey of members of the California State Psychological Association (CSPA) by the CSPA Task Force on Spirituality and Psychotherapy. Of the 1,400 members, only 272 usable responses were obtained. Most therapists were raised as Christians (60%) or Jews (27%), but as adults only 23% were still involved in a traditional religion, whereas 38% adhered to some alternative religion. Of the therapists, 13% said they were atheists, 11% agnostic, and 14% other. Therapists' ratings of high relevance of spirituality for their personal lives were related to frequent participation in traditional religion, high ratings of the

formal religion's contribution to spirituality, and low involvement in alternatives to traditional religion. Theoretical orientation and ratings of whether therapists thought spirituality was personally relevant predicted therapists' beliefs that spirituality was relevant for counseling (see also Kivley, 1986). Jungian and existential–humanistic counselors were most likely to think that spirituality was relevant for counseling. Cognitive therapists were likely to answer that they were not sure. Behavioral, psychoanalytic, and eclectic counselors rated the relevance of spirituality for counseling, on the average, between relevant and not sure.

Shafranske and Malony (1990b) surveyed 1,000 clinical psychologists across the United States and received responses from 409. Of the participants, 217 thought that religion was generally helpful for most people, 135 were neutral on the issue, and only 57 thought religion was undesirable for most people. Of the participants, 266 said that spirituality was personally relevant for them, but only 18% cited organized religion as the source of their spirituality. Ninety-seven percent of the participants claimed to have been raised within some religious tradition, but only 71% were still affiliated with organized religion. Almost 50% reported no attendance at religious services. Only 7% of the clinical psychologists reported a negative reaction to religion.

Similar results emerged from those surveys of professionals. Counselors substantially agreed about the values they wish to promote during therapy. Most are quite spiritual and think that spirituality may be appropriate for inclusion in therapy if the client and situation warrant it (Kivley, 1986). A small minority oppose religion.

Besides general mental health therapists, more specialized subgroups of professionals have also been examined, including explicitly religious psychiatrists and psychologists, licensed and credentialed pastoral counselors, and others (Eckhardt, Kassinove, & Edwards, 1992; Galanter, Larson, & Rubenstone, 1991; Gartner, Hermatz, Hohmann, Larson, & Gartner, 1990; Gibson & Herron, 1990; Jones, Watson, & Wolfram, 1992; Joseph, 1988). Differences can be seen across fields and within fields according to religious commitment and affiliation.

At the risk of overemphasizing differences and of defining categories that cannot be used to classify every professional, we tentatively propose that there are three groups of counselors—those highly committed to a particular formal religion (generally few; Shafranske & Malony, 1990b), those highly opposed or indifferent to most formal religions (even fewer; Shafranske & Malony, 1990b), and those who favor an inclusive stance (they accept almost all religious and broadly spiritual approaches as well as agnostic and atheism). Each of those groups can be subdivided into counselors who more *readily* include religious or spiritual values in therapy, those who *reluctantly* include religious or spiritual values in therapy, or those who *exclude* them altogether. The decision about inclusion or exclusion of spiritual and religious values in therapy may have as much to do with the counselor's theoretical orientation as his or her religious or spiritual beliefs.

Varieties of Explicitly Religious Counselors

Many nonprofessional helpers counsel, and many of those are religious. These include lay and paraprofessional helpers, spiritual directors, chaplains, and clergy. Researchers have addressed their clientele, but few have investigated their effectiveness.

Lay and paraprofessional counseling. Evidence has mounted that lay counselors have helped people in psychological distress as effectively as have professional therapists in many instances. Christensen and Jacobson (1994) reviewed the research on the effectiveness of paraprofessional counseling relative to professional counseling. They concluded that no difference could be documented from the research; however, they offered several caveats. First, inexperienced professional counselors have generally been compared with paraprofessional counselors. Second, comparisons did not include the full range of psychological disorders. Most studies used clients who were mildly or moderately disturbed. Third, professional therapists usually selected, trained, and supervised the paraprofessionals, and professional supervision might be necessary for successful paraprofessional counseling. Fourth, the conditions requiring professional versus paraprofessional counseling have not been identified (e.g., psychological diagnosis and presenting a problem).

Lay counseling programs within organized religion have become numerous (Tan, 1985, 1991a, 1991b). In the last decade, three empirical studies investigated the effectiveness of lay counseling within a religious context (Boan & Owens, 1985; Harris, 1985; Walters, 1987). The findings paralleled those summarized by Christensen and Jacobson (1994). Lay counseling was at least as effective at promoting positive changes in self-concept as was professional counseling (Harris, 1985). Furthermore, Walters found success rates equal to those of psychotherapy (Strupp, Hadley, & Gomez-Schwartz, 1977). However, the quality of the three studies on the effectiveness of religious lay counseling was not high. More definitive conclusions await empirical investigations of lay counseling with religious counselors and clients that have applied the same standards of research as have studies of paraprofessional counseling.

Spiritual direction. Spiritual direction is guided reflection about the spiritual aspects of one's life. For example, a person attending spiritual direction might meet with a spiritual director, who reviews the person's life circumstances with the goal of increasing the person's spirituality or religious devotion, not necessarily solving the person's problems. Spiritual direction is not counseling, although a spiritual director may give advice and suggestions about personal, emotional, or relationship difficulties. Spiritual directors are usually clergy who may have received training in spiritual direction. Ganje-Fling and McCarthy (1991) compared 68 spiritual directors (81% Roman Catholic, 13% Protestant, 3% other, and 3% nonreligious) with 50 psychotherapists (36% Protestant, 22% Roman Catholic, 10% Jewish, 14% other, and 18% nonreligious) on the extent to which each discipline was willing to incorporate the methods of the other disciplines into their work. Psychotherapists identified goals of promotion of psychological growth and resolution of psychological problems more frequently than did spiritual directors; spiritual directors identified goals of promotion of spiritual growth and resolution of spiritual problems more frequently than did psychotherapists. About three fourths of spiritual directors' clients were estimated to bring up problems

appropriate for psychotherapy, whereas only 17% of psychotherapy clients brought up religious topics.

Chaplains. Chaplains frequently work in hospital, correctional, and military settings. Barger, Austil, Holbrook, and Newton (1984), a special committee of the Omaha Area Institutional Chaplains Association, surveyed hospital chaplains throughout greater Omaha, Nebraska, about the role of the chaplain. They obtained a 53% response rate. Ten open-ended questions were coded for content. Chaplains had a low level of agreement about a chaplain's role. Most chaplains saw themselves as professional counselors focusing on patients' and their families' immediate needs. Only 11% of the chaplains saw themselves as religious functionaries.

Clergy. Between 1956 and 1976, the number and percentage of people surveyed who had sought help for a personal problem rose from 14% to 26% (Veroff, Depner, Kulka, & Douvan, 1980). Most went to mental health professionals (57%), but substantial numbers of people (39%) went to clergy. The number of people seeking help from clergy has been virtually unchanged since the mid-1950s; however, the number of clergy who are available to counsel has decreased over that same time span (Hohmann & Larson, 1993). In some localities, clergy are more popular sources of counseling than are mental health professionals (Chalfant et al., 1990). Most clergy counsel within their congregations; however, some pastoral counselors work in ecumenical and denominational agencies (Hochstein, 1986; P. Lyons & Zingle, 1990).

The implications of these data are serious. Fewer clergy who counsel will likely be sought for counsel by many more clients. This will probably be exacerbated because managed mental health care is restricting access to long-term psychotherapy. Many of the people who do not feel satisfied with brief psychotherapies may seek additional help from clergy. Even with decreasing membership in many religious denominations in the United States, people may still seek counseling from clergy simply because clergy counsel without financial charge or with greatly reduced charges.

Clergy generally see the same type of mental health problems as do mental health professionals. Benner (1992) surveyed 405 pastors sampling from every geographic area in the United States. Pastors identified the five concerns most frequently presented by their parishioners. Marriage and divorce was named by 84% of the pastors; depression, by 64%; addictions, by 44%; grief, by 38%; and guilt and forgiveness, by 37%. The distribution is similar to that found in past reviews (Arnold & Schick, 1979; Worthington, 1986). Few people attend counseling for spiritual issues relative to general mental health problems (cf. Royse, 1985).

The severity of problems seen in counseling by clergy rivals the severity of problems seen by mental health counselors. Larson, Hohmann, Kessler, and Meador (1988) examined data on 18,495 people (from the Epidemiological Catchment Area [ECA] study; Eaton et al., 1984; Eaton & Kessler, 1985; Regier et al., 1984) who sought help from both a mental health specialist and pastor, either counselor separately, or neither. Those who sought help from both sources were more likely to have been diagnosed as having major affective disorders or panic disorders than were other clients. Most people sought help from clergy as often as mental health specialists for serious problems; however, people were more likely to seek help from mental health specialists for substance abuse problems. Hohmann and Larson (1993), in analyzing other data from the ECA study, found that clients who were male, divorced, aged 25–45, possessors of professional degrees, and in the highest socioeconomic status (SES) were more likely to seek help from mental health professionals than from clergy.

