Religious Issues in Counselling: Are Australian Psychologists "Dragging the Chain"?

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Abstract

While American psychologists have been making significant contributions regarding the best ways to deal with religious issues in counselling, Australian psychologists have generally been less active in stimulating debate, conducting research, and making clinical applications in this area. In this paper, it is argued that consideration of religious issues is an important aspect of therapy. In framing this discussion, consideration is given to boundaries and the task and role of the therapist. Suggestions are given for understanding value conflicts, implementing religion-accommodative techniques, networking with colleagues in the religious community, and training psychologists to sensitively deal with religious issues in therapy.

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The inclusion of religious or spiritual issues in counselling has sometimes been met with resistance, especially from those who hold stereotyped views of religion and religious people (see Bergin, Payne, & Richards, 1996, for an historical review). However, to deny that religious issues have a legitimate place in the counselling context is to deny an important aspect of both the client's and counsellor's worldviews that could facilitate the therapeutic process. Indeed, Burke et al. (1999) argue that ignoring a client's religion "may jeopardize the forming of an effective therapeutic relationship and close the door to potentially pertinent intervention techniques" (p. 251).   In saying this, I am not suggesting that the therapist should indiscriminately initiate discussion of religious material without due regard to the particular client and his or her presenting problem, the nuances of the therapeutic relationship, or the setting of the therapy.   However, I believe religious issues are more relevant to the counselling context than many psychologists would acknowledge. To "drag the chain" is "to hinder others by doing something slowly" (Delbridge, 1987, p. 541). While there are some notable exceptions, I believe that this term captures the reluctance of many Australian psychologists to (a) explore religious issues in therapy, (b) develop strategies or therapeutic techniques for best dealing with religious issues, and (c) contribute to research and training with regard to religious issues in therapy.   In this paper, I will first outline reasons for considering religious issues in counselling, and then explain why I think Australian psychologists are generally lagging behind in this area. I will then consider relevant boundary issues as they pertain to the task and role of the therapist, and suggest ways in which religious issues could be sensitively and effectively addressed in the counselling context.

Why Include Religious Issues in Counselling?

Prevalence

First, the sheer prevalence of religious beliefs in Australia and throughout the world makes it an important topic to consider. According to 1997 figures, approximately 84.5% of the world's population adhere to some type of religious belief (Calhoun, 1998). Although Australia is often thought of as a largely secular nation, the majority of Australians still report a religious affiliation. Indeed, figures from the 1996 census (Trewin, 2002) indicate that 70.9% of Australians are affiliated with the Christian religion, while a further 3.4% are affiliated with another religion (e.g., Buddhism, Islam, Hinduism, Judaism). In addition to these figures, there would also be individuals who do not align themselves with a particular religion, yet still regard their own spirituality or spiritual journey as important. While the mere prevalence of religious or spiritual beliefs does not tell us much about the importance of those beliefs to the individual, these statistics should at least alert us to the fact that religious or spiritual issues will arise in the counselling context from time to time. The astute counsellor needs to be aware

of what to do when such issues do emerge, so as to ensure the best outcome for the client.

Religion as a Diversity Issue

Psychologists are ethically required to respect all clients and refrain from discriminatory practices based on human differences of any kind. The Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association (APA) states that psychologists should be "aware of cultural, individual, and role differences, including those due to age, gender, race, ethnicity, national origin, *religion* [italics added], sexual orientation, disability, language, and socioeconomic status" (APA, 1992, p. 5). Moreover, when such differences "significantly affect psychologists' work concerning particular individuals or groups, psychologists obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals" (p. 7).[1] In contrast to the American code, the Australian Psychological Society's (APS) Code of Ethics does not specifically mention religion. However, the Australian code does include the general principle that psychologists "must be sensitive to cultural, contextual, gender and role differences and the impact of those on their professional practice on clients" (APS, 1999, p. 1). In order to be sensitive to clients from different cultural backgrounds, we must also consider their religious beliefs and how these may impact on their emotions, cognitions, and behaviours. Indeed, such an awareness of religious issues was considered important enough for the Journal of Multicultural Counseling and Development to devote its October 1999 issue to "Spiritual and Religious Issues in Counseling Racial and Ethnic Minority Populations".   While religious issues overlap with ethnicity, religion can also be seen as a diversity issue in its own right. Indeed, individuals of the same ethnic background can vary widely in their religious or spiritual beliefs and practices. If psychologists are serious about addressing diversity issues, it is imperative that they also consider how religious or spiritual issues may affect the client, the counsellor, and the counselling process.

Best Practice Involves A Holistic Approach

I believe that best practice in a counselling situation will include a holistic approach that considers all relevant aspects of the client (e.g., emotional, mental, physical, social, cultural, and spiritual). There are at least three reasons for taking such a holistic approach.

