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# The influence of therapist-patient religious/spiritual congruence on satisfaction with therapy: A review of research

Tammy E. Henderson

Rowan University, hender76@students.rowan.edu

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**THE INFLUENCE OF THERAPIST–PATIENT RELIGIOUS/SPIRITUAL  
CONGRUENCE ON SATISFACTION WITH THERAPY: A REVIEW OF  
RESEARCH**

by

Tammy E. Henderson

A Thesis

Submitted to the  
Department of Psychology  
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In partial fulfillment of the requirement  
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Thesis Chair: Matthew Miller, Psy.D.

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## **Abstract**

Tammy Henderson

THE INFLUENCE OF THERAPIST–PATIENT RELIGIOUS/SPIRITUAL  
CONGRUENCE ON SATISFACTION WITH THERAPY:

A REVIEW OF RESEARCH

2017–2018

Matthew Miller, Psy.D.

Master of Arts in Clinical Mental Health Counseling

The goal of this review was to examine the relationship between mental health and religion and/or spirituality. Specifically, it was believed that religion and spiritual congruence had a positive influence on satisfaction with therapy. Indeed, the literature reviewed suggests that therapists should be more open to addressing a patient’s religious and/or spiritual beliefs as it could lead to more attuned therapeutic sessions. The importance of congruence between patient and therapist is a factor that can impact the therapeutic alliance, based on the literature, this concept appears to hold true for those that are or are not religiously and/or spiritually inclined.

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## **Chapter 1**

### **Introduction**

Although the link between mental health and religion/spirituality may not seem vital to some practitioners, due to the strong beliefs people hold and their conviction that there is a higher power, it is crucial that patients have access to therapists that will be sensitive and informed to their religious/spiritual values. Furthermore, studies have found that religious attendance and religious/spiritual values aid in the healing process much like other healthy coping measures. In light of this information, an important research question emerges: Do religious clients experience a better therapeutic outcome and therapeutic experience when the counselor and the patient are religiously similar? In other words, does religious congruence between the patient and therapist predict a better therapeutic experience for religious patients?

Despite researching the question for many years, little data has been proffered on the direct link between therapeutic experience/satisfaction and therapist religious/spiritual congruence. Instead, the literature required the examination of this relationship by making the connection between related factors that influence these concepts. Specifically, literature was reviewed to examine how religion/spirituality has been identified as a factor influencing the culture and multiculturalism of people. The literature suggested that religious congruence between patient and therapist made the therapist more culturally sensitive to the patients' values/beliefs, and thus less inclined to view the patient as experiencing psychopathology. In the past, general findings suggested that clinical judgments by therapists were more negative when therapist values and client values were incongruent. Indeed, since the recent trend has been to encourage multi-

cultural awareness, it would seem that the past findings would no longer prove true and in fact, a therapist sensitive to a patient's religious/spiritual views would have a better relationship with the patient. This more harmonious relationship causes a better and more sincere working alliance between the patient and therapist and hence a better therapeutic outcome (Fuertes, Gelso, Owen, & Cheng, 2013).

### **Religion/Spirituality for the Purpose of This Review**

Religion and spirituality are not subjects that can be or are easily defined. These terms can mean many different things for many people. However, at its core, Webster's Dictionary defines religion as, "the belief in a god or in a group of gods: an organized system of beliefs, ceremonies, and rules used to worship a god or a group of gods: an interest, a belief, or an activity that is very important to a person or group" (Merriam-Webster, 2016). Spirituality, which is very similar, is defined by Webster's Dictionary as, "the quality or state of being concerned with religion or religious matters: the quality or state of being spiritual" (Merriam-Webster, 2016). Despite the previous definitions, many people view the two as being similar, if not synonymous. In fact, some studies use the terms interchangeably. However, a closer examination of religion and spirituality demonstrates that studies have found that there are real distinctions. Specifically, people tend to view religion as relating to God or the belief in God, while viewing spirituality more broadly, as in experience or belief in a higher authority (Coward, 2014). Thus, spirituality seems to be viewed by some as more personal/individualistic, whereas religion is viewed as more systemic, organized, or institutionalized (Coward, 2014).

For purposes of this review, religion and spirituality will be viewed similarly, meaning, the goal is to review how religion and/or spirituality impacts therapeutic



counseling. Accordingly, whether a person is spiritual or religious, both or neither is what is important, neither concept matters more than the other.