The caseloads of clergy are variable. In Benner's (1992) survey of 405 pastors, 20% reported that they had counseled over 40 people in their office or home during the past year, 21% between 26 and 40 people, 35% between 11 and 25 people, and 24% between 1 and 10 people. Most counseling (74%) lasted from 2 to 5 sessions, and only 1% of the counseling lasted longer than 10 sessions. Generally, brief psychotherapy is considered to last 25 sessions or fewer (Koss & Shiang, 1994), with a median of 6 to 8 sessions (Garfield, 1986). By those standards, clergy generally conduct very brief counseling (cf. R. Rosenbaum, 1994, who reported on the increasing prevalence of single-session therapies).

Several variables predict which pastors counsel and which do not (Wright, 1984). Higher education, positive attitudes toward community mental health, and attendance at mental health workshops were associated with higher counseling loads (see also G. K. Lau & Steele, 1990). Most pastors (87%) believed that they needed more training in counseling. Given the amount of counseling clergy do and the severity of their clients' problems, clergy's professed desire for more training should be taken seriously (Domino, 1990).

Counseling by clergy deserves increased attention from researchers as well as from those who train clergy. With the likely increase in demand for counseling and the severity of problems that are often presented to clergy who may have little training or expertise in counseling, the quality of mental health of many people may depend on accurate assessments of how well clergy counsel, how to help clergy improve their counseling skills, and how to help clergy manage their caseloads so they do not burn out rapidly. At present, no such data are available.

Effectiveness of religious counselors. Throughout our review of the types of religious counselors, notably missing were reports of outcomes. No outcome studies—either clinical trials or field investigations—have been performed to investigate whether the counseling performed by spiritual directors, chaplains, or clergy is effective. The only outcome research that is available concerns the effectiveness of lay or paraprofessional counseling, and it is not of sufficient quality to compare with outcome research on secular therapy. At present, we can conclude only that much religious counseling may be occurring, but we do not know how effective it is.

Does Religion Affect Counselors' Clinical Judgment?

Highly religious clients believe that most secular counselors may view them negatively because the counselors are often thought to hold different religious values than do the clients. The national surveys by Bergin and Jensen (1990) and state and national surveys by Shafranske and his colleagues (Shafranske & Gorsuch, 1984; Shafranske & Malony, 1990a, 1990b) reveal that there are often differences in religious values between counselors and clients, especially with highly religious clients. Al-

though those differences are now known to be less than was previously believed, there is still a considerable chance that a highly religious client will encounter a secular or religious counselor with substantially different religious values than the client. Ten years ago, only three studies had addressed whether clinicians judged religious and nonreligious clients differently (Margolis & Elifson, 1983; Wadsworth & Checketts, 1980; Worthington & Scott, 1983). The evidence from those studies suggested that secular and religious counselors did not differentially diagnose religious and nonreligious people and that they could distinguish between real and fabricated religious experience or religion used responsibly or pathologically (Worthington, 1986).

Currently, the picture is not so clear. Several investigations have found counselor bias in evaluating religious clients (Gartner, Harmatz, Hohmann, Larson, & Gartner, 1990; Houts & Graham, 1986; Lewis & Lewis, 1985), whereas other studies found no bias (Kivley, 1986; Reed, 1992). Methodology of the studies that suggest a counselor bias in diagnosing clients is stronger than for studies that suggest no bias. For example, in one well-designed study, Gartner et al. surveyed 363 clinical psychologists. Clinicians rated two case histories that were identical except for two variables. In one, the patient was described as a member of an extreme political or religious group of either the right or left wing (e.g., John Birch Society, Fundamentalist Christian, American Socialist Party, or Atheists International); in the other, no mention was made of group membership. Gartner et al. tested three hypotheses. The first—that clinicians would be influenced by patient ideology—was supported. Patients who belonged to extreme groups were judged as promoting less clinician empathy, having more pathology, having more internal and external stress, and being less mature than were patients with the same symptoms but with no mention of membership in the extreme group. The second—that clinicians would rate clients more negatively whose ideologies were opposite from their own—was supported only in empathy promoted by the client. The third—that the patient–client ideology interaction would be strongest for clinicians whose own beliefs were more extreme—was supported only for judgments of maturity. Clinicians with liberal, left-wing views rated clients who belonged to right-wing organizations as less mature than those who belonged to left-wing organizations, but clinicians with moderately left-wing views did the opposite. (There were too few clinicians with right-wing views to analyze.)

Despite the suggestion that some therapists may show bias in clinical judgment, the present body of research is inconclusive. Research to date has been analogue, and all studies have been relatively remote from true clinical situations. For firm conclusions to be drawn, researchers must conduct and report field studies of actual patients and therapists.

The five investigations cited above examine whether nonreligious and religious therapists evaluate explicitly religious clients differently than they do clients whose religion is not known. The clinical judgment of highly religious counselors has not been investigated. (a) Do highly religious counselors negatively perceive clients who are clearly nonreligious, hold radically different religious beliefs from the counselor, or differ on other important value dimensions? This question is becoming an increasingly relevant one. A substantial minority of therapists in general practice are religious, and many explicitly label themselves as religious counselors (Bergin & Jensen, 1990; Shafranske & Malony, 1990b). Although more clients claim to be religious than nonreligious, a substantial minority of clients are nonreligious, antireligious, or embrace Eastern religion. (b) Do highly religious counselors evaluate their religious and nonreligious clients differently? Do counselors with theologically conservative or liberal views evaluate their religious and nonreligious clients differently? Both unexplored areas merit investigation. Only one study has addressed this issue. Hochstein (1986) surveyed 190 pastoral counselors and found that they did not rate their lesbian and gay male clients differently than they did their heterosexual clients. This suggests that perhaps pastoral counselors may not be biased against lesbian and gay male clients. Such a conclusion would be in-line with Allport and Ross's (1967) theorizing on prejudice and religion (for a review, see Gorsuch & Aleshire, 1974). However, the finding may also indicate a sampling bias, in that lesbian and gay male clients may differentially have sought pastoral counselors who would be likely to accept their homosexual behavior.

Even if there is some unintentional bias in judgment by religious or nonreligious counselors, clients are not helpless pawns at the mercy of powerful counselors. T. A. Kelly and Strupp (1992) investigated 36 therapist–client dyads in the Vanderbilt Interpersonal Psychodynamic Therapy Study. Kelly and Strupp found that, contrary to much previous research (see Tjeltveit, 1989, for a review), most of the value change in therapy was away from the therapists' values. Second, value change was usually toward seeking more prosocial goals and becoming more personally competent, not toward adopting different morals. Third, clients' religious values were especially impervious to change through the psychotherapy practiced in the Vanderbilt project.

Does Religion Affect Counselors' Clinical Behavior?

Referral to and from clergy. Worthington (1986) reviewed four studies and concluded that pastors referred difficult cases to secular professionals but were quicker to refer if they knew and agreed with the religious values of the professional to whom they were referring. Pastors reported almost no referrals from mental health professionals to them. Similar conclusions were reached by Meylink and Gorsuch (1988a, 1988b). In the last 10 years, samples have become larger and broader, and research sophistication has been greater (see G. K. Lau & Steele, 1990; Lowe, 1986).

Researchers have investigated why clergy are reluctant to refer. For instance, Wright (1984) surveyed 173 Protestant and Roman Catholic clergy in Canada and found that exposure to mental health training and education was correlated with clergy's involvement in counseling and referral. Other investigators have found theoretical orientation of mental health professionals to be a factor. O'Malley, Gearhart, and Becker (1984) surveyed 36 clergy and 29 mental health professionals. Generally, cooperation between clergy and mental health professionals existed if the therapists were humanistic or behavioral and if the clergy were mainline Protestant. However, fundamentalist and orthodox clergy were reluctant to refer to psychodynamic therapists. Lyles (1992) surveyed 17 Black pastors who stated that

racial concerns, financial considerations, and skepticism about treatment efficacy prevented their being more willing to refer.

Secular professionals rarely refer to clergy, even when difficult spiritual issues arise in counseling. Meylink (1988) found that an educational intervention significantly increased the willingness of doctoral students in clinical psychology at Fuller Theological Seminary to work together with clergy. Most doctoral students at the seminary were already open to religion. Such educational interventions might not be possible, desirable, or effective with counselors who already are not well disposed to religion. In short, it is unclear why professional therapists are reluctant to refer to clergy. It might be due to the therapist's inattention to religious issues, lack of confidence in counseling ability of clergy, paucity of contacts among clergy, or any of a number of other reasons. Research is needed to investigate the cause of the finding.

Empathy and confrontation in religious counseling. Previous research suggests that pastors demonstrate low levels of empathy (Virkler, 1979, 1980). P. Lyons and Zingle (1990) sought to differentiate which types of pastoral counselors demonstrate high empathy and which do not. They classified pastoral counselors on Batson's (Batson, Schoerade, & Ventis, 1993) scale of end-oriented, means-oriented, and quest-oriented religion. End-oriented religious motivation is akin to Allport's (1951) intrinsic motivation; religion is pursued as an end in itself. Means-oriented religious motivation is like Allport's extrinsic religious motivation; religion is pursued as a means to obtaining other ends, such as social status, security, acceptance, and business contacts. Quest-oriented religious motivation (Batson et al., 1993) assumes that religious or spiritual seeking is a worthy goal of religion; quest-oriented religion values the process of religious pursuit more than finding religious truth. Lyons and Zingle surveyed 45 pastoral counselors and 96 clients. They found that pastoral counselors high on end- or quest-oriented religious motivation were perceived by their clients to be more empathic than were pastoral counselors who were high on means-oriented religious motivation.