First, it ensures that the counsellor considers the whole person, rather than compartmentalising different aspects of the individual. In the past, some psychologists and theologians have argued that psychology and religion should be kept separate, since each deals with different issues (see Crabb, 1977, for a description and critique of this position). Thus, clients should see a psychologist if they have a psychological or emotional problem; a doctor if they have a physical problem; and a priest, pastor, or other religious counsellor or spiritual advisor if they have a religious or spiritual problem. By dissecting the person among these different sources, however, the counsellor may miss the obvious

connections among the different spheres of a person's life. Psychologists have long been interested in the mind-body distinction. For example, depression can have a physical cause (e.g., a chemical imbalance in the brain) or a psychological cause (e.g., faulty thinking). Physical and psychological factors can also interrelate (e.g., stress can cause physical symptoms such as headaches or gastric complaints, and such physical problems can further exacerbate stress). Though often overlooked, the spiritual or religious dimensions of a person's life can also interact with the mind-body dimension. For example, a person's view of God can affect such "psychological" aspects as self-esteem and depression (Anderson & Baumchen, 1999). Researchers are also becoming increasingly interested in possible links between religiosity and positive health outcomes (see Plante & Sherman, 2001). The counsellor who takes a truly holistic approach is less likely to miss or discount such connections.

A second reason for taking a holistic approach is that there is much overlap between spiritual or religious issues and the concerns that arise in a counselling situation. For example, the concept of forgiveness has previously been thought of primarily as a religious concept. However, forgiveness as a therapeutic technique has been receiving greater credence in mainstream psychological practice (e.g., Ferch, 1998; McCullough & Worthington, 1995). Issues concerning death and dying are also typically underscored by religious beliefs and values, and these cannot be ignored in therapy. For example, Balk (1983) interviewed 33 adolescents whose sibling had died. He found that 19 of the teenagers thought religion was helpful for them immediately following the death of their sibling, while 27 thought their religion was helpful in accepting the death of their sibling in their current situation. If the counsellor ignored or minimised the relevance of religious meaning for such clients, he or she would miss an important key to their well-being.

Third, religious beliefs can have a positive or negative effect on a person's mental health and behaviour, depending on the type of belief and the person's investment in that belief. The clinician needs to be aware of such effects so that he or she can identify factors that would facilitate or impede the counselling process.

This area is somewhat controversial and difficult to assess due to the various ways in which religiosity and mental health indicators have been measured. However, there is a growing body of evidence that indicates that healthy religious commitments are beneficial for one's mental health and general well-being (see reviews by Levin & Chatters, 1998, and Plante & Sharma, 2001). This link between religiosity and good mental health seems to be particularly strong for those who have an intrinsic religious orientation (Bergin, 1991; Worthington, Kurusu, McCullough, & Sandage, 1996). For example, Ventis (1995) noted that an intrinsic religious orientation, in which religion was an end in itself or a central motive in one's life, was generally associated with positive mental health indices such as appropriate social behaviour, freedom from worry and guilt, a sense of personal competence and control, and personality unification and organisation. A more extrinsic orientation, in which religion was seen as a means to some goal (e.g., social status or social support), was more

likely to be negatively associated with mental health indices. In their review, Plante and Sharma (2001) also found that the type of religious orientation or experience was important. Intrinsic religiosity was associated with lower levels of depression and anxiety, while unhealthy religious beliefs or more negative religious experiences were associated with more negative outcomes. For example, religiosity and anxiety were apparently more likely to be positively related "among individuals experiencing unusually strict religious upbringings or among individuals with underdeveloped, vague, or overemphasized ideas of religion or spirituality" (Plante & Sharma, 2001, p. 249).   Even Albert Ellis, a once ardent critic of religion, particularly absolutistic or dogmatic religion (Ellis, 1980; 1992), has recently noted that even "absolutistic religious views" can be associated with positive mental health outcomes (Ellis, 2000). In particular, he notes that "people who view God as a warm, caring, and lovable friend, and who see their religion as supportive are more likely to have positive outcomes than those who take a negative view of God and their religion" (Ellis, 2000, p. 31).

While much can be gained by exploring the ways in which healthy religious commitments can lead to positive mental health outcomes, these studies also underscore the importance of exploring the possible negative outcomes of some types of religious beliefs and experiences. Indeed, Shafranske and Malony (1996) note "that some religion can be toxic and can impede healthy adjustment" (p. 562). The negative effects of cults and cult leaders such as Jim Jones and the People's Temple have been well-documented.   A more recent case was the Movement for the Restoration of the Ten Commandments of God and its leader Joseph Kibweteere that led to the deaths of hundreds of followers in Uganda in 2000 (see relevant news articles on the web site for the Center for Studies on New Religions at http://www.cesnur.org/testi/uganda_updates.htm). Religious beliefs and practices have also been implicated in some instances of child abuse. For example, Bottoms, Shaver, Goodman, and Qin (1995) have reported cases in which children were (a) abused by parents or other religious representatives in an attempt to rid the child of the devil or evil spirits, (b) abused by religious clergy, or (c) denied medical treatment on religious grounds, resulting in harm to the child.   Since different types of religious orientations, commitments, or experiences seem to be associated with different mental health outcomes, it is essential that accurate assessments are made regarding the nature of a person's religiosity. This issue will be taken up later in this paper.   In any case, it would seem important for the clinician to view the client in a holistic manner in which the possible interrelationships between mind, body, and spirit are considered.