### **Importance of Religion and Spirituality in Our Culture**

Religion and/or spirituality and its relation to mental health has become an increasingly important topic for the health and wellness communities. The relationship between mental health and religion and/or spirituality however is one that is affected by many factors ranging from societal views to personal experiences.

In particular, there has been increasing evidence to support the notion that religion and/or spirituality is significant in the lives of many people throughout society (Shumway & Waldo, 2012). Indeed, over 95% of Americans profess a belief in God, 65% are members of a church, 60% say that religion is very important in their lives, and 62% believe that religion can answer all or most of today's problems (Shumway & Waldo, 2012). However it should be noted that, according to the Pew Research Center's Religious Landscape Study, Christian believers have been on the decline since 2007, with the population of adults identifying with no particular religion or religious organization growing by more than 6% from 2007 to 2014. Specifically, the research found that young American adults demonstrated the greatest decline of those self-identifying as Christians, although the trend was visible for American's of all ages. Furthermore, the trend was evident among Whites, Blacks, and Latinos. Still, despite the current trend, the U.S. has the largest population of Christians throughout the world, with "seven-in-ten" Americans continuing to identify as Christian (Pew Research Center, Religious Landscape Study, 2008). Furthermore, "90% of the world's population is involved today in some form of religious or spiritual practice" (Koenig, 2009, p. 283). In fact, people professing not to be

religious “make up less than 0.1% of the populations in many Middle-Eastern and African countries” (Koenig, 2009, p. 283).

Religion and/or spirituality has been a resource used by humans in order to cope with life in general, from stress to explanations of why things in the world happen the way they do. Michael Koenig, a Professor of Psychiatry and Behavioral Sciences at Duke University Medical Center, argues that religion and/or spirituality “is a powerful coping behavior that enables people to make sense of suffering, provides control over the overwhelming forces of nature (both internal and external), and promotes social rules that facilitate communal living, cooperation, and mutual support” (Koenig, 2009, p. 283).

Because of the significant role that religion and/or spirituality plays in the lives of many people throughout society, it would appear that the impact the subject has on mental health is a necessary discourse for caregivers, mental health providers, doctors, and any other field committed to helping others. However, historically, this discourse has been fraught with tension.

### **History of Religion and Mental Health**

Prior to the early 1600s, the connection between science and religion, though separate subjects, allowed for a certain level of interaction and discourse between the two fields (Nelson, 2009). Despite their association, many people believed that they each had their own independent roles and remained separate. However, notwithstanding their independent roles, well into the early 17th century, theologians and scientists freely exchanged information to aid in each discipline (Nelson, 2009). In point of fact, early mental hospitals were part of monasteries and facilitated by priests (Koenig, 2009). However, after the early 17th century the interaction between theology and science began

to change. Rivalry between the two was no longer superficial and limited to competition amongst professionals but began to take on a deeper division. As scientific study became more technical and methodological, the gap between science and religion and/or spirituality grew (Russell, 1935).

The 19<sup>th</sup> century brought about a significant change in the thinking of mental health professionals and the gap between mental health and religion and/or spirituality increased significantly. A number of scholars attribute this change as stemming from the theories of Jean Charcot and his famous pupil, Sigmund Freud. Charcot was a famous neurologist. Charcot and Freud promoted the notion that religion and/or spirituality was associated with neurosis and hysteria (Koenig & Larson, 2001; Koenig, 2009). This type of thinking caused a huge division that would lead to the separation of religion from mental well-being for at least the next century (Koenig, 2009). Well into the 20<sup>th</sup> century many prominent psychologists thought the less religious a person was the healthier they would be emotionally (Koenig & Larson, 2001). In fact, still today, psychotherapy, in the general sense, displays a relative indifference to God and peoples' spiritual relationships (McGowan & Midlarsky, 2012). Furthermore, the "religiosity gap," which represents the discrepancy between mental health practitioners' religiousness and the patient's (in general), demonstrates that the level of religiousness in the American population as whole is greater than the level of religiousness among mental health professionals (McGowan & Midlarsky, 2012). Indeed, when surveyed, one study found that although approximately 75 percent of Americans stated religion was key to how they approached life, only 32 percent of psychiatrists, 33 percent of clinical psychologists and 46 percent of clinical social workers expressed the same sentiment (Paul, 2005).