Whereas clients' perceptions that their counselors are empathic are important to success in brief counseling (Koss & Shiang, 1994), counselors must also be able to confront clients when warranted. Holden et al. (1991) studied 150 nationally certified counselors (from the *Directory of Certified Counselors*) and 150 clergy. Counselors and clergy judged equally well whether religious ideation of a depressed client was a misinterpretation of Judeo–Christian principles. However, only clergy thought they could challenge the client's erroneous religious beliefs. Whether counselors were reluctant to challenge religious beliefs because they lacked confidence or because they did not feel it was appropriate for a counselor to correct a client's theology (or for some other reason) was not investigated (see also Gibson & Herron, 1990).

Religious Techniques

Status in 1984

Worthington (1986) hypothesized the existence of three types of religious counseling techniques: (a) A religious counselor uses *secular* counseling theories and techniques but aims to influence the religious client's worldview to be more religious or spiritual. (b) A counselor uses techniques derived from a *religion* (e.g., prayer, meditation, and forgiveness) within counseling. (c) A counselor uses a secular approach with explicitly religious content (e.g., Christian adaptations of cognitive or psychoanalytic therapy), or integration. In 1984, except for many empirical investigations of the effectiveness of Buddhist- or Hindu-based meditation, only four studies of religious counseling were extant. Empirical research on religious and integration approaches is summarized in Table 4. No research has investigated secular approaches.

Techniques Originating in Religious Traditions

Brief overview. Several investigators have studied the relative frequency of use of various religious techniques within counseling. Others have investigated a single technique—such as prayer, forgiveness, or meditation—as an adjunct to counseling. Methodologically, research has become more sophisticated, and replications have become frequent.

Religious conversion is not a goal of religious counseling, but when clients and counselors talk about religious issues in context of a client's problems, the client might experience a religious conversion or a renewal of faith. Religious conversion is probably quite unlikely (T. A. Kelly & Strupp, 1992). Nonetheless, if conversion does occur, it is often attended by a number of beneficial effects (for reviews, see Albrecht & Cornwall, 1989; Batson et al., 1993; Bergin, 1991; and Spilka, Hood, & Gorsuch, 1985), although none of these reviews have addressed the effect of conversion during counseling. Many religious techniques aimed at helping clients change their psychological functioning might coincide with the promotion of more mature spirituality. The crystallizing of religious identity that occurs with a religious conversion in most cases is a powerful beneficial outcome of conversion (see Bergin, 1991).

Relative frequency of use of religious techniques. Ball and Goodyear (1991), in two studies, had members of the Christian Association for Psychological Studies (CAPS) rate their use of distinctively Christian counseling techniques. In the first study, of the 303 members surveyed, 174 (57%) responded. They identified 454 religious interventions, and each intervention was identified as belonging to one of the three categories suggested by Worthington (1986)—secular (27; 7%), religious (251; 71%), or integration (74; 21%). In the second study, in-depth interviews were conducted with 30 CAPS members, who reported critical incidents in Christian therapy, which "affected [their] subsequent skills or approaches to therapy" (p. 147). Those events were coded as 1 of 15 religious counseling techniques. In both studies, the most used technique was prayer (27% and 20%, for Studies 1 and 2, respectively). Prayer was followed, in turn, by teaching religious concepts (17% and 2%), reference to Scripture (13% and 3%), forgiveness (7% and 6%), use of self as technique (6% and 7%), religious homework (5% and 2%), and use of outside resources such as pastor or lay helper (4% and 11%), for Studies 1 and 2, respectively. Secular techniques—standard psychological interventions that seem to have no religious pertinence—were used in 37% of the critical incidents. P. S. Richards and Potts (1995) found similar patterns of use of religious and spiritual techniques in a survey of

215 Mormon therapists. They used an analysis of critical incidents to determine the usefulness of techniques apart from their frequency of use. The most useful were quoting Scripture to support an already made point, teaching clients about spiritual concepts, using religious-guided imagery, and using spiritual resources as biblio-therapy.

In an investigation of actual counseling, Worthington, Dupont, Berry, and Duncan (1988) studied seven practicing therapists in agency work or private practice, all of whom publicly identified themselves as Christian counselors. The counselors and 19 of their clients completed end-of-session surveys about what happened in each session. Overall, 92 counseling sessions were monitored. For 53 of those, both therapist and client reported on the use of 19 religious counseling techniques in the session. There were four major findings: (a) The most frequently used religious counseling techniques (according to the number of sessions in which at least 1 participant reported its use) were religious homework (37 out of 53 sessions), interpretation of Scripture (37 sessions), discussion of faith (31 sessions), quotation from Scripture (29 sessions), prayer (26 sessions), and teaching with Scripture (21 sessions). (b) Counselors used the most religious techniques when they perceived the client's religious commitment to be intense and used fewer when they perceived the client's religious fervor to be either very intense or of moderate, low, or no intensity. (c) The frequency of use of religious counseling techniques was not correlated with the client's perception of the session's helpfulness. (d) Counselors differed substantially in their use of number and variety of techniques. Worthington et al. (1988) concluded that

> Christian psychotherapy is not a unitary enterprise, which is hardly surprising to most practitioners but which is not always understood by the nonreligious and even by the religious nonprofessional. Being identified as explicitly Christian does not insure that a therapist will be rated as effective by Christian clients. (p. 291)

Jones et al. (1992) surveyed 1,548 alumni of three doctoral and four master's programs in clinical psychology, all of which were explicitly Christian. Only 640 surveys were returned (a 41% return rate). Counselors estimated the percentage of their clients with which they used various religious counseling techniques, and they were asked how appropriate each technique was for a Christian client and for use in general practice. They implicitly taught biblical concepts in 68% of the cases; prayed for clients outside of the session, 61%; instructed in forgiveness, 42%; explicitly taught biblical concepts, 28%; confronted clients over sinful life patterns, 28%; instructed clients about confession, 22%; prayed with clients in session, 18%; used guided religious imagery, 12%; and taught religious meditation, 12%. Only the three most frequent techniques (implicitly teaching biblical concepts, praying for clients outside of session, and instructing in forgiveness) were rated as more appropriate than not for general practice, although all techniques were rated as appropriate with Christian clients.

The lessons learned from these investigations of use of religious counseling techniques are several. First, a variety of methods have been used to investigate religious counseling techniques by Christian therapists. These include client and counselor ratings of sessions (Worthington et al., 1988), mail surveys (Ball & Goodyear, 1991; Galanter et al., 1991; Jones et al., 1992; Moon et al., 1991; Moon, Willis, Bailey, & Kwasny, 1993), and phone interviews elaborating critical events (Ball & Goodyear, 1991). Sample sizes have been substantial. Second, Christian techniques are not frequently used, but when they are, they are used much more with explicitly Christian and highly committed clients than with nonreligious clients (Jones et al., 1992; Worthington et al., 1988). Third, even when Christian techniques are used, they often are less powerful at producing critical moments in therapy than are many secular techniques (Ball & Goodyear, 1991). Fourth, some religious techniques are used more frequently than others, notably prayer, promoting forgiveness, teaching biblical concepts (though they may not be noted as such), and, to a lesser extent, Christian meditation (Ball & Goodyear, 1991; Jones et al., 1992; P. S. Richards & Potts, 1995; Worthington et al., 1988). Fifth, training programs seem to assume that their trainees will learn to perform the techniques effectively, even with little formal training in the techniques (Moon et al., 1991). This may not be a good assumption, and it needs to be tested.

Much work is still needed in this crucial area of religious counseling. For example, what is done and how is it done in counseling by clergy, religious lay counselors, and chaplains? What actually happens when a religious intervention occurs? There has been no real-time study of counselor and client behavior. Reports of client and counselor behavior have been retrospective, which may differ from what happened in counseling. Furthermore, all investigations of religious techniques in counseling have been within the Protestant or Mormon traditions. Religious techniques from other religious traditions have been suggested (e.g., sitting shiva, Minuchin & Fishman, 1981; the Muslim use of the five pillars of faith, El-azayem & Hedayat-Diba, 1994; and Buddhist interdependence and the middle way, Nakasone, 1994) but not tested. More investigations of techniques from a variety of religions are needed.

The use of religious techniques by explicitly religious therapists stands in some contrast to the general field of clinical psychology. Shafranske and Malony (1990b), in their national survey of 409 clinical psychologists, found that 59% supported the use of religious language or concepts in therapy, but 55% thought that it was inappropriate to use religious scriptures in psychotherapy (33% thought it was appropriate), and 68% thought it was inappropriate to pray with a client (19% thought it was appropriate). Whether overtly religious interventions are appropriate for use in psychotherapy depends strongly on the religious orientation of the client and the religious and theoretical orientation of the therapist.

Prayer. Prayer has often been used by religious counselors for religious clients as an adjunct to counseling (Ball & Goodyear, 1991; Jones et al., 1992). Investigations of prayer and its effectiveness have increased recently (McCullough, 1995). Does prayer have any effect on promoting positive mental health? (Some religious traditions might argue that prayer should not be expected to have short-term benefits to mental health.) This question has not been addressed. Most investigations of prayer have studied its effect on physical health (for reviews, see Duckro & Magaletta, 1994; Finney & Malony, 1985a; and McCullough, 1995) not mental health.