The Myth of Value-Free Counselling

In the past, some counsellors may have been reluctant to bring religious or spiritual issues into a counselling session because of a belief that counselling should remain value free. If by this we mean that the counsellor should not impose his or her beliefs on the client, then that is one thing. If we are assuming that there is such a thing as "value-free counselling", that is quite another. Either explicitly or implicitly, our worldview will affect the way in which we approach

human behaviour, the counselling model we adopt, the techniques we use, and the options we consider. As Burke et al. (1999) note, "spirituality appears in the goals of counseling theory ..., in philosophical assumptions about the purpose of life ..., and in applications of theories to human relationships ..." (p. 253).

While many psychologists had previously published in the areas of the psychology of religion (e.g., Argyle & Beit-Hallahmi, 1975) and the integration of psychology and religion (e.g., Crabb, 1977), Bergin's (1980) classic article on "Psychotherapy and Religious Values" was something of a watershed in stimulating discussion on the relevance of religious values in counselling. In arguing that values were "an inevitable and pervasive part of psychotherapy" (p. 97), Bergin drew interesting contrasts between theistic or religious values and clinical-humanistic values. Rather than ignoring our values, Bergin argued that "it would be honest and ethical to acknowledge that we are implementing our own value systems via our professional work and to be more explicit about what we believe while also respecting the value systems of others" (p. 101). Indeed, psychologists are bound by ethical principles of integrity and respect for the rights and dignity of their clients (see APA, 1992, and Yarhouse & VanOrman, 1999). However, we are fooling ourselves if we think that we can somehow "leave our values at the door" when a counselling session begins. If the counsellor ignores his or her values, there may actually be a greater chance of the imposition of those values onto the client (Burke et al., 1999). Indeed, Jones (1994) has argued that "the most limiting and dangerous biases are those that are unexamined and hence exert their effect in an unreflective manner" (p. 197). Rather than being reluctant to bring religious issues into the counselling session, they should be acknowledged and clarified whenever appropriate so that the client receives the best counselling service possible.   Of course, this raises the question, "When is it appropriate to address religious issues in counselling?" This will be addressed in a later section.

Summary

Thus far, I have argued that religious issues need to be considered in the counselling context because (a) such beliefs are widespread and will inevitably come up in therapy from time to time; (b) we are ethically bound to consider how diversity issues, including one's religious beliefs and/or practices, may influence thoughts, emotions, and behaviours; (c) a holistic approach that includes a consideration of religious issues, where relevant, represents best practice; and (d) it is better to acknowledge values than to pretend that they have no bearing on our work as psychologists. While there are some notable exceptions, I feel that Australian psychologists are generally lagging behind their American counterparts in stimulating debate, conducting research, and making clinical applications in the area of religious issues in counselling.

Differences Between the United States and Australia

In the previous section, I noted Bergin's (1980) article on "Psychotherapy and Religious Values". When this article was first published in the United States,

it created considerable debate. Bergin himself received over 1000 comments and requests for reprints (Bergin, 1991). There were some critics, such as Albert Ellis (1980) who argued that Bergin had misrepresented the views of probabilistic atheist clinicians, but there were also many supporters (Bergin, 1991). While certainly not embraced by all American psychologists, it is interesting to note the gradual shift towards the inclusion, or at least tolerance, of religious issues that has taken place in American psychology since the publication of Bergin's (1980) article. In 1988, Meyer critiqued the APA's (1981) "Ethical Principles of Psychologists" because it only mentioned religion in relation to inhumane, illegal, or unjustifiable practices that should be avoided. By 1992, the APA's "Ethical Principles of Psychologists and Code of Conduct" also included religion in a statement of human differences that could affect the psychologist's work. As noted earlier, this is in contrast to the Australian Psychological Society's (1999) Code of Ethics that still only includes a generic statement about being sensitive to cultural and contextual differences. The fact that religion is not specifically mentioned in the Australian code could have the effect of further hiding or marginalising discussion of the role of religious issues in counselling.

       A search of the titles and abstracts of all of the articles that have appeared in the Australian Journal of Psychology and the Australian Psychologist from 1980 to June 2002 revealed only 14 articles that have mentioned religion, religiosity, or related variables.[2]   One of these articles looked specifically at different aspects of religion (Grichting, 1987), one involved a discourse analysis of women's accounts of spirituality (Coombes & Morgan, 2001), two briefly mentioned religious groups or spiritual domains in discussions of euthanasia (Allen, 1998; Sanson et al., 1998), two used Catholic participants in their samples (Haines, Jackson, & Davidson, 1983; Moulds & McCabe, 1991), and seven included measures of religiosity or religious orientation (Craddock, 1991; Forgas & Jolliffe, 1994; Grichting, 1986; Griffiths, Dixon, Stanley, & Weiland, 2001; Larsen, 1981; Parnicky, Williams, & Silva, 1985; Woodward, Carless, & Findlay, 2001). No studies specifically focused on religious issues in counselling, though Larner (2001) mentioned spirituality as one of a number of contextual variables that therapists should consider. This is in contrast to the increased prevalence of articles in mainstream American psychology journals that specifically seek to address religious issues in counselling (e.g., Jones, 1994; Worthington et al., 1996; Yarhouse & VanOrman, 1999). There are also a number of American journals that specifically address the integration of religion and psychology (e.g., Journal of Psychology and Theology, Journal of Psychology and Christianity, Journal for the Scientific Study of Religion), and the American Psychological Association has published a number of books on the issue (e.g., Richards & Bergin, 2000; Shafranske, 1996). Doctoral programs that integrate religion and psychology have also been fully accredited by the American Psychological Association (e.g., the integrative doctoral program offered by Fuller Theological Seminary; Haque, 2001). See Haque (2001) for a comprehensive list of professional organisations, university programs, and journals that deal with the integration of religion and psychology.