Despite the scientific communities' slow overall acceptance of religion and/or spirituality's impact on health and well-being, today, attitudes toward religion in psychiatry have begun to slowly change (Koenig, 2009). Increasingly, studies have started to look more closely at the connection between mental health and religion and/or spirituality. During this time many psychologists, although still focused on education, science, and technological advancement as the key to human success, are beginning to think that maybe there is more to accomplishing human betterment (Mowrer, 1958). This acknowledgement has caused many practitioners in the area of mental health to look to additional guidance from the field of religion. Indeed, at a symposium in 1956, one psychologist stated,

Today, hardly anyone still seems to believe in the classical Freudian position that neurosis arises solely or even predominately from repressed hostility and sex. Instead, we now see how commonly depression, anxiety, and even panic stem from a neglected or outraged conscience. And this shift in perception has had the almost inevitable effect of bringing psychology and religion closer together and focusing them on common problems. (Mowrer, 1958, p. 577)

In fact, one particular area, amongst many, involving mental health that seems to be influenced by religion and/or spirituality is therapeutic outcome.

There is a connection between the mental health and the religion of an individual. Due to the connection, the relationship between client and therapist could greatly benefit if the therapist is attune to the religious values/beliefs of the patient. In other words, the therapeutic alliance plays an important role in the outcome of therapy. A successful alliance between the therapist and patient has positive influence on the successfulness of the therapy.

## **Chapter 2**

### **Religion and Mental Health**

#### **Religion and Mental Health Today in Connection With Therapy**

An examination of psychological principles concerning the interaction of religion and mental health can be explored through the use of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM is a manual produced by the American Psychiatric Association that has become the most trusted resource used by mental health professionals in the diagnosis of mental illness in the United States.

The first time religion was addressed in the DSM was with the publication of the DSM-III. According to the DSM-III, religion should be more tolerated by practitioners. However, this was in the context of psychopathology. Specifically, the heading for religion was titled: Dissociative Disorder Not Otherwise Specified. However, although the inclusion of religion was an important step towards mental health practitioners' acceptance that mental health was impacted by religion and thus needed to be addressed, the way it was addressed still cast religion into a less than positive light. In fact, Stephen G. Post examined the way religion was addressed in the DSM-III and concluded that it needed to be "more balanced and respectful" (Post, 1992, p. 81). He determined that the way the DSM discussed religion cast it in a stereotypical and biased light, increasing the view that religion caused various forms of mental distress. The next version of the DSM addressed some of Post's concerns.

In the DSM-IV issues affecting a patient's well-being that were religious in nature were relegated to a new diagnostic category (V62.89) termed "religious or spiritual problem." This new category was suggestive of the greater need for an understanding of

the relationship between religion/spirituality and mental illness. Since then, we have seen a sustained increase in the connection between the two. The publication of the DSM-IV had many researchers suggesting that a more balanced and respectful interpretation of religion be included in the DSM, since there are increased benefits for mental health healing when religion is involved.

The DSM-5 is the latest version of the DSM, and its section on religion is very limited. The manual continues to offer V Code, 62.89, Religious or Spiritual Problem; however it is now under Z-code, 62.89. Furthermore, the DSM-5 also includes an expanded understanding of culture and diversity and the impact of both when making a diagnosis. To be sure, this researcher finds it significant that a few researchers have gone so far as to pose “that counselors who neglect to raise religious or spiritual issues may influence clients to assume that such matters are not relevant for counseling and may be excluding an important issue of diversity” (Shumway & Waldo, 2012, p. 85). Indeed, today, part of the DSM-5 discussion of culture includes spirituality. Hence, the inclusion of the V and Z codes into the DSM has taken mental health practitioners from the position of viewing religion and/or spirituality as a pathology, and instead, as an aspect of one’s culture that can influence one’s psychological state. Finally, by offering religion and/or spirituality as a cultural aspect in some ways it has made it easier for practitioners to understand the impact of religion and why it can be a factor in building a better relationship between the client and therapist, hence impacting the therapeutic alliance.