One well-designed study investigated the effectiveness of prayer on physical health (Byrd, 1988). Over 10 months, patients who were admitted to the coronary care unit ($N = 393$) of San Francisco General Hospital were assigned randomly to one of two groups. In a prayer group, patients received daily prayer (as long as the patient was in the hospital) by three to seven Christians pray-

(*text continues on page 474*)

Table 4
Summary of Empirical Research on Religious Techniques

Study	Participants (age)	Design	Measures	Major findings
		Techniques originating in religious traditions		
Relative frequency of use of religious techniques				
Ball & Goodyear (1991)	173 Christian psychotherapists	Correlational questionnaire research	Questionnaire	Therapists used spiritual guidance techniques at different frequencies and differently with clients of differing religious intensity
Jones et al. (1992)	640 graduates of Christian graduate training programs	Survey research	Survey	Master's alumni were typically more morally and religiously conservative than were doctoral alumni; alumni reported themselves as evangelicals and reported a high frequency of religious behaviors; however, use of religious techniques was low; training had positive impact on personal faith and promoted moderate satisfaction on integration issues
Moon et al. (1993)	32 Christian psychotherapists, 28 pastoral counselors, 43 spiritual directors	Survey research	Self-report	Christian disciplines were used in professional practice, but the extent of use varied significantly with professional identity, level of education in pastoral counseling or psychology, work setting, and professional membership
P. S. Richards & Potts (1995)	215 Mormon psychotherapists	Survey research	Therapist report	Mormon therapists used a wide variety of spiritual interventions
Worthington et al. (1988)	7 mental health professionals, 27 adult clients	Survey research	Therapist and client report	Therapists used spiritual guidance techniques at different frequencies and differently with clients of differing religious intensity
Prayer				
Anson et al. (1990)	230 members of two Israeli kibbutzims (one religious and one secular)	Correlational questionnaire research	Measures on recent life events, health, and religiosity	Frequency of prayer was unrelated to any of the dependent variables
Bearon & Koenig (1990)	Stratified random sample of 40 adults (65–74)	Survey research	Self-report	Symptoms prayed over were more frequently treated with medication and discussed with a physician
Byrd (1988)	393 patients of a coronary care unit	Longitudinal	Physical measures	Patients who were not prayed for required ventilatory assistance, antibiotics, and diuretics more frequently than patients who were prayed for
Carroll (1993)	100 members of AA in southern California	Correlational questionnaire research	Questionnaire for Stages 11 and 12 of the AA program	Frequent use of prayer, meditation, and spirituality were positively correlated with purpose in life and length of sobriety
Cronan et al. (1989)	382 randomly selected community members reporting musculoskeletal complaints (M = 52)	Correlational questionnaire research	Questionnaire	Prayer was the most commonly used nontraditional method of coping with pain; of the 44% of respondents who used prayer, 54% reported that prayer was "very helpful"
Finney & Maloney (1985b)	9 clients	Quasi experimental	STAI, Stein and Chu adaptation of ESS, an inventory of religiosity, MS	Christian contemplative prayer was correlated with a marked decrease in distress on target complaints and a view that religion provides an emotional independence from one's circumstances
Gass (1987)	100 primarily Catholic widows (M = 71)	Survey research	Self-report	89% reported that prayer was useful for coping with loss
Gruner (1985)	416 married members of Catholic, liberal, sect, and evangelical churches	Pretest–posttest	Pre- and postscores on 11 measures of psychological symptoms (SCL–90–R)	Frequency of prayer was positively associated with marital adjustment
Keefe et al. (1990)	62 chronic low back pain patients	Correlational questionnaire research	CSQ, SCL–90–R	Diverting attention and praying accounted for 9% of the variance in reported pain (positive relationship between diverting attention and reported pain)

Table 4 (*continued*)

Study	Participants (age)	Design	Measures	Major findings
		Techniques originating in religious traditions (cont'd)		
Prayer, continued				
Koenig (1988)	263 participants in a lunch program for older adults	Correlational questionnaire research	2-item scale measuring use of prayer and religious beliefs in coping with life stressors, single-item measure of death anxiety	Use of prayer and religious beliefs were negatively related to death anxiety
Koenig et al. (1993)	1,299 adults (60 or over)	Survey research	A diagnostic interview and other measures of anxiety and religious behaviors	Frequency of private religious behaviors was unrelated to anxiety disorders or symptoms after statistically controlling for confounds
Koenig et al. (1988)	Stratified random sample of 100 older adults (M = 67)	Survey research	Self-report	26 reported using prayer to cope with at least one of three stressful life events
Levin et al. (1993)	266 African American and Hispanic American postpartum mothers	Longitudinal study	Measures on global health, worry over health, and functional health (both before and during pregnancy)	Self-reported global health before pregnancy and worry over health before and during pregnancy were positively related to prayer for one's baby during pregnancy
Long & Boik (1993)	625 children in Grades 3–7 from small rural towns	Longitudinal study	Self-report	For students in Grades 6–7, prayer at home was negatively related to alcohol use
Markides et al. (1987)	511 Mexican Americans and Anglos (60 and over) who were interviewed three times over 8 years	Longitudinal study	LSI	Frequency of private prayer was positively related to life satisfaction at only one of three times
Poloma & Pendleton (1989)	1,275 Assembly of God adherents	Survey research	Charismatic experience, evangelism	Ecstatic religious experience is an important factor in evangelistic activities that undoubtedly promote church growth
Poloma & Pendleton (1991)	560 randomly sampled adults in the Akron, Ohio, area—54% Protestant, 25% Catholic, 2% Jewish	Correlational questionnaire research	Measures on subjective well-being and religious practices	After controlling for education, gender, race, income, and age, prayer frequency was positively related to existential well-being and religious satisfaction and negatively related to happiness; religious experience during prayer was positively related to general life satisfaction, existential well-being, happiness, and religious satisfaction; ritual prayer was positively related to negative affect, and colloquial prayer was positively related to happiness; after controlling for religious commitment, most relationships between prayer variables and subjective well-being variables became nonsignificant
D. G. Richards (1990)	292 "spiritual seekers" in a spiritual growth program from various religious affiliations	Correlational questionnaire research	PIL	Frequency of prayer was positively related to purpose in life
D. G. Richards (1991)	345 "spiritual seekers" in a spiritual growth program from various religious affiliations	Correlational questionnaire research	PIL	The prayer types labeled concern with others, experiencing God's presence, feeling that prayers were answered, feeling energy, feeling attuned to the consciousness of God, and feeling unlimited capabilities during prayer were positively related to purpose in life

(*table continues*)

Table 4 (*continued*)

Study	Participants (age)	Design	Measures	Major findings
		Techniques originating in religious traditions (cont'd)		
Prayer, continued				
Saudia et al. (1991)	100 coronary surgery patients—87% Protestant	Survey research	Self-report	95 patients reported using prayer; 70 patients rated prayer "extremely helpful" for coping with the surgery
Sodestrom & Martinson (1987)	25 cancer patients—56% Protestant, 32% Catholic	Survey research	Self-report	Prayer was the most frequently used spiritual strategy for coping with cancer
Turner & Clancy (1986)	74 chronic low back pain patients	Correlational questionnaire research	CSQ, BDI	Diverting attention and praying was positively related to average pain; increased use of praying and hoping following psychological treatments for pain was associated with decreased pain reports
Tuttle et al. (1991)	181 chronic pain patients ($M = 42$)	Correlational questionnaire research	CSQ, pain ratings and psychological symptoms (SCL–90–R)	Praying and hoping was positively related to reported pain
Forgiveness				
Bassett et al. (1990)	146 volunteers from a college community	$2 \times 2 \times 2 \times 2$ MANOVA	Guilt/Sorrow Questionnaire, Shepherd Scale, SWS	Mature Christians were better able to distinguish between guilt and Godly sorrow than less mature Christians
DiBlasio (1992)	90 clinicians (46 or older), 77 clinicians (45 or younger)	Correlational questionnaire research	Questionnaire	Clinicians over 45 years old had more favorable attitudes about forgiveness, had a stronger development of forgiveness techniques, believed more emphatically that anger and depression were related to a need for forgiveness, and were more open to clients' religious issues than the younger clinicians
DiBlasio (1993)	70 social workers	Interview	Forgiveness attitude	Regardless of participants' religious beliefs, social workers were equally capable and willing to address clients' religious issues
DiBlasio & Benda (1991)	167 marital and family therapists	Correlational questionnaire research	Questionnaire	Religious and nonreligious clinicians are equally inclined to develop forgiveness strategies and to believe that forgiveness is essential to relieving anger or depression
DiBlasio & Proctor (1993)	128 clinical practitioners	Survey research	Self-report	Therapists' age and openness to clients' religiosity were significant predictors of the development of therapeutic techniques for using forgiveness in treatment
Enright et al. (1989)	119 predominantly Catholic 4th, 7th, and 10th graders; college students; and adults	Correlational questionnaire research	Forgiveness interview that assessed six stages of forgiveness development, DIT, REL	Forgiveness and justice were related but distinct constructs; there were strong age trends for forgiveness and justice; participants who practiced their faith more were higher in the forgiveness stages; findings support evidence that people's understanding of forgiveness develops with age
Gorsuch & Hao (1993)	1,030	Correlational questionnaire research	GPQ	Protestants, Catholics, evangelicals, and the more personally religious reported more forgiving responses than the Jewish, no or other religious preference, nonevangelical, and less personally religious respondents
Hebl & Enright (1993)	24 elderly women ($M = 74$)	Pretest–postest	Two forgiveness scales, SEI, BDI, STAI	The experimental group showed significantly higher forgiveness profiles at posttest compared with the control group; both groups significantly decreased from pretest to posttest on psychological depression and trait anxiety
McCullough & Worthington (1995b)	86 undergraduate students	3×3 repeated measures	Wade (1989) Forgiveness Scale	Participants in the psychoeducational forgiveness groups reported greater forgiveness than those in the control group