While the Australian Journal of Psychology and the Australian Psychologist have not published any articles in the last two decades that specifically focus on religious issues in counselling, this does not mean that no research or discussion of religious issues is being carried out among Australian psychologists.   Some psychologists may have published elsewhere on this topic, while others have presented their findings or ideas at various conferences. Indeed, the 2000 APS conference included a forum on religion in clinical practice and the 2001 conference of the Society of Australasian Social Psychologists included a symposium on empirical studies of spirituality. The APS also has a Christianity and Psychology Interest Group, tertiary institutions such as Christian Heritage College (2001) offer courses that seek to integrate psychology and Christian principles, and some psychologists are affiliated with groups such as the Christian Counsellors Association of Australia.   While these efforts are to be applauded, the fact that discussions specifically concerning religious issues in counselling are largely restricted to conference presentations, Interest Groups, or avenues outside of mainstream forums invariably means that they do not reach the ears or eyes of most Australian psychologists. This would not be a problem if it did not have such a bearing on the counselling process. If we were to adopt the American Psychological Association position on this matter, psychologists do not really have a choice as to whether or not they consider religious issues in the counselling context. Rather, the onus is on the psychologist to ensure that he or she is aware of how the religious orientation of the client may impact on beliefs, attitudes, and behaviour; and to be able to adequately deal with religious issues that arise in therapy. While numerous authors have suggested ways in which therapists can deal with religious issues in counselling, the methods chosen will largely depend on one's views regarding the therapeutic relationship and the appropriateness of various approaches and strategies. With this in mind, I will begin the next section by considering the role and task of the therapist. I will then discuss various strategies for dealing with religious issues in therapy. While certainly not exhaustive, these strategies may provide a starting point for helping psychologists to better handle religious issues when they do arise within the counselling context.

Suggestions for Dealing With Religious Issues in Counselling

Boundary Issues and the Role of the Therapist

While all reputable therapists would recognise the importance of setting boundaries in the counselling context, there is much variation in what is regarded as appropriate. (See Smith & Fitzpatrick, 1995, for an excellent review of boundary issues). Religious issues in counselling are something of a "hot potato" in this area, with clinicians and academics disagreeing on the extent to which religious issues should be addressed in counselling and the manner in which a therapist would deal with such issues.

A counsellor's theoretical orientation will affect the likelihood of religious issues being discussed in therapy and the way in which the therapist deals with such issues when they do arise. For example, Rizzuto (1996), a psychodynamic

therapist, argues that the analyst should "*never* make any pronouncement about God or religion" (p. 429) because it disrupts the client's ability to work through his or her own religious beliefs and representation of God. Conversely, some cognitive-behavioural therapists have argued that it is important to develop and evaluate religiously sensitive therapeutic techniques that can be used with religious clients (e.g., Johnson, Ridley, & Nielsen, 2000). While some authors have suggested ways in which therapists from different theoretical orientations may conduct therapy with religiously committed persons (see Shafranske, 1996), it is difficult to make definitive statements about the way in which different theoretical frameworks impact on such therapy. There are both religious and non-religious therapists working within each of the major theoretical orientations, and many therapists adopt an eclectic approach in practice. The question then becomes one of personal judgement or discernment by the clinician as he or she seeks to help clients by methods that are both ethical and effective.   When religious or spiritual themes do emerge in therapy, the counsellor can choose to take an implicit or explicit approach.

According to Tan (1996), implicit integration is a relatively covert process in which the therapist does not initiate discussion of religious material or directly use spiritual resources in therapy. This does not necessarily mean that the therapist is insensitive to religious issues or that religious issues are never discussed in therapy. Indeed, the therapist may discuss and interpret religious material when raised by the client. He or she may be a religious person and may even pray silently for clients during or outside of sessions.   If clients wish to explore religious issues more directly or use religious resources in the counselling session, however, this type of therapist would most likely refer them to another suitably qualified counsellor or religious advisor. Conversely, an explicit integration model involves a more overt approach in which religious or spiritual issues are dealt with directly and systematically during therapy. A counsellor operating from an explicit orientation would be more likely to use religious resources such as prayer, sacred texts, or religion-accommodative approaches. (N.B. These will be addressed in a later section).

