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P. Scott Richards

Richard W. Potts

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P. Scott Richards, PhD[1]
Richard W. Potts, MEd

Abstract

Three hundred members of the Association of Mormon Counselors and Psychotherapists (AMCAP) were randomly selected and asked about their use of spiritual interventions in their professional work. Two hundred and fifteen (72%) AMCAP members responded to the survey and indicated that they use a wide variety of spiritual interventions. Praying silently for clients, teaching spiritual concepts, encouraging forgiveness, using the religious community as a support, and encouraging clients to pray were used much more frequently than were priesthood blessings by therapists, praying with clients, and asking clients to memorize scriptures. Critical incident case examples provided by the therapists revealed that a wide variety of spiritual interventions were perceived as potentially therapeutic. Clinical guidelines regarding the use of spiritual interventions were offered by the therapists and ethical concerns were raised. Implications for AMCAP members are discussed.

Members of the Association of Mormon Counselors and Psychotherapists (AMCAP) have had a long interest in integrating spiritual values and interventions into their professional work. In fact, an express purpose of the AMCAP organization is to promote

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professional practices which are in harmony with moral and spiritual principles (Article 1, Section 2, AMCAP bylaws [as amended Sept. 30, 1981]). Members of AMCAP have discussed and written much over the past two decades about religious and spiritual issues and interventions (e.g., Allred, 1987; Broderick, 1975; Brown, 1975; Burton, 1984; Byrd, 1993; Hardy, 1989; Hurst, 1981; Judd, Bingham, & Williams, 1988; Kelly, 1980, 1981; Madsen & Millet, 1981; Paul, 1983; Pritt & Pritt, 1987), and some members of AMCAP have contributed nationally and internationally in this domain (e.g., Bergin, 1980, 1988, 1991; Bergin & Payne, 1991; Koltko, 1990; Payne, Bergin, & Loftus, 1992; Richards, Owen, & Stein, 1993).

Although considerable work has been done within AMCAP, we still do not have a very clear idea of how widespread or frequent the use of various spiritual interventions is by members of AMCAP. In addition, we still know very little about the types or effectiveness of therapeutic outcomes that result from AMCAP members' use of spiritual interventions. We also know very little about AMCAP members' attitudes regarding the ethical appropriateness of using spiritual interventions in their professional work.

In an effort to gain more insight into these questions, we surveyed members of the AMCAP organization and investigated the following three research questions:

1. How frequently do AMCAP members utilize various spiritual interventions in their professional work?

2. What spiritual interventions are most often perceived by AMCAP members as effective or ineffective and what outcomes are associated with these interventions?

3. What are AMCAP members' attitudes regarding the ethical appropriateness of using various spiritual interventions in their professional work?

Methods

Procedures

After receiving approval to proceed with the study from the Brigham Young University Human Subjects Review Committee in late

September 1992, we randomly selected three hundred psychotherapists in the United States and Canada from the current AMCAP membership directory. In late October 1992, participants were mailed a survey packet which included a cover letter, informed consent document, and copy of the survey. The cover letter and informed consent document solicited therapists' participation and briefly explained that the purpose of the study was to "determine what spiritual interventions members of AMCAP use in their professional work and to gain insight into when such techniques are most effective in facilitating client change." The informed consent document also assured participants of confidentiality, and asked the participants to avoid disclosing details about their clients that could make it possible to establish clients' identity. In early January, 1993, a follow-up letter and second copy of the survey was sent to therapists who had not yet responded to the survey. In early March 1993, a postcard was sent to therapists who had not yet responded to the survey.

Participants

Approximately 130 participants returned the survey after the first mailing. Approximately 70 more participants returned the survey after the second mailing. Approximately 15 participants returned the survey after the postcard was sent. Thus, a total of 215 participants returned the survey for a total return rate of 72%. Actual response rates vary somewhat for each variable and are provided in appropriate places in the text and tables.

There were 122 (60%) male and 83 (40%) female therapists. The average age of the therapists was 48 years (SD = 9.9 years). One hundred and thirty-two (70%) of the therapists were licensed. The average caseload of the therapists was 20.6 clients per week (SD = 15.9). On the average, 63% (SD = 34.2%) of the therapists' clients each week were LDS. Other demographic characteristics of the therapists such as theoretical orientation, professional specialty, work setting, geographic location, and type of clientele are presented in Table 2.

Survey Description

The survey was constructed for the present study by the researchers. The first page of the survey asked respondents to provide

background and demographic information. On page 2 of the survey, nine "In-Session Spiritual Techniques" were listed (see Table 1) and defined, and the respondents were asked to indicate on a 6-point Likert scale (0 = Never, 1 = Rarely, 2 = Occasionally, 3 = Often, 4 = Very Often, 5 = Always) how frequently they have "used these techniques or interventions during the past year in your professional therapeutic role." An "Other (please describe)" category was also provided so respondents could indicate how frequently they have used in-session spiritual interventions which were not listed in the survey.

On page 3 of the survey, nine "Out of Session Spiritual Techniques" were listed (see Table 1) and defined, and the respondents were again asked to indicate on the 6-point Likert scale how frequently they have used these techniques during the past year. Once again, an "Other (please describe)" category was provided. At the bottom of page 3, we also asked respondents to indicate (Yes or No) whether they believed there are any religious or spiritual techniques that therapists should not use in their professional role; that is, interventions that should only be used by religious leaders. Respondents who answered "yes" to this question were asked to indicate what spiritual techniques they believed therapists should not use in their professional role.

On pages 4 and 5 of the survey, we used a version of the critical incident technique in an attempt to learn more about AMCAP members' perceptions of when spiritual interventions have been particularly effective or ineffective in their therapeutic work. On page 5 the instructions read, "We are interested in finding out when you feel religious or spiritual techniques have been effective or ineffective with your clients. Please recall, if you can, an occasion where you felt a religious/spiritual technique was particularly effective in helping your client grow or change. Without disclosing details which would make it possible to establish the client's identity, please briefly describe: (1) Client demographics (e.g., age, gender, marital status, religious affiliation, convert or lifetime member); (2) What the client's presenting problem was; (3) What spiritual/religious intervention was used; (4) At what point in therapy you used it; (5) Your rationale for using it; (6) The outcome of this spiritual or religious intervention; (7) Any

other comments that you believe would help us better understand this technique/intervention."

The instructions on page 5 were identical except respondents were asked to recall and describe an occasion when they felt a religious/spiritual technique was clearly ineffective in helping a client change. Finally, on page 6 of the survey, we invited respondents to share any other insights or comments with us regarding the use of spiritual techniques in therapy that had not been addressed in our survey.