Table 4 (*continued*)

Study	Participants (age)	Design	Measures	Major findings
		Techniques originating in religious traditions (cont'd)		
Meditation				
Alexander et al. (1989)	73 residents of eight homes for older people ($M = 81$)	Four factor repeated measure	Paired associate learning; two measures of cognitive flexibility; word fluency; mental health; systolic blood pressure; and ratings of behavioral flexibility, aging, and treatment efficacy	Dependent variable measures of participants in the mindfulness training group in active distinction improved the most, followed by DV measures of participants in the transcendental meditation on perceived control group
Carlson et al. (1988)	36 college students—18 men, 18 women	Three factor ANOVA	Measures of muscle tension, anxiety, emotion, and psychological symptoms	Muscle tension decreased across time for participants in the DM group, whereas it increased for participants in the PR group; DM participants were significantly lower in measures of anxiety and anger than were PR participants
Black religious approaches				
Griffith & Mahy (1984)	23 members of the Spiritual Baptist Church in the West Indies	Interview	Self-report	Participants reported relief of depressed mood, attainment of the ability to foresee and avoid danger, improvement in decision-making ability, heightened facility to communicate with God and to meditate, a clearer appreciation of their social origins, identification with church hierarchy, and physical cures
Griffith et al. (1986)	16 members of the Spiritual Baptist Church in the West Indies	Interview	SCL-90-R	Participants' SCL-90-R results showed a significant decrease of psychological distress
		Integration of religiosity into general theoretical approaches		
P. S. Richards et al. (1993)	15 religiously devout university students	Pretest–posttest	BDI, SEI, Burns's (1980) Perfectionism Scale, SWS	Participants were less perfectionistic and depressed after treatment, and their sense of self-esteem and their feelings of existential well-being became more positive
Sweet & Johnson (1990)	Boy involved in a custody case (17); man with avoidant, dependent, and passive aggressive personality traits (24); man diagnosed with paranoid personality disorder (59)	Analysis of therapeutic interaction	SASB	MEET with its multidimensional approach toward empathy and its cognitive behavioral procedures was viewed as points of convergence with a core of psychological knowledge in common western psychologies
Worthington & Gascoyne (1985)	55 non-Christians, 197 Christians	Correlational questionnaire research	Questionnaire	Participants preferred counselors who shared similar beliefs to themselves; views concerning Christianity did not affect expected counselor style and performance ratings
Cognitive therapy				
W. B. Johnson et al. (1994)	56 clients	$2 \times 2 \times 4$ factorial design	BDI, Newcastle Rating Scale, ROS	RET and a Christian version of RET have similar beneficial effects on Christian clients with mild to moderate depression

(*table continues*)

Table 4 (*continued*)

Study	Participants (age)	Design	Measures	Major findings
Integration of religiosity into general theoretical approaches (cont'd)				
Cognitive therapy, continued				
W. B. Johnson & Ridley (1992)	18 theology graduate students, 3 local church members	One-way ANCOVA with blocking variables	ROS, BDI, Automatic Thoughts Questionnaire, Ellis (1981) Irrational Values Scale, Counselor Rating Form—Short Version	RET and a Christian version of RET were effective for treating depression in Christians
Pecheur & Edwards (1984)	21 Christian college students with depression	Pretest–posttest	BDI, RDC for Depression, Hamilton's (1960) Rating Scale for Depression, Visual Analogue Scale, TSCS, Hopelessness Scale	Religious and secular cognitive behavior interventions were significantly more effective than no treatment on depression; no significant differences were found between religious and secular interventions
Propst et al. (1992)	59 religious patients	2 × 4 × 4 factorial design	RDC	Nonreligious therapists using cognitive–behavioral therapy with religious content were significantly more effective in treating depression than standard cognitive–behavioral therapy at one time
P. S. Richards et al. (1993)	15 religiously devout university students	pretest–posttest	BDI, SEI, Burns Perfectionism Scale, SWS	Participants were less perfectionistic and depressed after treatment; their sense of self-esteem and their feelings of existential well-being became more positive
Marriage and family counseling				
Worthington et al. (1993)		Empirical investigation on publication frequencies	Frequencies	Of the 1,140 articles in the *Journal of Psychology and Christianity*, only 61 concerned marriage or marriage therapy

Note. AA = Alcoholics Anonymous; ANCOVA = analysis of covariance; ANOVA = analysis of variance; BDI = Beck Depression Inventory (Beck, 1978); CSQ = Coping Strategies Questionnaire (Rosentiel & Keefe, 1983); DIT = Defining Issues Test (Rest, 1979); DM = devotional meditation; DV = dependent variables; ESS = Ego Strength Scale (Barron, 1953); GPQ = Gallop Poll Questionnaire (No. 293, Gorsuch & Hao, 1993); LSI = Life Satisfaction Index (Neugarten, 1964); MANOVA = multivariate analysis of variance; MEET = meditation enhanced empathy training; MS = Mysticism Scale (Hood, 1975); PIL = Purpose in Life Test (Crumbaugh, 1968); PR = progressive relaxation; RDC = Research Diagnostic Criteria; REL = Religiosity Scale (Rohrbaugh & Jessor, 1975); RET = rational–emotive therapy; ROS = Religious Orientation Scale (Allport & Ross, 1967); SASB = structural analysis of social behaviors; SEI = Coopersmith Self-Esteem Inventories (Coopersmith, 1967); STAI = State–Trait Anxiety Inventory (Speilberger, Gorsuch, & Lushene, 1970); SWS = Spiritual Well-Being Scale (C. W. Ellison & Paloutzian, 1978); TSCS = Tennessee Self-Concept Scale (Fitts, 1965).

ing outside the hospital. Patients did not know they were being prayed for. Those who prayed knew the patient's first name, diagnosis, and general condition, and they received periodic updates on the patients' condition. In the no-prayer group, patients were not assigned to people for daily prayer. Physicians did not know which patients were in which group, nor did the researcher of the study, who collected and analyzed the patient outcome data. For days in the critical care unit, days in the hospital, number of medications at discharge, development of new symptoms, and rated course of treatment as outcomes, patients who were prayed for did substantially better than did patients who were not prayed for. Although the study was well designed with high statistical power, its results—as with all scientific results—are inconclusive. The study is a single study and could have produced its findings simply by chance. The validity of its findings depends on replication. Despite the careful design, there were methodological weaknesses. Participants were not matched on many potentially relevant variables, such as their own religiosity. No effort was made to measure the amount of prayer that might have been offered on the behalf of patients by people who were not prayer group members. The findings of the study must be seen within the wider context of many empirical investigations of prayer, and not all of those are as supportive of the efficacy of prayer. Nonetheless, the study merits replication.

Prayer appears to be the most common form of religious coping by most religious people, and even nonreligious people often turn to prayer in the throes of suffering. Different types of prayer may have different effects (Poloma & Pendleton, 1989, 1991). Meditative prayer is devotional and usually engaged in as a form of worship. Petitional prayer is aimed at alleviating a particular suffering, one's own suffering, or the suffering of another (intercessory prayer). Ritual prayer is repetitive and may have

either calming effects or negative psychological and physical effects (depending on the person and situation). Colloquial prayer is like a conversation with God, in which the person may seek guidance or forgiveness or simply talk with God about positive or negative experiences.

In general, researchers of empirical studies of the use and effectiveness of prayer in naturalistic settings have documented its importance to religious people, but the usefulness of prayer as an adjunct to counseling is almost completely uninvestigated. Since 1957, only one empirical study of prayer in counseling has been made (Finney & Malony, 1985b).

Forgiveness. Forgiveness, like prayer, has been frequently used by counselors (Jones et al., 1992). Unlike prayer, though, forgiveness has often been used in secular counseling by nonreligious counselors and clients in individual, marital, and family therapies. In fact, research on forgiveness appears about equally in primarily religious journals and general psychological journals. Several research programs that have investigated forgiveness, both as a personal activity and as part of counseling, have sprung up (for reviews, see McCullough & Worthington, 1994a, 1994b). The most extensive program is headed by Enright, who has applied forgiveness to adolescents (Enright, Santos, & Al-Mabuk, 1989), studied the development of reasoning about forgiveness across a variety of ages (Enright et al., 1989), and investigated forgiveness in other countries (Huang, 1990). Hebl and Enright (1993) have studied a treatment to promote forgiveness ($n = 13$), comparing an eight-session structured group with a discussion group unrelated to forgiveness ($n = 11$). The participants were older women selected from a Christian church who sought to forgive an offender for a specific offense. Participants in the forgiveness group had higher indices of forgiveness on four of six outcome measures and lower indices of depression and trait anxiety than did participants in the control group.