While some psychologists would argue that an explicit approach is appropriate in the therapeutic context, provided that certain guidelines are followed (e.g., Yarhouse & VanOrman, 1999), others believe that religious interventions fall within the domain of clergy or spiritual directors rather than psychologists (e.g., Tillman, 1998). Before using a religious intervention, it is important for the psychologist to consider the role he or she is to play in therapy, the setting of the therapy, and the reason the client is seeking help (Chappelle, 2000). Is it the psychologist's role to adapt therapeutic techniques to the religious framework of the client? If a psychologist uses religion-accommodative approaches, is he or she crossing a boundary or usurping the role of the client's religious or spiritual leader? Is the role of the psychologist distinct from that of a more explicitly religious service provider, such as a pastor or a spiritual director, or is there overlap among these roles? These are difficult questions to answer. If the therapist's primary goal is to provide spiritual direction or theological correction, the counsellor has probably missed his or her calling and may be

better suited to some kind of pastoral work or religious ministry. However, if the goal is to provide best practice for the client, a range of implicit and/or explicit therapeutic strategies may be appropriate. Chappelle (2000) discusses ethical considerations in dealing with religious issues and provides some excellent guidelines regarding the appropriate use of spiritual interventions in therapy.

From the foregoing discussion, it can be seen that different psychologists are likely to hold divergent views on how best to deal with religious issues in counselling depending on their theoretical orientation and the way in which they view the role of the psychologist. While a thorough discussion of how best to deal with religious issues in counselling is beyond the scope of this review, the following section outlines some of the common ways in which therapists operating from an implicit and/or explicit orientation might deal with religious issues in the therapeutic context.

Understanding Potential Value Conflicts

Earlier, it was argued that value-free counselling is a myth since the worldview of a counsellor will either directly and/or indirectly affect the way in which human behaviour is approached and the kinds of counselling models and techniques that are adopted. In a similar way, clients have value systems that affect their attitudes and behaviours. For some, such as those with strong religious beliefs, these values may be explicit and directly affect choices about the type of counsellor to choose or the types of topics to disclose in a therapy session. Others with less well-defined or more implicit value systems still operate according to some presuppositions about the world in which they live (e.g., the types of behaviours they think are acceptable). Thus, the potential for value conflicts between a therapist and a client are very real, particularly when dealing with value-charged topics (e.g., an unplanned teenage pregnancy, a marriage breakdown, a client's sexual orientation, or a terminal illness).

With regard to counsellor values, Principal B (Integrity) of the Ethical Principles of Psychologists and Code of Conduct of the APA (1992) states that psychologists should "strive to be aware of their own belief systems, values, needs, and limitations and the effect of these on their work" (p. 5). In relation to religious issues, I would add that counsellors who are not religious, or anti-religious, should be aware of any attitudes they hold, or experiences they have had, that may bias their ability to work with religious clients. Conversely, counsellors who are committed to particular religious beliefs should be aware of any biases they may have that could affect their work with non-religious clients or those of other religious backgrounds.   In some cases, therapists may not even realise the extent of their own biases until salient issues emerge within a counselling session. As Zeiger and Lewis (1998) note, "negative countertransference reactions can occur when seemingly similar religious beliefs have different origins or functions for the client and the therapist, or when the therapist overly identifies with the religious conflicts of the client" (p. 420).   In order to effectively manage such countertransference, the therapist needs a high level of self-awareness and openness, and must feel comfortable with his or her own belief system (see Zeiger & Lewis, 1998, for further suggestions).

Furthermore, counsellors need to be aware of the presuppositions underlying the various theories or therapeutic techniques they employ, so that they can (a) choose approaches that are compatible with their own worldviews and (b) avoid approaches that may be incompatible with their clients' worldviews. For both Christian counsellors and those working with Christian clients, Jones and Butman's (1991) book is an invaluable resource that provides a Christian appraisal of the presuppositions of all the major psychological theories and treatment techniques. Clouse (1997) also provides a useful summary of the similarities and differences between a Christian worldview and the major psychological theories.

Awareness of client values is equally important. Client values can be ascertained through formal assessment or through the natural course of the counselling process. Formal assessment of religion could be included when gathering the usual history or background information of the client. Chirban (2001) has developed a detailed inventory that can be used to gather information about a client's religious or spiritual history. Rather than being used verbatim, however, Chirban recommends that clinicians use his outline to select and explore pertinent aspects of religion or spirituality in the client's life. Numerous structured questionnaires are also available to assess a plethora of religious dimensions such as religious orientation, religious attitudes, religious commitment and involvement, and adherence to various beliefs and practices. Hill and Hood (1999) provide copies and reviews of most of the major scales. If the counsellor does not wish to use structured questionnaires, informal questions could be asked about the client's faith (e.g., When you were growing up, did your family hold any particular religious beliefs? Are religious beliefs important to you? Do you belong to a religious group or faith community? In what ways have your religious beliefs or faith community been helpful to you? Are there any ways in which you feel your religious beliefs or faith community have had a negative impact on you?). Some of Chirban's (2001, p. 287) questions may also be relevant here (e.g., "What are the beliefs and values that guide your life?"; "Do religion and spirituality affect your daily life?"). The counsellor can also gain an understanding of the client's values during the usual counselling process by first creating an atmosphere in which the client feels comfortable in sharing his or her beliefs without fear of being judged, ridiculed, or devalued; and then further exploring any religious or spiritual issues that do arise.