Quantitative Data Analysis

Means, standard deviations, and frequencies were computed to describe how often the AMCAP members used the various spiritual interventions. To avoid undue inflation of the Type I error rate (Haase & Ellis, 1987; Leary & Altmaier, 1980; Rencher & Scott, 1990), multivariate analysis of variance (MANOVA's) were then computed to determine whether different types of psychotherapists differed in the frequency with which they use various spiritual interventions. When the MANOVA's were statistically significant, the correlated univariate F-tests were interpreted (Haase & Ellis, 1987; Leary & Altmaier, 1980; Rencher & Scott, 1990), and where needed, least significant difference (LSD) pairwise comparisons were computed to determine which specific spiritual interventions therapists differed on. Finally, chi-square analyses were done to determine if different types of therapists differed in their attitudes regarding the ethical appropriateness of utilizing various spiritual interventions. Alpha levels of $< .05$ were utilized in all analyses.

Qualitative Data Analysis

A licensed counseling psychologist and two counseling psychology graduate students served as judges and used qualitative data analysis procedures (as described in Taylor & Bogdan, 1984, p. 129-142) to analyze the critical incident responses. Each judge independently studied the therapists' responses and carefully searched for possible themes or categories in the data. After independently identifying possible themes in the data and documenting which therapist responses

fit into the various themes, the judges met to compare and clarify their descriptions of the themes and the supporting evidence (therapist responses/quotes).

Results

Table 1 reports the utilization rates of the various spiritual interventions by all psychotherapists who responded to the survey. "Therapist (silent) prayer" was the most frequently used "in-session" spiritual intervention. The mean endorsement rate across all therapists for therapist (silent) prayer was 2.97 (SD = 1.51) which indicates that on the average the Mormon psychotherapists "often" offer silent in-session prayers on behalf of clients. The least frequently used in-session spiritual interventions were "blessing by therapist" (M = 0.43) and "therapist and client prayer" (M = 0.72).

"Encouraging client forgiveness" was the most frequently used "out-of-session" spiritual intervention. The mean endorsement rate across all therapists for "encouraging client forgiveness" was 2.88 which indicates that on the average the Mormon psychotherapists slightly less than "often" encourage clients to forgive others. The least frequently used out-of-session spiritual intervention was "client scripture memorization" (M = 0.55).

Table 2 reports the average frequency with which different types of psychotherapists use in-session and out-of-session spiritual interventions. The Wilks's lambda MANOVA's, univariate F-tests, and LSD pairwise comparisons revealed that therapists who work for LDS Social Services or in university settings were more likely to pray with their clients, teach spiritual concepts, make reference to scripture, use religious imagery, do spiritual assessments, and give clients blessings than were therapists who work in hospital and school settings. Male therapists were more likely than female therapists to pray with clients, make reference to scripture, and give clients blessings. Female therapists, however, were more likely than male therapists to pray silently for their clients. Masters level therapists were more likely to use religious imagery and do spiritual assessments than were doctoral level therapists. However, doctoral level therapists were more likely to give clients blessings.

Table 1

Utilization Rates of Various Spiritual Interventions by the Psychotherapists

	Response Option (%)[1]								
Spiritual Intervention	0	1	2	3	4	5	Mean	SD	N
In-Session Interventions									
Therapist Prayer	7	11	19	21	23	18	2.97	1.51	190
Teaching Spiritual Concepts	4	11	39	28	16	3	2.47	1.10	192
Reference to Scripture	11	25	41	15	7	1	1.85	1.09	193
Spiritual Self-Disclosure	9	32	36	14	7	1	1.80	1.09	193
Spiritual Confrontation	10	33	36	13	5	3	1.77	1.11	192
Spiritual Assessment	29	23	21	14	10	4	1.66	1.48	190
Religious relaxation/imagery	41	28	19	6	6	1	1.09	1.20	192
Therapist & Client Prayer	54	29	13	2	2	1	0.72	1.00	192
Blessing by Therapist	69	21	8	2	1	0	0.43	0.75	186
Out-of-Session Interventions									
Encouraging Forgiveness	4	5	23	39	24	5	2.88	1.12	189
Use Religious Community	4	10	32	33	17	5	2.64	1.13	193
Client Prayer	8	19	31	24	13	4	2.28	1.26	193
Encouraging Client Confession	13	22	36	17	6	6	2.00	1.29	190
Referral for Blessing	19	20	33	18	7	4	1.84	1.31	193
Religious Journaling	22	21	30	18	7	3	1.76	1.33	193
Spiritual Meditation	13	22	32	22	9	2	1.67	1.22	192
Religious Bibliotherapy	22	25	32	11	6	3	1.62	1.27	192
Scripture Memorization	63	23	11	1	2	0	0.55	0.85	193

[1]Percentages reflect % of the psychotherapists who endorsed the response option: (0=Never; 1=Rarely; 2=Occasionally; 3=Often; 4=Very Often; 5=Always).

Table 2

Average Frequency of Use of In-Session and Out-of-Session Spiritual Interventions by Different Psychotherapists

	In-Session Inteventions			Out-of-Session Interventions			Manova's	
Demographic Variable	N	Mean	SD	N	Mean	SD	F(IS)	F(OS)
Professional Specialty								
Clinical Social Workers	56	1.64	0.66	60	2.14	0.80	1.40	1.49*
Marr./Family Therapists	32	1.89	0.78	30	2.34	0.97		
Psychologists	36	1.50	0.49	39	1.68	0.59		
Counselors	39	1.53	0.86	39	1.71	0.91		
Other	13	1.61	0.99	13	1.67	1.22		
Theoretical Orientation								
Eclectic	87	1.71	0.72	88	1.99	0.87	1.06	1.20
Cognitive-Behavioral	57	1.46	0.65	61	1.81	0.81		
Other	21	1.50	0.80	22	1.76	1.02		
Work Setting								
University	15	1.86	0.35	15	2.01	0.53	1.68**	2.16***
Hospital	18	1.13	0.46	17	1.32	0.41		
Community M.H. Center	23	1.52	0.66	23	1.72	0.84		
Private Practice	59	1.71	0.78	64	2.11	0.96		
LDSSS	35	1.91	0.61	35	2.36	0.62		
School	15	1.10	0.75	16	1.22	0.93		
Other	12	1.47	0.95	13	1.70	0.73		
Geographic Location								
Utah	65	1.51	0.62	70	1.72	0.69	1.11	1.19
California	27	1.64	0.76	25	2.03	1.10		
Idaho	23	1.76	0.97	24	2.16	0.92		
Other Western States	40	1.67	0.81	42	2.08	0.94		
Eastern States	16	1.73	0.57	17	2.12	0.98		
Gender								
Male	108	1.65	0.71	113	1.98	0.83	5.72***	2.96***
Female	71	1.58	0.78	72	1.87	0.95		
License Status								
License	121	1.65	0.70	125	2.01	0.83	0.81	1.61
No License	48	1.46	0.80	48	1.73	1.02		
Age								
< 49	86	1.60	0.81	90	1.89	0.93	1.02	2.29*
≥ 49	91	1.64	0.67	93	1.99	0.84		
Degree								
Masters	108	1.70	0.76	111	2.08	0.86	3.61***	3.20***
Doctorate	60	1.53	0.64	64	1.76	0.82		