McCullough and Worthington (1995b) compared two 1-hr psychoeducational group interventions—one based on conceptualizing forgiveness as self-enhancement (e.g., "It is helpful for you if you forgive the one who hurt you"; $n = 35$) and the other on conceptualizing forgiveness as restoring interpersonal harmony ($n = 30$)—with a waiting-list control ($n = 21$). Both hour-long interventions produced more forgiveness than did the waiting list on five of nine measures, and the self-enhancement conceptualization produced more forgiveness on three of the nine measures than did the interpersonal conceptualization.

Although (a) a variety of investigations of the benefits of forgiving have been performed, (b) many recommendations have been made by counselors writing case studies and theoretical papers about its therapeutic effectiveness, and (c) numerous studies have reported that individual, marital, and family therapists use it during counseling (see DiBlasio, 1992, 1993; DiBlasio & Benda, 1991; DiBlasio & Proctor, 1993), only the two studies above tested the effectiveness of forgiveness as an intervention, and neither involved a clinical population (Hebl & Enright, 1993; McCullough & Worthington, 1995b). Furthermore, granting forgiveness is undoubtedly important in fostering smooth interpersonal relationships and positive mental health, but seeking forgiveness when one has wronged another is also important. Only a few empirical studies of seeking forgiveness have been reported in the social psychological literature (Bassett, Hill, Pogel, & Lee, 1990; Cody & McLaughlin, 1988; Weiner, Graham, Peter, & Zmuidinas, 1991), and no clinical investigations have been undertaken.

Meditation. During the 1960s and 1970s, many studies were performed on Hindu-based and Buddhist-based meditation (for a review, see Smith, 1975). Since the early 1980s, research on meditation has tapered off. For example, in Blanchard's (1994) exhaustive review of behavioral medicine and health psychology, only one passing reference to meditation was found (Schoicket, Bertelson, & Lacks, 1988). In one study of the effectiveness of meditation, Alexander, Langer, Newman, and Chandler (1989) examined meditation within 73 residents of a home for older people. Half were assigned to daily meditation, and half were not. After 3 years, a fourth of the no-treatment group had died, but none of the meditation group had died.

Carlson, Bacaseta, and Simanton (1988) compared devotional meditation with progressive relaxation and found them to be equal. In general, that finding summarizes research on meditation. Most of what can be accomplished therapeutically with meditation can be accomplished with relaxation training, which is generally easier and avoids the religious associations of meditation. While Hindu-based, Buddhist-based, Christian-based, or nonsectarian meditation may have modest positive effects at promoting spiritual or religious goals, research investigations on their therapeutic use have progressively disappeared from the literature.

Black religious approaches. Generally, the majority of religious expression of Christians in the United States and Canada has developed from an Eurocentric background (of Roman Catholicism or Protestantism), rather than other Middle Eastern and orthodox backgrounds. Religious expression of Christians in the United States hailing from other origins than Europe often blends behavior and traditions of their origins into Eurocentric Christianity. For example, in the West Indies, the Black Baptist church incorporates elements that do not appear in most churches in the United States. "Spiritual mourning" is one such practice. Spiritual mourning is not to be confused with experiencing grief over loss. Rather, spiritual mourning is a period in which mourners are isolated for 7 days, during which the individual prays, fasts, and may experience dreams and visions. Such experiences are not unlike various forms of penitent behavior of purging rituals engaged in by religious adherents from a variety of religious traditions, regardless of ethnicity. Griffith and his colleagues studied 13 individuals (8 women and 5 men) who mourned and 10 older women who attended the mourners during the period of mourning. They evaluated the experience qualitatively (Griffith & Mahy, 1984) and quantitatively (Griffith, Mahy, & Young, 1986). In interviews (Griffith & Mahy, 1984), mourners reported eight therapeutic benefits of mourning: relief of negative mood, avoidance of future quarrels and conflicts, improvement of decision making, heightened ability to communicate with God, clearer appreciation of racial origins, receiving a sense of calling, validation by the bishop of readiness for church leadership, and healing of illness. Griffith et al. studied 16 other individuals who went through mourning by administering a symptom checklist before and after the experience. Frequency of eight of nine symptoms decreased after the experience, as did a measure of global symptom severity

and the total number of symptoms. There were no experimental controls, which prevents drawing causal inferences. The total-immersion experience of spiritual mourning for Barbados Blacks certainly produced extreme self-reports of increased psychological functioning in the near term.

Missing from the empirical literature on religion and psychotherapeutic processes and outcomes are studies of African American Christians or Muslims and their experience with counseling. Given the large number of African Americans in the United States and the prominence of religious expression in the African American community (Lincoln & Mamiya, 1990), it is incumbent on researchers to systematically study this population. Furthermore, the recent growth of the number of adherents to Islam within the African American community provides an excellent opportunity to investigate religious counseling with people who are not Christian or Jewish or to compare Christian, Muslim, and nonreligious clients' responses to counseling.

Integration of Religiosity Into General Theoretical Approaches

Payne et al. (1992) summarized religious adaptations of cognitive–behavioral, psychodynamic, existential–humanistic, and health psychology programs; however, they reviewed little empirical research. Most theoretical integration has combined Protestant Christianity and some approach to counseling. Fewer theorists have sought to integrate Judaism (Meier, 1988), Mormonism (P. S. Richards, Owen, & Stein, 1993), or Eastern religions (Sweet & Johnson, 1990) and therapy.

Worthington and Gascoyne (1985) investigated students' perceptions of five Protestant approaches to counseling. Students read one description of Protestant counseling by one confrontive–behavioral, one psychoanalytically informed and one cognitive–existential, or one of two cognitive–behavioral approaches. Students preferred the cognitive–behavioral approaches most and the confrontive–behavioral and psychoanalytically informed approaches least. Most students evaluated all Protestant approaches positively and said they would refer Christian friends to counselors advocating any of the approaches. Students were more reluctant to say that they would refer non-Christian friends, especially to the confrontive–behavioral approach. Christian students rated the approaches more differentially, whereas non-Christian students made fewer distinctions among the Protestant approaches.

Cognitive therapy. Two versions of cognitive therapy have been tested. One version (Propst's, 1988) is more Beck-like (Beck, Rush, Shaw, & Emery, 1979), and the other is more Ellis-like (1981). Propst et al. (1992) conducted a clinical trial of Propst's therapy for depression with religious clients. They compared nonreligious cognitive–behavioral therapy (NRCBT), religious CBT (RCBT), pastoral counseling treatment (PCT), and waiting-list clients (n = 11). Therapy involved eighteen 1-hr sessions in both CBT groups. In PCT, 75% of each session was spent in nondirective listening, and 25% was spent discussing Bible verses or religious themes of interest to the clients. Clients (N = 59) were assessed before treatment, posttreatment, after 3 months, and after 24 months. Ten therapists participated—five religious and five not. The religiosity of the therapist was crossed with NRCBT or RCBT treatments; religious therapists conducted PCT. For depression by the end of treatment, RCBT reduced depression more than the waiting list; NRCBT and PCT did not. When a measure of clinically relevant change in depression was used, RCBT again was superior to the waiting list but no other treatment was.

In examining the interaction between religiosity of the therapists and the treatment, Propst et al. (1992) found a surprising interaction. Nonreligious therapists using RCBT outperformed both the waiting list and nonreligious therapists with the NRCBT treatment. The religious therapists with the NRCBT treatment were superior to the waiting list but not to the RCBT treatment. At follow-up, the waiting list had been removed from the analyses. There were no treatment effects at follow-up; however, there were significant interactions between religiosity of therapist and treatment. For the RCBT treatment, surprisingly, clients of nonreligious counselors had lower depression than did clients of religious counselors. Furthermore, religious counselors performed better in the NRCBT treatment than in the RCBT treatment. Much has been made of the interaction effects found by Propst et al. Beutler et al. (1994) suggest that the counterintuitive finding might imply that the manualized version of RCBT might be applied effectively by nonreligious counselors. Given that the findings are counterintuitive and have not been replicated, drawing even tentative conclusions from this single study might be premature. One implication of this finding, if found to hold up after replication, is that nonreligious therapists who counsel religious clients can improve their effectiveness by modifying treatment to include the religious worldview of the clients. This suggestion is further strengthened by the finding that the poorest group performance was nonreligious counselors providing NRCBT to the religious clients.

Almost overlooked within the report is the essential equivalence of the pastoral counseling intervention with cognitive–behavioral treatments, regardless of whether they were adapted to the clients' religion. Furthermore, the RCBT treatment was superior to the NRCBT treatment at posttest (but not at either follow-up), suggesting—as Propst et al. (1992) said—"cautious support" for adapting CBT to religious clients. In a separate study, P. S. Richards et al. (1993) applied Propst's (1980) treatment (using Mormon content) to perfectionistic Mormon clients. Clients reduced their perfectionism and depression and increased their self-esteem and sense of existential well-being. Clients did not change their sense of religious well-being over the course of counseling.