A healthy therapeutic alliance, which can be viewed as the “collaborative and affective bond between the therapist and the patient” (Weck, Grikscheit, Jakob, Hofling, & Stangier, 2015, p. 91) makes it essential that therapists understand their clients beliefs

and values in order to make a proper diagnosis (Bergin, 1991). Educational training programs, ethics codes, and general discussion forums related to mental health all address the need for cultural awareness in therapy due to the increasing number of multicultural patients and issues. Importantly, religion has been identified as one important cultural aspect that therapists should be aware of for treatment purposes (Ellor, 2013). In 2013 James Ellor wrote an article discussing the history of religion and spirituality and its evolving relationship with clinical diagnoses. He used the evolution of the DSM, to show that more and more scholars and, importantly, mental health practitioners have begun to embrace a wider discussion of religion and/or spirituality as a facet of culture (Ellor, 2013). In fact, one researcher goes so far as to state the following, “the concept that religion and spirituality are as much a part of a person’s orientation of life as their ethnicity, gender, and culture is becoming a standard within the therapeutic community” (Eck, 2002, p. 266). Accordingly, understanding this area (multiculturalism/culture) is essential if clinicians are to form a solid working alliance and help patients recover from mental distress (Arredondo & Torporek, 2004; James & Foster, 2006).

The integration of religion and/or spiritual interventions or even discussions into the therapeutic process has implications for multicultural competence, which many graduate schools are requiring students to have training in; there are implications relating to referrals, and even collaboration with other professionals, including priests or pastors. As stated previously, religion and/or spirituality have increasingly come to be viewed as an aspect of one’s culture, at a minimum religion and/or spirituality are part of an individual’s socio-cultural context. Being familiar with the socio-cultural context of an individual can help the therapeutic alliance in many ways, a few of which are the

following: it can help determine what a client will or will not report to the therapist; it can aid in determining what the therapist will or will not say to the client; and it can also help aid in how therapists interpret the information they are receiving from the client (Nakash, Nagar, & Kanat-Maymon, 2015). Specifically, understanding one's cultural background, which includes religion, gives the therapist and others an idea of what a patient views as normal, thus aiding in the determination of pathology, and ultimately helping to build a stronger therapeutic alliance as the therapist is in a better position to understand the client and the issues that they may present (Nakash et al., 2015).

### **Religion and Mental Health Today**

Since the 1950s, up to and including today, numerous studies have focused on the relationship between mental health and religion. According to research by Worthington and Sandage (2001), since 1980, "the volume and quality of literature on religion and spirituality in psychotherapy increased, and the trend continues to be visible today" (p. 473). One early study examined the emerging trend of religion as an avenue for increased mental healing. In the study, therapists encouraged the relationship, while clergy/theologians qualified the connection between the trend based upon differing religious views (Mann, 1959). The study demonstrated that the introduction of religion to the therapeutic process did not hinder transference, the process of redirecting one's feeling and desires onto another person, but in fact made the process of transference appear to be safer to the patient. Typically, those feelings or desires are unconsciously retained from childhood. Transference can be beneficial in helping a therapist understand their patient's current feelings.



A similar relationship between religion and better mental health was found to still hold true in a more recent study by Ai, Bjorck, Huang, and Appel (2013). With increasing rates of depression expected amongst people in the United States, the study looked at religious involvement and how it may mitigate symptoms of depression amongst Asian Americans here in the United States. The study demonstrated that religious attendance decreased the likelihood of depression. Furthermore, other studies have examined the relationship between stress and religion. In one particular study done by Bryan-Davis & Wong (2013) it was asserted that positive religious coping decreased the stress individuals dealing with trauma experienced, which was in fact later confirmed to be the case.

Another study by Stanford (2007) evaluated the attitudes and beliefs that Christian people with a mental illness faced when seeking help for their illness from a church. The study looked at the reactions the participants were faced with. The author's findings indicated that the majority of those seeking help received a positive and helpful response, while approximately 30% of those seeking help encountered negative reactions. However, the study failed to examine the connection between the results and particular religious ideologies and the role that gender played in the equation.

In addition to the possible benefits of balancing a therapeutic relationship between mental health and religion and/or spirituality, some studies have noted a number of problems. The main problem being the possible transference of the therapist's own religious beliefs or values onto the patient. In addition, another issue is when a therapist makes a mental health judgment on a patient due to lack of religious belief or extreme religious commitment. In fact, past studies suggest that patient ideology, therapist

ideology, and the interaction between the two may influence clinical judgment, making it increasingly important that therapists remain aware of ideological countertransference.

Bottom line, the therapeutic alliance plays an important role in the outcome of therapy. A successful alliance between the therapist and patient has positive influence on the successfulness of the therapy. Religious belief/spirituality appears to have an impact on the strength of the therapeutic alliance and increasing the overall mental health of the patient through the use of therapy.