Demographic Variable	In-Session Inteventions N	Mean	SD	Out-of-Session Interventions N	Mean	SD	Manova's F(IS)	F(OS)
Type of Clientele								
< 50% LDS	49	1.36	0.76	48	1.60	0.94	3.25***	2.53**
≥ 50% LDS	126	1.74	0.70	133	2.08	0.82		
No Children	85	1.59	0.76	90	1.84	0.89	0.78	1.89
Children	92	1.65	0.71	94	2.01	0.86		
< 10% Adolescents	75	1.53	0.74	81	1.82	0.82	1.24	1.38
≥ 10% Adolescents	102	1.68	0.73	103	2.02	0.91		
≤ 20% Young Adults	82	1.48	0.76	86	1.80	0.98	1.93	1.55
> 20% Young Adults	95	1.73	0.69	98	2.04	0.76		
< 39% Middle-Age Adults	88	1.55	0.75	91	1.80	0.90	0.55	1.59
≥ 39% Middle-Age Adults	89	1.69	0.72	93	2.05	0.84		
No Elderly Adults	82	1.59	0.81	88	1.93	1.03	1.23	1.55
Elderly Adults	95	1.64	0.67	96	1.93	0.71		
Type of Therapy								
< 19% Marriage	79	1.42	0.73	81	1.65	0.86	2.97**	2.51**
≥ 19% Marriage	99	1.77	0.70	102	2.15	0.83		
< 9% Family	79	1.39	0.68	80	1.60	0.76	2.27*	3.24***
≥ 9% Family	99	1.80	0.72	103	2.18	0.88		
< 49% Person./Emotional	77	1.72	0.75	78	2.08	0.96	0.72	1.88
≥ 49% Person./Emotional	100	1.52	0.71	104	1.81	0.80		
No Career/Vocational	129	1.59	0.71	133	1.96	0.87	1.05	0.91
> 0% Career/Vocational	49	1.68	0.79	50	1.83	0.90		
No Alcohol/Drug	116	1.54	0.69	118	1.88	0.89	0.99	0.92
> 0% Alcohol/Drug	62	1.76	0.79	65	2.01	0.85		
No Pastoral	146	1.51	0.69	147	1.86	0.88	3.98***	1.35
> 0% Pastoral	32	2.08	0.74	36	2.21	0.83		

Note: Response scale was: 0=Never; 1=Rarely; 2=Occasionally; 3=Often; 4=Very Often; 5=Always. *<.05. **<.01. *** <.001. F(IS)=F-test for in-session intervention comparisons; F(OS)=F-test for out-of-session intervention comparisons.

Therapists with more LDS clients (caseload greater than 50% LDS) were more likely to pray with their clients, teach spiritual concepts, make reference to scripture, and engage in spiritual self-disclosure than were therapists who worked with fewer Mormon clients. Therapists who provided more marriage and/or family therapy were more likely to use most in-session spiritual interventions (e.g., pray with their clients, make reference to scripture, engage in spiritual self-disclosure, use spiritual confrontations, do spiritual assessments, and give clients blessings) than were therapists who did less marriage and/or family therapy. Therapists who did some pastoral counseling were more likely to use all in-session spiritual interventions (except spiritual assessments) than were therapists who did not do any pastoral counseling.

The Wilks's lambda MANOVA's, univariate F-tests, and LSD pairwise comparisons also revealed that marriage and family therapists and clinical social workers were more likely than were psychologists, counselors, and other professionals to encourage client prayer, use resources in the religious community, use religious bibliotherapy, refer for blessings, encourage spiritual meditation, and encourage clients to forgive others. Therapists who work for LDS Social Services, in private practice, and university settings were more likely to employ all out-of-session interventions (except encouraging forgiveness) compared to therapists who work in hospital and school settings.

Male therapists were more likely than female therapists to assign scripture memorization to clients, but male and female therapists did not differ in the frequency they used other out-of-session interventions. Older therapists were more likely than younger therapists to assign scripture memorization, but older and younger therapists did not differ in the frequency with which they used other out-of-session interventions. Masters level therapists were more likely than doctoral level therapists to encourage client prayer, use resources in the religious community, encourage spiritual meditation, assign spiritual journaling, and encourage clients to forgive others.

Therapists who worked with more LDS clients were more likely to encourage client prayer, use resources in the religious community, encourage client confession, use religious bibliotherapy, refer for bless-

ings and encourage clients to forgive others than were therapists with fewer LDS clients. Therapists who provided more marriage and/or family therapy were more likely to use most out-of-session interventions (e.g., encourage client prayer, use resources in the religious community, assign scripture memorization, use religious bibliotherapy, refer for blessings, suggest spiritual meditation, and encourage clients to forgive others) than were therapists who did less marriage and/or family therapy.

Spiritual Interventions Therapists Should Not Use

In response to the question of whether there are any spiritual interventions that therapists should not use in their professional role, 73% of the therapists responded "Yes," while 27% responded "No." Chi-square analyses revealed that masters degree level therapists (77.9%) were slightly more likely to respond "Yes" ($x^2 = 3.27$, $p < .05$) than were doctorate level therapists (65.1%). There were no other significant differences between therapists on this question.

The spiritual interventions mentioned most frequently by the therapists as inappropriate for therapists to use in their professional role were priesthood blessings by therapist (mentioned by 79 therapists), encouraging clients to confess (34 therapists), client and therapist in-session prayer (33), and spiritual self-disclosure or modeling (22). Also mentioned by the therapists, though infrequently, were spiritual assessments (12), assigning client scripture memorization (9), encouraging clients to forgive others (8), judging or criticizing clients (8), spiritual relaxation/imagery (5), spiritual confrontations (5), and performing exorcisms (3).

Qualitative Results

One hundred and seventeen therapists described at least one occasion when they had utilized a spiritual intervention and had perceived that it had been particularly effective in helping their client grow or change. Seventy-three therapists described at least one occasion when they utilized a spiritual intervention and perceived that it was particularly ineffective in helping their client grow or change. Some therapists described several effective or ineffective attempts to use spiritual inter-

ventions. Characteristics of the spiritual interventions the therapists perceived as effective or ineffective are summarized in Tables 3 and 4.