Regardless of whether the client's religious or spiritual values are determined through formal or informal means, however, it is important that the counsellor explores the personal meaning of religion or spirituality to the client rather than making assumptions on the basis of a religious preference. While religious affiliation certainly provides some information, it says nothing about the importance of religion to the person, how committed the client is to the beliefs and practices of that religion, or whether he or she has an intrinsic or extrinsic religious orientation. These aspects of religiosity are more important than affiliation alone in determining the effect of the person's religion on his or her attitudes and behaviour. There may also be individual differences in the meaning of beliefs for the particular client. For example, two people who identify with the

same religion or denomination may still differ in their beliefs on certain issues (e.g., liberal versus conservative views).   Others may describe personal spiritual experiences or a spiritual journey that does not necessarily align with any particular religion. There may also be cultural differences. For example, an Australian-born client of Muslim heritage may have quite different beliefs to a Muslim who has just migrated from an Islamic nation. In any case, it is essential that the counsellor clarifies the nature of the client's beliefs so that he or she can understand how the beliefs of that particular client affect his or her attitudes and behaviour.

If the client is of a religious orientation that is not clearly understood by the counsellor, more knowledge can be gained through further education, training, experience, consultation, or supervision (APA, 1992; Bergin et al., 1996; Shafranske & Malony, 1996; Yarhouse & VanOrman, 1999). For example, Collins (1988) outlines Christian perspectives on various issues that may arise in counselling (e.g., anxiety, loneliness, depression, self-esteem, pregnancy issues, addictions). In addition to Christianity, Richards and Bergin (2000) present issues that are relevant when counselling clients from a variety of other religious backgrounds (e.g., Judaism, Islam, Buddhism, Hinduism).

Therapist Disclosure of Religious Beliefs

There has been a lengthy debate in the literature concerning therapist self-disclosure in general, and disclosure of religious beliefs and values in particular. While theoretical orientation will to some extent dictate a therapist's views on the self-disclosure of religious values, the appropriateness of the disclosure is probably the more pertinent issue.   Appropriate therapist disclosure is that which is done for the client's benefit, rather than for the benefit of the counsellor, though this may be difficult to ascertain in practice (Smith & Fitzpatrick, 1995).   Balance is needed, with decisions about therapist disclosure "requiring a general assessment of the patient's capacity to make use of self-disclosure, the status of the transference, and careful monitoring of countertransference attitudes" (Tillman, 1998, p. 284).

The timing of therapist disclosure is also important. Hawkins and Bullock (1995) argue that counsellors may need to be explicit about religious values early in therapy, when relevant, in order to meet the ethical requirements of informed consent. Conversely, Guinee (1999) argues that premature disclosure of religious beliefs could result in client opposition and put the therapeutic relationship at risk. Tillman (1998) raises similar concerns that "disclosing information about oneself prior to, or instead of, exploring the patient's concerns and fantasies about the therapist runs the risk of being off task and foreclosing the patients' opportunity to learn more about themselves in a diverse world" (p. 274). Conversely, a well-timed disclosure may be therapeutic. Nyman and Daugherty (2001) asked psychology students to read one of two scenarios in which a counsellor disclosed the use of prayer. In one scenario, therapist disclosure about prayer came after the client spoke about prayer (i.e., a congruent disclosure); while in the other scenario, the counsellor disclosed without a prior statement about prayer by the client (i.e., incongruent disclosure).

Results indicated that the congruent counsellor was rated as more attractive than the incongruent counsellor, though no significant differences were obtained for trustworthiness or expertness.   Respondents in the congruent condition were also more likely to choose the counsellor for personal counselling than were those in the incongruent group. Although caution is needed in extrapolating from this analogue study to a real-life counselling situation, the findings raise the possibility that the timing of therapist disclosure could affect the therapeutic relationship in positive or negative ways.

Religion-Accommodative Approaches and Religious Interventions

Therapists who operate from an explicit integration orientation could "offer treatment that has been adapted to the language and experience of religious clients" (Yarhouse & VanOrman, 1999, p. 561). For example, if the counsellor was offering a desensitisation technique that involved imagery, religious clients could be given the option of using religious imagery that holds more meaning for them. Religiously sensitive versions of rational emotive behaviour therapy (REBT) have also been developed for use with religious clients (Johnson et al., 2000; Nielsen, Johnson, & Ridley, 2000). For example, Nielsen et al. presented a case study in which a Biblical parable was used to challenge a devoutly religious client's belief that she was not intrinsically worthy or valuable as a person. Albert Ellis (2000, p. 33) has even suggested God-oriented counterparts to various tenets of REBT philosophy (e.g., "Only God is perfect. I am merely a human, not a god, and I can therefore try to do well but not demand that I do perfectly well").   Narramore (1994) also provides case examples and guidelines for working within the framework of the client's faith to deal with religious resistances in therapy.