Three investigations of adaptations of rational–emotive therapy (RET) have shown it to be similarly effective. W. B. Johnson and Ridley (1992) compared RET and a Christian version of RET for 10 Christian clients with mild depression. Six 50-minute sessions were conducted within 3 weeks. Participants were tested pre- and postintervention for depression, automatic negative thoughts, and irrational ideas. Participants in both treatments improved in depression and automatic negative thoughts. Only Christian RET participants reduced their irrational ideas. Religious values did not change for either treatment. RET and Christian RET did not differ in the amount of change they produced. W. B. Johnson, DeVries, Ridley, Pettorini, and Peterson (1994) replicated the study with 32 Christian

clients. Similar findings were obtained by Pecheur and Edwards (1984), who provided 8 hr of therapy over 4 weeks to Christian students who have mild depression (for additional issues in RET with Christian clients, see Watson, 1994).

Overall, religiously adapted cognitive therapy has been found to be effective with religious clients having mild depression (see W. B. Johnson, 1993, and W. B. Johnson & Ridley, 1992, for reviews) but only marginally more effective than nonreligious versions. Christian versions of cognitive therapies have not affected religious orientation or religious behavior more than have the nonreligious versions. One might conclude that whereas highly religious people might prefer religiously adapted therapies, thus far there is little evidence that they respond any differently to actual therapy that is matched to their religion than therapy that is not, if the nonreligious therapy is respectful and encouraging of their religion. One possible exception to that conclusion is that nonreligious therapists who work with religious clients might profitably use a religious adaptation of treatment.

Narrative approaches. In recent years, narrative approaches to therapy have become more numerous within psychology (McAdams, 1988; O'Hanlon, 1994; Vitz, 1992a, 1992b). Narrative approaches explain people as creating stories or narratives that give life events connectedness and meaning. When people have problems, narrative therapists seek to help them construct new narratives that help them deal more effectively with their lives and experience less distress.

Narrative approaches have been popular longer in pastoral counseling, which enjoys a tradition of hermeneutics, than in psychotherapy, which has been traditionally more interested in using the scientific paradigm to bolster counseling theories. Narrative approaches treat therapy less like an archeological dig and more like a courtroom drama. That is, traditional science-based approaches to therapy seek to uncover accurate historical truth, whereas narrative approaches are literature based and seek to reveal literary truth. Narrative therapy is similar to working a jigsaw puzzle. The client may have sections of the puzzle completed, but recent stressful events and client reactions have somehow revealed a fundamental brokenness of the puzzle. Separate sections of the puzzle simply do not seem to fit together. In narrative therapy, therapist and client coconstruct an account of the client's life that connects sections of the puzzle—not perfectly but in a way that provides more of a sense of unity and allows the client to act differently as a consequence.

Although narrative approaches are not new, Vitz (1992a, 1992b) argued that they are congruent with religious worldviews and thus merit development. With the field of counseling staggering with epistemological uncertainty, testing narrative approaches for effectiveness presents an interesting conundrum (Strong, Yoder, & Corcoran, 1995) and challenge.

Marriage and family counseling. Recall that the most frequent problem seen by religious counselors is marital distress. Numerous theoretical expositions of Christian marital therapies have been proposed (see Worthington, 1994, for nine summaries). In light of the prevalence of the problem and the surfeit of supposed solutions, one might think that empirical research on the efficacy of religious marital counseling would be a garden of delight. Instead, it is a wasteland. Relatively little research on either marriage or marital therapy with explicitly religious people exists (Worthington, Shortz, & McCullough, 1993). Family problems are almost as frequently presented to religious counselors as are marital problems, and the empirical research on family problems and family therapy with religious people is likewise sparse. In fact, there has not even been an investigation of the extent of family counseling with religious clients.

What's Missing?

Investigation of religious techniques has increased in frequency and sophistication, as much as has research in religion and clients and religion and counselors. Studies documenting the use of explicitly religious counseling techniques have been numerous, but studies of clients' reactions to the use of the techniques have been infrequent. Outcome research on integrations of religion and secular therapy has been embarrassingly sparse, involving two versions of cognitive–behavioral therapy. Whereas Propst et al.'s (1992) study is a state-of-the-art outcome study, the general level of quality of research on religious techniques has not advanced to the level of the field of outcome research as a whole. Sample sizes have been small and treatment manuals rare. On the positive side, most studies of religious counseling techniques used standardized measures, appropriate controls, and relatively sophisticated statistical analyses.

There have been no investigations of inpatient treatment, although several national chains offer explicitly Christian inpatient care, and no studies of managed care networks. Few models of brief religious counseling have been proposed, and none investigated. Community interventions have not been proposed or investigated. Religiously oriented group therapy or psychoeducational groups have been uninvestigated despite widespread use of groups within formal religion in the United States and the prevalence of group therapy in secular counseling. Almost no attention has been given to either promotion of positive mental health or prevention of problems. Paradoxically, people live in a time of almost cynicism about the possibility of the existence of any differential effectiveness among psychological interventions, yet there are strident demands for accountability for the services delivered. Frankly, the investigation of religious counseling techniques is not keeping up, and it is characterized more by glaring omissions than by what has been studied. This small research base weakens the conclusions presented in this section. Most conclusions are based on a few studies. More definitive conclusions await additional research by different scholars who have dealt with these problems using different methods. Only then can we gain confidence that we are beginning to know what is occurring in religious counseling.

Research Agenda for the Next 10 Years

Our Mental Set in Recommending a Research Agenda

In the past, it has been customary to assume that research agendas would reflect "more of the same"—filling in the missing gaps. This is no longer a prudent way to set a research agenda for religion and counseling or for the field of general counseling and psychotherapy. Today's research agenda should be as much a function of current social pressures on the field of counseling

and psychotherapy as it is a function of questions that arise from past research and theory.

We suggest a research agenda based on the status of current research and theory within today's social constraints. Naturally, this leaves our conclusions open to criticism by those who do not approve of sullying scientific understanding by social analysis and by those who differ in their analysis of the social situation and its implications for counseling.

Influence of the Value on Health Versus Productivity

In the United States, historically two values have influenced society's response to mental health problems—the values on health and productivity. In the 20th century, much of the reaction to mental health problems has been driven by Freud's (1902/1954) theorizing which used a medical model and by advances in psychoactive drugs. Both emphasized health. Under that model, people who had a mental health problem were thought to be ill and the goal of treatment was to restore patients to health. Psychotherapy sought to cure patients, and patients were satisfied only if they were substantially healed. Much of Christian and Jewish religious ideology fit well with health values. In the Christian framework, sin, for example, needed complete eradication through the sinner's faith—much like cancer or depression needs complete eradication through the patient's treatment.

In recent years, though, businesses have absorbed much of the cost of mental health treatment. Most businesses care more about their workers productivity than their complete health. (A healthy worker will usually be productive, but a person may be productive without being fully healthy.) With a stronger presence of the business in the negotiation of acceptable outcomes of psychotherapy, the main criterion for positive outcome in treatment of mental–emotional problems has become "good enough to be productive" rather than "cured."

This shift in emphasis on values has several implications for religious counseling: (a) Professional models of counseling have become briefer than in the past (Wylie, 1990) and have been aimed more at getting people to function productively than to cure them. (b) Religious counselors, who have embraced models of psychotherapy because they desire to heal patients, may resist changes to productivity-oriented approaches being suggested by professional counselors today. Thus, the fields of religious counseling and professional counseling may diverge in the near future. (c) Professional counselors who counsel religious clients might operate at cross purposes to the clients more frequently than in the past. The emphasis of many professional counselors is on efficiency and effectiveness, whereas religious (and many nonreligious) clients seek counseling that will lead to healing.[3] (d) To the extent that religious clients become increasingly dissatisfied with the amount and depth of professional counseling they receive, they may seek counseling with religious counselors, which will increase the demand for counseling from pastors and lay counselors operating in religious contexts.

Decreased Supply of Therapists, Increased Demand for Religious Counseling

Although it is difficult to predict in a changing climate of national health care, it appears as if psychologists, social workers, and counselors may soon be paid essentially the same for counseling (Lipchik, 1994; Wylie, 1994). Consequently, fewer aspiring mental health professionals may be attracted to doctoral level counseling and clinical psychology. Less counseling will probably be done by psychologists (Austed & Hoyt, 1992). There may also be less third-party reimbursement for mental health counseling (Austed & Hoyt, 1992). If so, this will contribute even more to people gravitating toward nonpaid counseling, which will increase the need for counseling by clergy and lay counselors.

How will the religious community respond to this increased demand? Clergy are already overstressed, and in recent years fewer have entered that field. In parallel, clergy are becoming more specialized in role and function within many formal religious traditions. The implications are several. First, clergy must develop briefer models (see Benner, 1992), using rationales consistent with their religious denominations' theology and ecclesiastical practice rather than rationales based on increasing productivity. After they are developed, those pastoral counseling models need to be tested empirically. Psychologists are well-equipped to help do this. Second, clergy must train lay counselors to meet overflow demand. Many clergy have not been trained in supervision, program development, teaching of counseling skills to nonprofessionals, and evaluation of program effectiveness. Again, psychologists can collaborate with clergy. Third, after training programs for clergy are developed, they must be empirically evaluated. Yet again, psychologists are well-prepared to help do this. Fourth, most clergy say they could benefit by more training in psychology; psychologists could benefit by training clergy. In summary, it behooves clergy and psychologists to form better alliances.

Pressures to Make Counseling Briefer

Brief models of religious counseling—done by professionals, clergy, and lay counselors—need to be developed and tested. Research is needed on how to reduce time in counseling, while maintaining efficacy of counseling. To shorten treatment, there will likely be more use of pretherapy information and bibliotherapy (using media other than print media, which is brought about by changes in communication technology). The effectiveness of those interventions, especially if counselors introduce their religious values to clients before counseling, requires more investigation.