Process Themes or Guidelines

Eight major process themes or guidelines regarding the use of spiritual interventions in therapy were identified in the qualitative data and are listed below with several illustrative quotes from therapists.

1. ***Use spiritual interventions only when prompted and guided by the spirit of God to do so.*** One therapist said that she used a particular spiritual intervention "as I felt prompted by the spirit." She went on to say that "this is a spiritual intervention, not a therapeutic one, and should be done only under spiritual direction." Another therapist said that he decided when working with two young Mormon clients to disclose "a tremendous spiritual experience I had (without being particularly directed by the spirit to do so) ... When I shared this experience with these two clients I could see their eyes glaze over and they tuned out ... I came to realize that it was my experience and it could only be understood in the context of the spirit ..." Another therapist said, "Hopefully, therapists are not trying to collect a book of "how-to's" as to when ... spirituality is appropriate. As soon as we do that then there is no place for the spirit to guide and direct the work." Another therapist said, "Religious techniques should be ... used only under the direction of the spirit and require a deep personal commitment from the therapist." Another therapist said, "To reap the full results of using these techniques lies within the therapist's own spiritual preparedness. This is the way we can receive inspiration for each client."

2. ***Establish a relationship of trust with the client before using spiritual interventions.*** One therapist who was working with a severely depressed female, Mormon client said that "First rapport had to be built with patient. We dealt with concrete problems, in an empathetic, caring manner. Patient became involved with psychiatric care involving drug treatment.... Patient began to request blessings, prayer, sharing of religious experiences. Only when patient felt unconditionally accepted, then she requested religion to become a part of our discussion." Another therapist, who used several spiritual interventions (e.g., teaching spiritual concepts, spiritual self-disclosure, spiritual

Table 3

Description of Effective Interventions Reported by the Psychotherapists

Characteristic of Intervention	Number Times Reported
When Used	
Early in Therapy (1 - 10 sessions)	42
Midpoint (11 - 40 sessions)	12
End of Therapy (41 - termination)	5
Impasse Point	24
Clients	
Female	60
Male	21
Single	31
Married	45
Lifetime LDS	41
Convert LDS	22
Non LDS	4
Client Presenting Concerns	
Depression/hopelessness/grief	32
Marital conflict	24
Childhood sexual abuse/PTSD	20
Low self-esteem/poor self-concept	14
Violations of values (e.g., law of chastity)	14
Difficulty coping with stress & frustration	9
Suicidal ideation	8
Rage, anger	7
Eating disorder	4
Homosexuality	4
Effective Interventions	
Reference to gospel doctrine/scripture	41
Private prayer (client or therapist)	23
Client scripture study	19
Confession to religious leader & others	14
Spiritual imagery	12
Encouraging repentance	12
Encouraging forgiveness	11
Priesthood blessing by religious leader	10

Table 3 continued on next page

Table 3 (continued)

Description of Effective Interventions Reported by the Psychotherapists

Characteristic of Intervention	Number Times Reported
Effective Interventions (continued)	
In-session client/therapist prayer	10
Use of Church support system	9
Priesthood blessing by therapist	6
Spiritual confrontation	5
Client temple visits/Temple prayer role	4
LDS psychological bibliotherapy	4
Sharing of testimony/belief in God's love	4
Role reversal (empty chair) with diety/spirit self	3
Reading/discussing client's patriarchal blessing	3
Meditation	3
Reframing client's view of Church/Doctrine	3
Positive Outcomes	
Strengthened client's self-esteem/self-worth	28
Helped client cope & overcome depression	21
Increased client's hope, optimism & peace	16
Helped client draw closer to spirit/clarify values	12
Improved marital & family relationships	12
Resolved unfinished business with parents/others	11
Deepened client's resolve/motivation to change	8
Increased faith in God/spiritual insight	8
Client returned to Church activity/temple	7
Guilt resolved	7
Client began repentance/change process	6
Increased coping ability/frustration reduction	5

TABLE 4

Description of Ineffective Interventions Reported by the Psychotherapists

Characteristic of Intervention	Number Times Reported
When Used	
Early in Therapy (1 - 10 sessions)	18
Midpoint (11 - 40 sessions)	5
End of Therapy (41 - termination)	1
Impasse Point	5
Client Demographics	
Female	34
Male	16
Single	24
Married	26
Lifetime LDS	15
Convert LDS	12
Non LDS	8
Client Presenting Concerns	
Marital & family conflict	23
Violations of religious values	15
Childhood sexual abuse	13
Anger/Rage	12
Depression	11
Personality Disorders (OC, B, N)*	5
Homosexuality	4
Low self-esteem	3
Psychosis	2
Sexual addiction	2
Severe anxiety/agoraphobia	2
Drug/alcohol abuse	2
Prostitution	1
Suicidal ideation	1
Bipolar disorder	1
Ineffective Interventions	
Use of scripture/gospel doctrines/Church publications	31
Request for divine intervention (prayer, blessings)	14
Suggesting client speak to religious leader	10
Encouraging forgiveness (too early)	7
Spiritual confrontation/Encouraging repentance	7
Spiritual self-disclosure/modeling	3

Table 4 continued on next page

Table 4 (continued)

Description of Ineffective Interventions Reported by the Psychotherapists

Characteristic of Intervention	Number Times Reported
Negative Outcomes	
No change	40
Refusal to follow therapist suggestions	25
Anger at therapist	20
Premature termination	10
Client becomes more closed	9
Client becomes more disturbed	7
Client confusion	5
Client becomes dependent on therapist	1
Client divorces spouse	1

* OC = Obsessive-compulsive; B = Borderline; N = Narcissistic.

assessment) with a Mormon male who was having marital problems, said that he used the spiritual interventions "after meeting with him five or six times and establishing a definite relationship and trust .... I believe it is beneficial to utilize certain spiritual interventions after you have established rapport and trust."

3. ***Obtain the client's permission before using spiritual interventions to make sure the client is comfortable with using them.*** One therapist said, "The issue of employing religious or spiritual techniques depends, I believe, upon the desire of the client to do so. I would in no case utilize religious concepts unless the client wished me to." Another therapist said, "Employment of spiritual interventions and techniques should be the result of heavy client participation in deciding when, how, and to what extent those interventions are to be used." Another therapist said, "I believe that spiritual and religious interventions are an invaluable tool when working with Mormon clients, but they should be used with full client consent as part of the client-therapist contract. The more openly this is addressed, the more effectively it can be used or avoided."