In a recent meta-analysis, McCullough (1999) compared the efficacy of religion-accommodative therapy for depression with standard counselling approaches. Since the religion-accommodative approaches were no more or less effective than the traditional approaches, McCullough argued that religion-accommodative approaches should not be withheld from those clients who would prefer such interventions. Indeed, he suggested that such approaches may be the treatment of choice for some highly religious clients. Moreover, Koenig and Pritchett (1998) suggest that clients may be more likely to comply with treatment programs that are compatible with their belief systems.

As well as adapting traditional therapeutic techniques to the language and experience of religious clients, Yarhouse and VanOrman (1999) suggest that specific religious interventions that are consistent with the values of the client could be used (e.g., prayer or meditation). In view of the possible power differential between the counsellor and the client, particularly when the client is a child or adolescent, the counsellor should always seek permission before using a technique such as prayer with religious clients. Indeed, seeking direct permission would be good practice regardless of whether the therapist is using spiritual or non-spiritual interventions. It may be better still if the request for religious interventions comes from the client.   Chappelle (2000) further argues that "a therapist should obtain informed consent each time he or she wishes to

use a particular spiritual intervention inside (as well as outside) of therapy" (p. 48) and that the counsellor should also inform the client of alternative treatment methods. There may also be times when a religious intervention may be contraindicated. For example, Chappelle (2000) suggests that it is unwise to use spiritual interventions with clients who are actively delusional or psychotic. He also argues that the use of spiritual interventions should be documented and that such interventions should only be used if the therapist can "justify their use with a sound rationale or integrate them with additional interventions that are scientifically proven to be effective" (p. 50). Indeed, more outcome research on religion-accommodative therapy and explicitly religious interventions is needed. It is beyond the scope of the current paper to evaluate the relative merits of different types of religion-accommodative techniques (see Worthington et al., 1996, for a review). However, I do wish to raise the issue of competence. If therapists attempt to use religious interventions in therapy, yet are not competent in the use of those techniques, they may be in breach of APS and APA codes of ethics.   Indeed, therapists are not to practice outside the boundaries of their own competence (Chappelle, 2000; Johnson et al., 2000), but are to "obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals" (APA, 1992, p. 7).   The issues of referrals and training will be dealt with in the next two sections.

Networking and Referrals

When a counsellor feels that his or her ability to effectively assist a religious client is restricted, he or she could either work together with others in the client's faith community (e.g., pastor, rabbi, or other religious leader or spiritual director) or refer the client to another appropriate counsellor (Chappelle, 2000; Yarhouse & VanOrman, 1999). As Koenig and Pritchett (1998) note, however, it is first important to assess the client's current spiritual needs and past positive and negative experiences of religion so that an informed decision about referral options can be made. Unfortunately, many professional counsellors are reluctant to work with, or refer to, religious leaders such as clergy. While the reasons for this are not clear, Worthington et al. (1996) suggest that "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" (p. 468). Chaddock and McMinn's (1999) survey of psychologists and evangelical clergy further identified value differences as a potential barrier to collaboration, especially for clergy; while Weaver (1998) identified lack of education or knowledge about the potentially powerful role the clergy can play in helping those in distress.

Whatever the initial reasons for lack of collaboration, Yarhouse and VanOrman's (1999) recommendations may be helpful in breaking down barriers that could exist between counsellors and clergy. Their suggestions for clinicians who provide services to religious clients include the following:

Become a gatekeeper to community resources for religious persons….

Develop a referral and consultation network of religious colleagues from a variety of faith traditions….Engage religious leaders and invite them to

understand your work and hear the concerns they may have for those under their spiritual care. (p. 561)

If therapists ignore these suggestions and continue to under-utilise churches and other religious resources, they may inadvertently cut their clients off from potentially useful treatment options.   Fortunately, some psychologists are starting to see the value of such collaboration. For example, the journal "Professional Psychology: Research and Practice" devoted a special section in its December 1999 edition to "Collaboration Between Psychologists and Clergy". As such topics move into the mainstream, barriers between religious and mental health professionals may be broken down further.   A recent study compared the values of three groups of counsellors: Christian spiritual directors, Christian psychologists who were members of the Christian Association for Psychological Studies, and a sample of practising clinical psychologists randomly selected from the membership directory of the American Psychological Association (Howard, McMinn, Bissell, Faries, & VanMeter, 2000). While the groups differed in the extent to which they endorsed some mental health and spiritual values (e.g., forgiveness), all three groups endorsed a mature outlook, integration/coping, freedom/autonomy, and expression of feelings. When psychologists and clergy collaborate, it would be helpful for each to remember that they share some values in common that would allow them to work together, even though they may have certain religious differences.

Training

While all psychiatric residency programs in the United States have been required to formerly address spiritual and religious issues in their training since 1996 (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002), the incorporation of religious or spiritual issues in the training of psychologists has been more variable. For example, Brawer et al. surveyed 98 clinical training directors at APA-accredited programs within the United States and Canada regarding the extent to which religious or spiritual issues were dealt with in the training offered to their students. While most programs offered some degree of training with regard to religious or spiritual issues, there was a wide variety in the depth and breadth of coverage. Only 13% of the directors indicated that their programs contained a specific course on religion and psychology, while 61% of directors indicated that religion or spirituality was dealt with in another course (e.g., cross-cultural psychology).   Only 17% of directors indicated that religion and spirituality were given systematic coverage in their program (i.e., through course work, research, and supervision), while 16% indicated that it was not covered at all. If a similar survey were to be conducted in Australia, I suspect the percentage of programs that systematically cover religion or spiritual issues would be much lower. If this is the case, we are failing to train our students in the skills necessary to deal with religious diversity in the counselling context. In order to address this issue, we need to consider the goals of such training.