## Chapter 3

### Therapeutic Alliance

So what is the working alliance, also referred to as the therapeutic alliance? The therapeutic alliance or working alliance, as it will be identified throughout this study, thus the two terms should be considered interchangeable, can be defined as “the extent to which a client and therapist work collaboratively and purposefully and connect emotionally” (Hanson, Curry, & Bandalos, 2002, pp. 659-660). Importantly, research has demonstrated that therapeutic alliance is one of the most influential factors affecting the outcome of patient therapy. The more positive the therapeutic alliance is, the more positive and effective the therapeutic sessions will be in terms of producing a successful therapeutic outcome. Schmidt, Chomycz, Houlding, Kruse, & Franks (2014) stated that the therapeutic alliance “has been postulated to play a critical role in facilitating better outcomes in therapy” (p. 1337). Additionally, the concept of the working alliance is believed by most practitioners to be universal in relation to its impact on therapeutic outcome, it cuts “across theoretical orientations as an important variable in determining treatment outcomes for patients” (Swift & Greenberg, 2015, p. 137).

A review of various studies examining the therapeutic alliance and its relationship with therapeutic outcome demonstrated the existence of a moderate relationship between the therapeutic alliance and outcome of therapy (Ardito & Rabellino, 2011). Furthermore, the research indicated that the quality of the alliance was far more important than any other variable tested. The review discussed studies that focused on exploring tools designed to measure correlations between psychotherapeutic outcome and therapeutic alliance. The authors note the difficulty in measuring a concept as complex as the

therapeutic alliance. In fact, they address a number of limitations they and others believe have hindered research in relation to this subject. Some of the limitations listed included the following: the failure of single case research to capture the complexities of various methodological factors; the lack of ability to get an adequate number of repeated measurements and the ability to conclusively generalize the results; the fact that although meta-analysis is capable of allowing researches to examine the results of multiple studies on the topic of therapeutic alliance, it is less valid if the subject being investigated is not as specific, which is the case with therapeutic alliance. According to the authors, this is especially true since the therapeutic alliance is influenced by many factors that may be viewed differently by the various people involved in the studies. In other words, the client, the clinical observer, and even the therapist could have widely different perceptions of the various characteristics of the therapeutic alliance, thus raising issues with objectivity.

Despite the various hindrances to the study of therapeutic alliance, the authors conclusively state that numerous instruments have been developed to examine the therapeutic alliance. Using these various instruments researchers found that even though one might conclude that a more positive therapeutic outcome would result from a linear pattern of growth during the therapy session of patients, more positive therapeutic outcome resulted when there were ruptures in the alliance that were addressed and fixed during the therapy sessions. Additionally, the authors note that a number of researchers have concluded that the most important phases of the therapy process for the formation of a positive alliance were at the initial meeting stage and the later phases of therapy. Specifically, the author's note that one research study found that "the extent of the

relationship between alliance and outcome was not a direct function of time,” but instead it was found that “measurements obtained during the earliest and most advanced counseling sessions were stronger predictors of outcome than those obtained during the middle phase of therapy” (pp. 7-8). The authors conclude their review by stating the need for future research to pay attention to how patients and therapist each assess the therapeutic alliance as they have been known to differ, with evidence suggesting that the patient’s assessment of the therapeutic alliance is a stronger predictor of the outcome of psychotherapy. Accordingly, it is my opinion that one such way the patient and therapist can get their assessment closer in line with each other is by the formation of an initial bond between the two during the intake and early therapeutic sessions.

Swift & Greenberg uphold, “when the therapeutic alliance is strong, the perceived benefits of working collaboratively with an understanding and empathic therapist can help outweigh almost any other costs associated with attending therapy” (2015, p. 138). Because therapeutic alliance is significant to therapeutic outcome, it is extremely important for mental health professionals to know what factors go into creating a successful therapeutic alliance.

In 1979 Edward Bordin developed a working theory in regards to the therapeutic alliance. Bordin suggested that the therapeutic alliance consisted of three components, which he believed to be critical for successful psychotherapeutic treatment. The three components were goals, tasks, and bond, which he stated made up the working alliance (Bordin, 1979). According to Bordin, during the initial stage of therapy, the therapist and patient discuss and develop a list of goals for therapy, they then agree on what tasks should take place during the therapy that will help the client meet those goals and finally,

through the process of fulfilling the agreed upon goals, a bond will form between the two. The bond refers to the degree of trust, mutual respect, and a general sense of affinity between the two, which then aids in the completion of tasks to attain goals and hence improve the patient' well-being (Taber, Leibert, & Agaskar, 2011).