4. ***Assess the client's religious beliefs and doctrinal understanding*** **before** ***using spiritual interventions.*** One therapist, who was working with a 19-year-old female Mormon client, said "The client was in a religiously rebellious mode because of her family of origin. Religious treatment was offered but she rejected anything to do with religion. Her parents (father) had misused religious concepts to force her to do their will. I only attempted [the religious intervention] once, then seeing the negative effect switched to a different approach." Another therapist, who was working with a depressed 30-year-old Mormon female client said that she "suggested personal prayer for relief.... The woman confessed nonbelief [in God] or at best, confusion regarding religion generally and Mormonism specifically.... Personal prayer ought not to be recommended unless religious experiences of individual are assessed. I clearly erred in assuming religiosity upon appearances alone."

5. ***Work within the client's value framework and level of spirituality.*** One therapist said, "I always work within the framework of the client's value system." Another said, "I feel that all therapists should work within the framework of the client's moral code." Another said, "I do

make an active effort to work within the values frameworks of all my clients, and see their religious values and experiences as critically important (I see clients from many different religious groups)." One therapist said, "Religiously grounded interventions are much like those of other therapist choices. Timing, the readiness of the client, adapting the intervention to the client rather than using it as a stock item or a simple size to fill all are among the more important." Another said, "Some people are spiritually sensitive and aware—and therefore receptive to spiritual techniques—and some are not."

6. Use spiritual interventions carefully and sparingly. One therapist said, "Utilization of religious concepts should take place with tremendous care and caution, for each individual sees and experiences the gospel uniquely." Another therapist said, "Spiritual interventions can be very powerful but should be used with great care and discretion." Another therapist said, "I believe spiritual and religious techniques have to be used with extreme care. They should only be used after rapport and trust have been well established. Therapists need to ask for permission to do so or many times the clients may feel like their boundaries have been violated." Another therapist said, "Religious techniques should be used rarely and only under the direction of the spirit."

7. *Spiritual interventions may be less effective with severely disturbed clients.* One therapist, in relating an ineffective attempt to use a spiritual intervention, said, "The technique was marginally effective mostly, I believe, due to the client's poor functional state. She was hospitalized two time in the past year and was on psychotropics." Another therapist, in relating an ineffective spiritual intervention, said, "This man was so narcissistic and pathological he could relapse in his behavior so quickly that no permanent change could occur." Another therapist said, "I believe the issues of serious addiction, neurotic, and psychotic behavior may not yield to normal spiritual approaches ... the client is 'beyond feeling the spirit'."

8. *Use caution in utilizing spiritual interventions if religion seems to be part of the client's problem.* One therapist said, "Spiritual interventions are difficult when the client was abused as a child and blames God for not protecting them. In such cases deity becomes enmeshed in the client's adverse feelings and becomes part of the problem."

Another therapist, who encouraged a 16-year-old female sexual abuse victim to pray, said that the client got angry at her for suggesting prayer. The therapist explained that "the abuser in this client's life had used prayer and God as part of the abuse." Another therapist who was working with a 30-year-old female Mormon client "suggested some goal setting around her spiritual and religious concerns and desires.... She was quite resistant, which we explored. Her husband's style of Franklin-day-planner religion was a turn-off to her as he used his own religiosity to make her feel inferior, and it was a real power struggle between them. Setting religious goals meant giving in and losing to his preference and style." Another therapist said, "Never use religious 'techniques' when [in their] background ... a person has been forced to attend church, to believe this way or that, to conform in some religious way, or who has been wrongly dealt with by Church courts, leaders, etc. They will rebel at you, as they did their authority figure.... It will backfire and not help them."

Ethical Concerns

The therapists raised several ethical concerns regarding the use of spiritual interventions in therapy. Five major ethical concerns or dangers that were mentioned in the qualitative data are listed below along with several illustrative quotes from therapists.

1. ***The danger of engaging in dual-relationships, or of usurping religious authority.*** One therapist said, "I consider assessing spiritual status and in-session priesthood blessings to be unethical ... [It is] a dual-relationship. I see these 'techniques' as a sign of one-upmanship.... I am a psychologist and I see the role of a therapist as separate from that of a religious leader." Another therapist, in working with a 37-year-old, Mormon male client, gave the client a priesthood blessing and said that it "failed miserably. I was desperate. Convinced me once again that a psychologist should be a psychologist and a bishop a bishop." Another therapist, who was working with a couple in marital therapy, reported that he quoted a Biblical scripture to the couple and the "husband revolted and pulled away saying, 'If I wanted to be read scriptures I would go to my bishop'." Another therapist said, "When I limit my role to that of a therapist, helping clients explore and discover, things

generally go well. If I confuse my role with that of an ecclesiastical role not held by myself in relationship to my clients, I fall into the realm of unrighteous dominion.... It makes progress in therapy much more difficult." Another therapist said, "I believe we must be careful not to confuse our role and the priesthood leader's role lest we supplant them inappropriately through our role authority in therapy. I feel the need to sustain the ecclesiastical leader in his ministry to my clients. One way to avoid confusion is not to have prayer and priesthood blessings as a part of therapy." Another therapist said, "The mental health profession has struggled to gain legitimacy in the church because some professionals, in the past, have usurped ecclesiastical authority unrighteously and guided members into inactivity or worse. Is it not still an unrighteous usurpation of ecclesiastic authority when we provide services (spiritual) that others, not we, have been called to provide?"

2. ***The danger of engaging in priestcraft.*** One therapist said, "I have always feared slipping into priestcraft. I give blessings to family and friends—for no money. I suggest clients seek blessings from family members, home teachers, or other priesthood leaders." Another therapist said, "Therapists should seek spiritual guidance from spiritual guides that have that calling. A priesthood blessing should not come from someone who is being paid." Another therapist said, "Invoking the religious or spiritual is to call forth the powers of heaven. I am slow to do this ... because I reflect upon the many scriptural warnings against building false idols, using the name of the Lord God in vain, and presuming to exercise Priesthood in any degree of unrighteousness....When I have attempted to consciously formulate and apply one of these 'techniques,' I have (at best) detracted from the task at hand, and maybe, sometimes, I fear, been on the border of (or beyond) blasphemy and idolatry."

3. ***The danger of trivializing the numinous or the sacred.*** One therapist said, "I find the idea of a 'spiritual or religious technique' hard to understand. I do not find responding to the prompting of the spirit as a 'technique'." Another therapist said, "If reference to spiritual matters is used as a technique or tool, it is ... likely to be ineffective." Another therapist said, "Personally, I am rather uncomfortable with the use of the word 'technique' ... as soon as I focus on the technique I am no

longer seeing their [the client's] face—they cease to be real to me. Someone observing me may 'recognize' a technique, but if my heart is right what I do transcends technique." Another therapist said, "My understanding of the divine and my experience both persuade me to avoid consciously-planned use of explicit religious or spiritual matters in my work in therapy. I even cringe thinking of these as "techniques," just as I am troubled by having such matters as "love" and "faith" spoken of as "techniques.... My primary concern is not our corrupting our therapy. Heaven knows that whatever I do in therapy is a perverse polymorphous polyglot of theory and practice from wherever. My concern is our trivializing the numinous, our losing our awe of the divine, our forgetting the fear of the LORD. My worry is more about corruption of my religion than about enhancement of my therapy."