Impact of Public Demand for Accountability

Increased public demand for accountability will force psychologists to be increasingly involved with research and program evaluation; however, much research on counseling outcome is moving away from universities, where investigators usually have access to limited samples, toward managed care corporations with enormous databases. Those corporations do

[3] Not all professional counselors adopt brief models of counseling and psychotherapy. Some undoubtedly continue to offer fee-for-services therapy. It appears, however, that an increasing number of counselors are adopting brief counseling models (Koss & Shiang, 1994; Lipchik, 1994; Wylie, 1994).

not generally value theory-based research as much as do university faculty. Psychologists will feel the pressure to do less theory-driven and more applied research, which could have a negative impact on the advancement of understanding of religious counselors, clients, and techniques. Thought must be given to answering practical questions about outcomes of religious counseling, while simultaneously addressing theoretically relevant questions.

Furthermore, religious counselors have generally been less inclined to conduct any research on their treatment than have secular therapists. This stance is partially related to the epistemological stance of most clergy (authority based rather than science based). The demand to make religious counseling empirically accountable may meet with philosophical resistance from many clergy, which may create an interesting dynamic especially with pastoral counselors, who often receive third-party reimbursement for counseling.

Religious Counseling in Other Than Outpatient Settings

Religious counseling in the public mental health sector has been ignored. People with chronic mental illness move within the public mental health system among community service boards, institutions, halfway houses, and outpatient counseling. Families, communities, and providers of services join mental health consumers in desiring better services to consumers, many of whom are religious. To date, researchers have focused on outpatient or pastoral counseling for religious people. Researchers need to focus on the entire continuum of mental health services. In particular, inpatient mental health treatment by religiously oriented hospitals, medical centers, clinics, or programs has not been subjected to research scrutiny despite millions of dollars spent by consumers on private inpatient care. Are religiously oriented inpatient programs effective?

Treatment is increasingly occurring with coordinated community and family involvement to supplement professional care. Byrd's (1988) study of the efficacy of intercessory prayer has shown a positive effect of involvement by a religious community through prayer on the physical health of patients. Other forms of health-promotion (including mental health-promotion) activities by communities need to be developed and evaluated.

Impact of Multicultural Influences on Research and Training

Multiculturalism is well-established and must be accommodated. Multicultural emphasis as a fourth force in psychology means that religious clients are more acceptable for nonreligious counselors and theoreticians to discuss and treat. New-age spirituality, renewed enthusiasm by Christians with conservative views, and the influx of immigrants from a variety of religious traditions have increased interest in spirituality and religion. Furthermore, religious pluralism forces counselors to deal with other religious traditions and to formulate positions about the interaction between their own religious beliefs and values and those beliefs and values of their clients. This has several implications for research.

First, additional attention is needed to theories that are broader than those within a single religious tradition (see Beutler & Bergan, 1991). A growing number of Muslims in the United States has necessitated a theory of counseling with Muslims. Currently, there is neither theory nor research on this. There is also a need for theories aimed at counseling people with Eastern religious beliefs, both people who have hailed from cultures and ethnic groups that have adhered to those traditions and people who have converted to religion with bases in Eastern religion.

Second, counselors might more frequently see clients who are attending a spiritual adjunct to counseling, such as spiritual retreats, shamans, new-age seminars or workshops, or sweat lodges. Are such adjuncts effective additions to counseling?

Third, the rise in salience of minorities has created a phenomenon that has not been given previous attention. Generally, psychologists have assumed that any influence on religious beliefs and values would flow in one direction: The counselor would influence the client. Psychologists also assumed that counselors had a diverse clientele and the impact of one client on a counselor's values would be counterbalanced by the competing impact of another client. Recently, however, counselors have been more likely to specialize. Some counselors work almost exclusively with Christians with conservative views, people who have AIDS, older people, prisoners, or people with drug and alcohol addictions. In those instances, the counselor is confronted with a continual barrage of clients who may have similar values to each other but (perhaps) different from the counselor. Researchers need to study the effects of client values on the values, beliefs, attitudes, and behaviors of counselors.

Fourth, even within Christian counseling, distinctive ethnic minorities require special attention. For example, the Korean Christian Church within the United States is large, and little attention has been given to empirically investigating counseling people from that cultural–religious heritage (see also the African American church; Lincoln & Mamiya, 1990).

Implications for Training

Rapid change within the United States has catalyzed a number of changes in the practice of psychotherapy in general and psychotherapy with religious people in particular. Researchers and theoreticians must accommodate those cultural changes in designing their practices and their research. We have summarized the shift in cultural values concerning health and productivity, brief counseling, accountability, outpatient treatments, and multiculturalism. These shifts have important implications for training.

Strongly religious people are probably as numerous within the United States as are major minorities (e.g., African American Blacks and Latinos). It is imperative that counselors in training learn to distinguish between religious pathology and strongly held "normal" religion (especially in religious traditions that are unfamiliar to the counselor). Counselors—religious and nonreligious—must learn to evaluate and recognize their biases and competencies, so they can treat some religious clients effectively, refer religious clients whom they cannot treat effectively, and know the difference. Likewise, explicitly religious counselors need to make similar distinctions concerning nonreligious clients whom they can and cannot treat effectively.

A familiarity with research on psychotherapeutic processes and outcomes with religious clients should be built into the multicultural curriculum for therapists.

Research That Builds on the Established Literature

For those researchers continuing to pursue traditional empirical methods, several hot questions should be investigated.

Religious clients. For religious clients, the questions that deserve special empirical attention are the following: (a) What religious values, beliefs, and behaviors from various religious traditions produce what particular manifestations of good and poor mental health in what kind of clients? (b) Which religious values, beliefs, and behaviors promote effective coping in stressful situations, and how does the person's religion specifically affect coping with stress? (c) For highly religious people, what activates religious schemas that affect judgments, attitudes, and behavior? Why do some highly religious people behave in ways that are grossly at odds with their religious schemas? (d) Under what conditions do religious values, beliefs, and behaviors affect preferences for, expectations of positive outcomes for, and actual outcomes for religious counseling? How are preferences, expectations, and outcomes related to each other and why? Methodologically, innovations are needed. Researchers must study samples of controls, as well as people who seek help from friends, lay counselors, clergy, and professional therapists. Researchers must move beyond questionnaire studies and investigate actual help seekers in the environment in which they seek help. Other methodologies such as structural linear modeling and multivariate analyses are needed to supplement the extant less-sophisticated designs and analyses. Furthermore, investigation of values, beliefs, and behaviors (and their interconnections) might lend itself to qualitative methods, especially for hypothesis generation.

Religious counselors. For religious counselors, most of what is known concerns religious (mostly Protestant, Mormon, and Jewish) professional mental health counselors. Research is needed on the characteristics, training, and effectiveness of each type of counselor. More investigators must sample clergy of different religious affiliations and lay counselors in different religious contexts. In addition, religious counseling by nonreligious professionals needs further investigation, as does the counseling of nonreligious people by religious counselors.

Religious counseling techniques. For religious counseling techniques, research is needed on the effectiveness of techniques that are explicitly religious—such as prayer, use of Scriptures in counseling, and the like. More research is especially needed on techniques that can cut across religious and nonreligious populations—such as the promotion of forgiveness. Outcome research is needed on secular approaches (besides religiously oriented cognitive therapy) that have been adapted for use with highly religious clients. Great improvements are needed in the sophistication of most outcome studies involving religious people (Propst et al., 1992, notwithstanding). Design of such studies should be held to the same standards as are studies that test the efficacy of secular approaches.

A challenge to researchers. We offer a challenge to researchers in religion and psychotherapeutic processes and outcomes. Research simply must become more precise than it is now. Relative to the 10 years of research we have reviewed, agreed-on definitions must be used more often in research, populations must be more clearly delineated, standardized measures must be used more often, and hypotheses must be more specific. In particular, we challenge researchers to specify whether they are hypothesizing one-way effects of a treatment (vs. none), two-way interactions (the treatment works differentially for people with certain religious beliefs or values than for people with other religious beliefs or values), or three-way interactions (religious beliefs or values of the client's primary reference group may interact with treatment and the individual client's religious beliefs or values). Increased specificity is needed to advance research in the area. Furthermore, researchers need to determine which disorders are likely to respond best to which religious interventions. For example, much evidence shows that both religious and spiritual 12-step programs are effective for people with alcohol and drug addictions, and perhaps more effective than nonreligious or nonspiritual programs. For religious clients with depression, cognitive therapy has been shown to be effective, although religious cognitive therapy is apparently only marginally more effective than is nonreligious cognitive therapy. For marital and family problems, religious people prefer religious therapy (Privette, Quackenbos, & Bundrick, 1994), but whether those approaches are more effective has yet to be investigated. A match of effective techniques and problems for religious clients (with different beliefs and values in different communities) is needed.

Conclusion

In the 10 years since Worthington's (1986) review of religious counseling, the quality of science has improved, the number of studies has mushroomed, and new topics that need investigation have opened up. The world has changed dramatically, creating a different climate within which to see the role and future of research on religion and counseling. Continued progress will only occur as the demands of science and the demands of the public in identifying new research for religious counseling are considered.

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