The first goal of training should be to encourage students and trainers to recognise their own biases, religious or non-religious, so that they will be better equipped to effectively treat their clients or know when to make referrals

(Worthington et al., 1996). A related goal would be to increase students' (and trainers') awareness of religious and spiritual issues, in much the same way that they are taught to consider other diversity issues such as ethnicity (Brawer et al., 2002). Thirdly, psychologists should be trained to recognise the difference between normal and pathological manifestations of religion (Bowman, 1998; Worthington et al., 1996). While this task is in itself somewhat value-laden, there is substantial literature on the relationship between religion and mental health from which to draw (see earlier section). In particular, psychologists should be aware of the types of religious beliefs, practices, or experiences that can enhance or hinder well-being and mental health.   Finally, boundaries and ethical issues should be covered. While such issues should be addressed in any professional psychology program, they are particularly important when dealing with religious topics and processes in counselling (see Chappelle, 2000).

With these goals in mind, there are a number of ways in which religious or spiritual issues could be addressed in psychology programs. An obvious way would be to develop courses that specifically deal with religious issues (e.g., courses on the psychology of religion or the integration of psychology and religion). Such training could also be incorporated into existing counselling courses or other courses or modules that deal with multicultural issues or diversity. Religious issues could also be considered in generic subjects that deal with topics not covered in other psychology courses. Over the last four years, for example, I have run a "Religious Issues in Counselling" subject under the banner of a generic third-year course called "Special Topics in Psychology". I have found this to be an effective way of stimulating students to think about how religious issues and values intersect with the theory and practice of psychology. Bowman (1998) has also suggested that religious or spiritual issues could be addressed in more informal settings such as seminars or case conferences. If academic staff do not feel they have the necessary expertise to deal with such issues, suitably qualified guest lecturers could be brought in (Brawer et al., 2002).   Souza (2002) has also noted that religious issues could be explored in supervision. She particularly notes that "supervision is the ideal place to work with students who seem capable of imposing their beliefs on clients" (p. 215). I would add that it is essential for supervisors or educators to monitor their own potential biases with regard to religious issues so that they do not impose their beliefs on the trainees. Indeed, educators must create a non-judgemental atmosphere in which students can explore religious or spiritual issues in their training. Finally, more attention could be given to research in this area.   I've already noted the need for more research regarding the effectiveness of religion-accommodative approaches and explicitly religious interventions. There is also a need for more specific research within the Australian context (e.g., How do Australian clients, psychologists, and academics view religious issues in counselling?).

Conclusion

At the outset, I asked whether Australian psychologists were "dragging the chain" with regard to religious issues in counselling. While there are a number of notable exceptions, I believe I have provided sufficient evidence that Australian psychologists are generally lagging behind their American counterparts in this area. This is unfortunate because it means that we run the risk of misunderstanding or overlooking important variables that may be affecting our clients' thoughts, feelings, and behaviours. We may also be cutting our religious clients off from potentially useful therapeutic processes and techniques. Returning to Delbridge's (1987) definition of "drag the chain", we may well be *hindering* the progress of some of our clients by being *too slow* to adequately consider the role of religious issues in therapy. I have suggested some ways in which religious issues could be addressed in the counselling process, and have noted the importance of a careful consideration of boundary issues, particularly as they relate to the task and role of the therapist. However, I am also acutely aware that I have only scratched the surface of this area. Indeed, many of the issues raised in this paper could have easily been expanded into separate articles in their own right. My hope is that this paper will at least prompt counsellors to be more aware of how their own values and those of their clients can influence the process and outcome of therapy. As more discussion, research, and training is conducted on this topic, it is hoped that more holistic models will emerge that enable psychologists to provide the best treatment options and outcomes for their clients.

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Footnotes

[1]   At the time of writing this paper, the APA was in the process of revising their guidelines. However, statements referring to religion in the May 2002 draft (i.e., Draft 7) were virtually unchanged from the previous code, though some statements appear in different sections. The draft document is available at the following web site:

http://anastasi.apa.org/draftethicscode/Draft%207%20clean.doc

[2]   This information was obtained via a search of the PsycINFO database from 1980-June 2002. In the search, the names of each of these journals was linked with the following words: religion, religious, religiosity, spiritual, spirituality, Christian, Christianity, Catholic, Catholicism, Protestant, Jew, Jewish, Judaism, Muslim, Islam, Islamic, Hindu, Hinduism, Buddhist, Buddhism, and New Age. Seven articles that referred to the Protestant Work Ethic were not included in the total of articles cited, as these articles were primarily about work ideology rather than religion. Articles were also omitted from the total if the search words did not appear in the title or abstract.