4. ***The danger of imposing our religious values on clients.*** One therapist said that she is careful "never to push my religious orientation or beliefs." Another therapist said, "I consider how unusual it would be to be able to do clinical work using my values directly and openly. There have been times when I saw an opening in the session to actually mention something about my spiritual self, but declined so as not to confuse personal values with professional tasks." Another therapist said, "I have strong feelings about using religious techniques in therapy and about therapists who use them to "make sure" their patients make the right choices. I don't believe we can walk with our patients in their unique pain if we, in essence, do the work of their bishops instead of our work."

5. ***The danger of using spiritual interventions inappropriately in certain work settings.*** One therapists said, "In a public school setting I am extremely careful not to use religious techniques (or mention religion)." Another therapist said, "I personally believe that the use of spiritual and religious techniques in therapy depends on the nature of the work place. I work for the state ... and am not at liberty to use spiritual or religious techniques I would like...." Another therapist said, "I often feel extremely hampered through working for the schools. My hands are so tied by the separation of church and state that I am overly cautious in my use of any spiritual intervention."

Spiritual Interventions Belong in Therapeutic Practice

Despite the ethical concerns raised and the belief expressed by some therapists that spiritual interventions have no place in professional therapeutic practice, a majority of AMCAP members expressed a belief that spiritual interventions, if used appropriately, can significantly enhance the efficacy of psychotherapy. One therapist said, "I believe the spiritual is a significant aspect of the psychological, and to most effectively treat our clients, needs to be included." Another therapist said, "All good therapy is based on gospel [spiritual] principles." Another said, "Whether we work with members, nonmembers, active, inactive, or whatever the client's spiritual status, we know the value of prayer, humility, and the Lord's input. We should never approach a client for whom we have not enlisted the inspiration and help of the Lord." Another said, "If we as therapists are prepared both spiritually and professionally we can help our clients at the stage of growth they are at. We can use either psychological or scriptural language. I believe that there is more power in the scriptural language." Another said, "I feel much more effective and complete when I am able to appropriately use spiritual and religious techniques in my therapy efforts. I also feel the use of these techniques helps clients gain an expanded view of their problem in the eternal scheme of things and gives them renewed hope to keep working on their problems." Another said, "All good therapy is a spiritual endeavor." Another said, "Spiritual values and techniques are a must in counseling." Another said, "I believe that spiritual and religious interventions are an invaluable tool." Another said, "[Spiritual interventions] are very critical ... for maximum recovery for most clients (LDS and non-LDS) in my experience." Another said, "Many [non-LDS] therapists are also recognizing the importance of addressing the spiritual part of our being with their clients.... It is becoming a more common practice and more accepted as many see it as essential in the process of healing."

Discussion

The findings of our survey revealed that many AMCAP members do use a wide variety of spiritual interventions in their professional therapeutic work. This finding is consistent with other recent studies

which have shown that therapists of other Christian denominations also use a variety of spiritual interventions (Ball & Goodyear, 1990; Worthington, Dupont, Berry, & Duncan, 1988). Interestingly, many of the spiritual interventions utilized most often by the AMCAP members (i.e., therapist silent prayer, encouraging clients to forgive others, using the religious community, teaching spiritual concepts, encouraging clients to pray, and reference to scripture) were similar to those used most frequently by other Christian therapists (Ball and Goodyear, 1990; Worthington et al., 1988).

Our findings also revealed that there is considerable variation in how often AMCAP members use specific spiritual interventions. The LDS therapists we surveyed more often use less religiously explicit spiritual interventions such as praying silently for their clients and teaching spiritual concepts compared to more explicit interventions such as giving their clients priesthood blessings and praying vocally with their clients. On the average, AMCAP members also more often encouraged out-of-session spiritual "homework" activities rather than using spiritual interventions explicitly during therapy sessions. Why do AMCAP members tend to more frequently use less religiously explicit interventions? Perhaps they believe there is less risk of confusing professional and religious role boundaries when less explicit interventions are used. Perhaps they believe they are less likely to offend clients, or perhaps they simply believe less explicit interventions are more effective. Further research is needed to investigate this question.

Our findings also revealed that different types of AMCAP members (e.g., those differing in professional specialty, work setting, gender, age, degree status, and type of clientele) differed in the frequency with which they used certain types of spiritual interventions. The finding that the therapists who work in school and hospital settings tended to use spiritual interventions less often than did therapists in other settings is of interest. The strong emphasis in school settings on the separation of church and state may have a constraining influence on therapists' use of spiritual interventions in schools. Several therapists who work in school settings specifically mentioned this concern in their qualitative responses. In hospital settings, therapists tend to work more often with people who are in crisis or who have severe

pathology. Bergin (1993) and several therapists in the present study have expressed the belief that spiritual interventions may be less effective with clients who have severe pathology or who are in crisis. If this is true, it could account for why LDS therapists in hospital settings were less likely to utilize spiritual interventions.

Our finding that male therapists were more likely to use more explicit, directive spiritual interventions (i.e., pray with clients, make reference to scripture, give clients blessings, and ask clients to memorize scriptures) than were the female therapists can perhaps best be understood in light of LDS religious beliefs regarding the priesthood and gender role differences. Because LDS men hold the priesthood and more often serve in church leadership positions, it may be that they feel more permission to use explicit, directive spiritual interventions. They are, after all, more likely to have used such interventions in their priesthood and leadership roles in the church. Because of these gender differences in religious roles, there may be more of a danger for LDS male therapists to overstep professional role boundaries and confuse their professional and religious roles.

The finding that AMCAP members who have a heavier caseload of LDS clients use spiritual interventions more frequently than therapists who see fewer LDS clients was not surprising. Therapists and clients who share a common religious world view will probably find it easier and safer to work on religious and spiritual issues in therapy because misunderstandings and doctrinal disagreements are less likely. A case example from our critical incident data illustrates this point. One AMCAP member reported that while working with a Jewish client, he made a reference to Jesus Christ while discussing a spiritual concept. The client was offended by the therapist's religious insensitivity and a rift was created in the therapeutic relationship. Mistakes such as this are less likely when both the therapist and client are LDS. We believe extra caution is warranted in using spiritual interventions when working with clients who are not LDS.

Our finding that AMCAP members in Utah were not more likely to use spiritual interventions than were AMCAP members from other geographic regions surprised us. We had thought that AMCAP members in Utah might be more likely to use spiritual interventions

because of the predominantly LDS population in Utah. However, our data revealed that therapists in Utah were no more likely (and perhaps slightly less likely) to use spiritual interventions than were LDS therapists from other geographic regions. We cannot be certain why this was the case, however, a therapist's comment from our qualitative data may shed some light on this finding. The therapist said, "I don't really ever bring in religion [to therapy] unless the client desires to talk about it. I practice in Salt Lake City where so many people feel religion (Mormonism) is pushed on them." Thus, though therapists in Utah may work with predominantly LDS clients, many of these clients may be less religiously active or disaffiliated from the Church. Therapists should not make assumptions about the religious beliefs and values of clients, even when the client is LDS. Out of respect for individual differences, therapists should seek to understand each client's unique religious perceptions and beliefs.

The finding that AMCAP members who spend more of their time doing pastoral counseling used in-session spiritual interventions more frequently than did AMCAP members who do not do pastoral counseling was not surprising. It seems logical that therapists whose professional role is more closely intertwined with a religious role (e.g., chaplains and LDS Social Service therapists) would likely feel greater freedom to use more religiously explicit in-session spiritual interventions. This finding is consistent with previous research which has found that spiritual directors or pastoral counselors are more likely than professional psychotherapists to discuss spiritual concerns and issues with clients and to use spiritual interventions (Ganje-Fling & McCarthy, 1991).

The qualitative finding that a variety of spiritual interventions, according to AMCAP members, have resulted in positive, sometimes powerful therapeutic outcomes for clients with a variety of presenting concerns was of much interest. Bergin (1988, 1991) has expressed the belief that spiritual influences and interventions can give people added power to heal and change. While our study has not empirically proven that spiritual interventions can cause therapeutic change, the case examples provided by the therapists attesting to this possibility gives added incentive for further empirical study of such interventions.

The qualitative finding that many of the same spiritual interventions therapists reported were effective with some clients were also ineffective on other occasions was of interest, but should not be surprising. It is well known that the effectiveness of an intervention does not depend on the technique alone (Bergin & Garfield, 1994), but also depends on a host of other influences such as client variables (e.g., severity of pathology), counselor variables (e.g., trustworthiness), and process variables (e.g., timing of the intervention). The clinical guidelines offered in this study by AMCAP members provided some valuable insight into client, counselor, and process variables which could influence the effectiveness of spiritual interventions and may prove valuable to therapists and are deserving of empirical study.

The qualitative finding that spiritual interventions can sometimes, according to AMCAP members, result in negative outcomes for clients is of serious concern. While negative outcomes are a possibility when using any therapeutic approach (Lambert & Bergin, 1994), this finding nevertheless emphasizes the need for more outcome research on spiritual interventions. When new therapeutic orientations and interventions are being developed and implemented, therapists have an added responsibility to monitor and evaluate the efficacy of their work. This has not always been done in the field of psychotherapy (Garfield & Bergin, 1986), but in order to protect the welfare of clients and to establish the professional legitimacy of spiritual interventions, we believe it is crucial for AMCAP members who use spiritual strategies to document the efficacy of their work.

The qualitative finding that some AMCAP members believe there are real ethical dangers in using spiritual interventions is also of concern and deserves careful consideration. The possible ethical dangers associated with the use of spiritual interventions raises the question of whether we need more specific standards of training and practice within AMCAP to guide us in our use of spiritual interventions.

Tan (1993) believes that training and supervision in religious and spiritual issues is necessary for therapists, and he has pointed out that the current American Psychological Association (APA, 1992) ethical guidelines acknowledge the need for such training. We agree with him. Just because most AMCAP members are LDS and can be called

to serve in ecclesiastical positions within the Church without receiving any special theological training or degree does not necessary mean we are also qualified to integrate religious and spiritual interventions into our professional work.

The professional standards of most helping professions specify that we should only use techniques which we are qualified by training and experience to use, and that we maintain knowledge of current scientific and professional information related to the services we render (Corey, Corey, & Callanan, 1988). There is now a rather large body of scientific and professional literature available regarding religious and spiritual issues in personality development, mental health, and psychotherapy. We believe this literature has advanced to the point where it would be inappropriate and perhaps even unethical for psychotherapists to use spiritual interventions in therapy without being conversant with it. We believe that an important task for the future is for AMCAP members to work together to define and implement training opportunities to help ensure that AMCAP members who wish to use spiritual interventions know how to do so in the most effective and ethical manner possible.

We also believe that more explicit ethical guidelines or standards of practice are needed within AMCAP to guide our use of spiritual interventions. In our study, there seemed to be widespread agreement among AMCAP members that dual relationships (professional and religious), usurping or trivializing religious authority and tradition, and imposing religious values on clients all need to be avoided. However, there seemed to be a considerable lack of agreement about how to implement these beliefs during the therapeutic hour. What type of information should be shared as part of informed consent procedures, what spiritual interventions should be avoided, and who should initiate consideration of spiritual concerns and interventions during the therapy hour were all issues about which AMCAP members seemed to have divergent opinions.

We believe that AMCAP members who may utilize spiritual interventions in their professional work need to inform clients of this possibility during informed consent procedures. Spiritual interventions which may be used should be mentioned and AMCAP members

should inform clients' that such interventions will not be used without their consent. AMCAP members should also remind clients that they have no religious or ecclesiastical authority over the client and that they cannot speak for or act on behalf of the Church or its leaders. AMCAP members may also wish to briefly describe some of their fundamental spiritual beliefs which are relevant to their therapeutic work. Because of the ethical imperative psychotherapists have to avoid dual relationships (APA, 1992; Corey et al., 1988), we believe AMCAP members should avoid providing psychotherapy to members who belong to the same ward as they do, or to members for whom they have ecclesiastical responsibility.

We also believe AMCAP members should avoid using spiritual interventions which might blur the boundaries between professional and religious roles. For example, we believe that giving a client a priesthood blessing during a therapy session is clearly problematic because this increases the likelihood that the client will misperceive or be confused about the therapist's role. If the client is paying for the session, it also raises questions about the possibility of priestcraft. We believe further discussion and debate within AMCAP about other controversial interventions such as praying with clients and encouraging clients to confess is clearly needed to determine if any type of consensus can be reached about the appropriateness of such interventions.

Limitations of the Study

A couple of limitations of this study should be kept in mind. First, though we randomly sampled therapists who belong to AMCAP, not all LDS therapists are members of AMCAP. One of AMCAP's purposes is to promote professional practices which are in harmony with moral and spiritual principles and so therapists who belong to AMCAP may be more interested in spiritual interventions than other LDS therapists. Thus, we cannot safely generalize to all LDS therapists. Second, as with all survey studies, the data was obtained by self-report and is only descriptive in nature. The spiritual intervention utilization rates reported by the therapists may not necessarily accurately reflect actual utilization rates. All of the critical incident data regarding the outcomes of various spiritual interventions is based on thera-

pists' perceptions and may not accurately reflect the actual therapeutic outcomes that occurred.

Conclusions

Despite its limitations, our study has provided considerable insight into the beliefs of AMCAP members about spiritual interventions and the prevalence with which AMCAP members utilize various spiritual interventions in their professional work. It has also highlighted the need for more therapy outcome research in this domain. Finally, it has made it clear that there is a need for further discussion and debate within the AMCAP organization concerning ethical guidelines and standards of practice and training for therapists who wish to use spiritual interventions in their professional work. It is our hope that members of AMCAP representing diverse professional and theoretical perspectives will contribute to this important dialogue and research.

References

American Psychological Association (APA) (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47,* 1597-1611.

Allred, G. L. (1987). The therapy of faith. *AMCAP Journal, 13 (1),* 9-36.

Ball, R. A. & Goodyear, R. K. (August, 1990). Self-reported professional practices of Christian psychologists. Paper presented at the annual meeting of the American Psychological Association, Boston, MA.

Bergin, A.E. (1980). Psychotherapy and religious values. *Journal of Consulting and Clinical Psychology, 48,* 95-105.

Bergin, A.E. (1988). Three contributions of a spiritual perspective to psychotherapy and behavior change. *Counseling and Values, 33,* 57-59.

Bergin, A. E. (1991). Values and religious issues in psychotherapy and mental health. *American Psychologist, 46,* 394-403.

Bergin, A. E. (1993). Role of personal, social and spiritual resources versus professional and technical resources in treating mental disorders, as a function of severity of disorder. Unpublished handout, Department of Psychology, Brigham Young University, Provo, Utah.

Bergin, A. E. & Garfield, S. L. (Eds.) (1994). *Handbook of psychotherapy and behavior change* (4th ed.). New York, NY.: John Wiley & Sons.

Bergin, A. E. & Payne, I. R. (1991). Proposed agenda for a spiritual strategy in personality and psychotherapy. *Journal of Psychology and Christianity, 10,* 197-210.

Broderick, C. (1975). New wine in new bottles. *AMCAP Journal, 1* (October), 30-35.

Brown, V. L. Jr. (1975, October). Truth, sin, guilt, punishment, and redemption. *AMCAP Journal, 1,* 30-35.

Burton, D. J. (1984). Helping those with religious questions and doubts. *AMCAP Journal, 10 (1),* 12-14, 24.

Byrd, A. D. (1993). Interview: An LDS reparative therapy approach for male homosexuality. *AMCAP Journal, 19 (1),* 91-104.

Corey, G., Corey, M. S., & Callanan, P. (1988). *Issues and ethics in the helping professions* (3rd ed.). Pacific Grove, CA.: Brooks/Cole.

Ganje-Fling, M. A. & McCarthy, P. R. (1991). A comparative analysis of spiritual direction and psychotherapy. *Journal of Psychology and Theology, 19,* 103-117.

Garfield, S. L. & Bergin, A. E. (Eds.) (1986). *Handbook of psychotherapy and behavior change* (3rd ed.). New York, NY: John Wiley & Sons.

Haase, R. F. & Ellis, M. V. (1987). Multivariate analysis of variance. *Journal of Counseling Psychology, 34,* 404-413.

Hardy, K. R. (1989). An appetitional theory of sexual motivation: Its contemporary status and applications in an approach to change. *AMCAP Journal, 15 (1),* 21-41.

Hurst, J. C. (1981). Handling values conflicts with LDS and non-LDS clients. *AMCAP Journal, 7 (2),* 31-35.

Judd, D. K., Bingham, R. D., & Williams, R. N. (1988). Agentive theory as therapy: An outcome study. *AMCAP Journal, 14 (1),* 37-54.

Kelly, B. C. (1980). Scriptural insights into human behavior and the facilitation of behavior change. *AMCAP Journal, 6 (3),* 19-25.

Kelly, B. C. (1981). Meeting personal challenges and solving personal problems through the words of Christ. *AMCAP Journal, 7 (1),* 25-30.

Koltko, M. E. (1990). How religious beliefs affect psychotherapy. *Psychotherapy, 27,* 132-141.

Lambert, M. J. & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.). New York, NY.: John Wiley & Sons.

Leary, M. R. & Altmaier, E. M. (1980). Type I error in counseling research: A plea for multivariate analyses. *Journal of Counseling Psychology, 27,* 611-615.

Lovinger, R.J. (1984). *Working with religious issues in therapy.* New York: Jason Aronson.

Madsen, C. H. & Millet, R. L. (1981). The gospel and psychotherapy: A Mormon counselor's dilemma. *AMCAP Journal, 7 (2),* 11-14, 35-36.

Paul, K. L. (1983). Transference to deity. *AMCAP Journal, 9 (1),* 15, 23-24.

Payne, I. R., Bergin, A. E., & Loftus, P. E. (1992). A review of attempts to integrate spiritual and standard psychotherapy techniques. *Journal of Psychotherapy Integration, 2,* 171-192.

Pritt, T. E. & Pritt, A. F. (1987). Homosexuality: Getting beyond the therapeutic impasse. *AMCAP Journal, 13 (1),* 37-66.

Rencher, A. C. & Scott, D. T. (1990). Assessing the contribution of individual variables following rejection of a multivariate hypothesis. *Communications in Statistics: Simulation and Computation, 19,* 535-553.

Richards, P. S., Owen, L., & Stein, S. (1993). A religiously oriented group counseling intervention for self-defeating perfectionism: A pilot study. *Counseling and Values, 37,* 96-104.

Tan, S. Y. (1993, January). Training in professional psychology Diversity includes religion. Paper presented at the National Council of Schools of Professional Psychology (NCSPP) Midwinter Conference on "Training in Professional Psychology. La Jolla, CA.

Taylor, S. J. & Bogdan, R. (1984). *Introduction to qualitative research methods* (2nd ed.). New York, NY: John Wiley & Sons.

Worthington, E. L. Jr., Dupont, P. D., Berry, J. T., & Duncan, L. A. (1988). Christian therapists' and clients' perceptions of religious psychotherapy in private and agency settings. *Journal of Psychology and Theology, 16,* 282-293.