A number of factors can go into forming the bond part of the therapeutic alliance. For instance, if the therapist is willing to embrace the cultural aspects of the patient. Whether the patient perceives the therapist as being caring. All of these things can influence the bond aspect of the therapeutic alliance.

With this in mind, the present literature review examines one factor that may influence therapeutic alliance, which is therapist-patient congruence.

### **Congruence and the Therapeutic Alliance**

As, previously stated, “a crucial outcome for predicting positive therapeutic outcome lies in the quality of the working alliance” (Taber et al., 2011, p. 376). In fact, the therapeutic alliance is so critical to therapeutic outcome that it takes the forefront to both the theoretical orientation of the therapist and the particular issue that the patient may be experiencing. That being said, one factor that has been shown to affect the working alliance is client-therapist congruence. Indeed in a study by Taber, et al, it was demonstrated that there was a definite relationship between client therapist congruence and the bond between the patient and therapist. Importantly, congruence accounted for 24% of the variance within the bond relationship.

Importantly, the study demonstrated that the bond aspect of the therapeutic alliance has the greatest impact on working alliance (Taber et al., 2011).

In the study by Taber, et al., the researchers conducted research at a medium sized Midwestern university. The study was conducted at the university's counseling center, which consisted of master's and doctoral-level students. The study measured personality similarity between therapists and patients and how the concepts of bond, goals, and tasks related to their personalities and the working alliance and therapeutic outcome. The study used the Self-Directed Search Form R to examine personality type, which measures resemblance to the RIASEC. The RIASEC is a measure of a theory of careers and vocational choices based off of various personality types that have been defined and given certain combinations. The next test used by the researchers was the Working Alliance Inventory-Short Revised. This test measures the strength of the working alliance based off of Bordin's three dimensional model of bond, goals, and tasks. The higher the score on each scale, the stronger the working alliance. Finally, the researchers used the Outcome Questionnaire-45.2. The test requires patients to self-report their symptoms, syndromes, and stressors. The total score ranges from 0 to 180, with the higher scores indicating higher levels of symptom severity. The results of the study found that a moderate relationship exists between client-therapist congruence and bond. Accordingly, congruence accounted for about a fourth of the variance between client and therapist bond. While, congruence did not significantly correlate with task and goal agreement or therapeutic outcome. However, both task and goals did correlate moderately with therapeutic outcome. Accordingly, just as other studies on the topic have found, congruence is related to the working alliance, most significantly influencing the bond element of the working alliance. This is an important finding despite the lack of a significant relationship finding between congruence and the tasks and goal agreement

aspects of the working alliance and therapeutic outcome because it suggests that bond is significant during the early stages of therapy and the formation of a positive working alliance, thus making further research necessary on the factors that influence bond and thus increase a greater working alliance, which studies have consistently shown does influence therapeutic outcome.

### **Religious Congruence and the Therapeutic Alliance**

If bond is an important element of the working alliance, then it would follow that because the bond can be influenced by the patient's perception of the therapist, a therapist willing to explore various aspects of the patient's personality would increase the bond between the two. It would also follow that the more similar a patient and therapist are in the religious and/or spiritual beliefs or lack thereof, the more easily a bond may form, hence the working alliance will be influenced. Indeed, it is not uncommon for client's to prefer a therapist with a similar spiritual/religious perspective (Hathaway, 2008).

As addressed previously, numerous studies have demonstrated that the United States Public in general is comprised of people that are generally religious and/or spiritual (Barnett, 2016). Despite this finding, there are a number of indications that psychologists, at large do not reflect this phenomenon, with research suggesting that they are oddly nonreligious when viewed in light of the general population (Hathaway, 2008). Despite this difference in therapists and patients, if therapists are to fully address the well-being of patients, they must address a patient's personality in its entirety (Barnett, 2016). Part of this includes looking to the patient's religious and/or spiritual beliefs because religious and/or spiritual issues may be an area of concern for the patient. Religious and/or spiritual problems may be a part of the difficulty that the patient is



presenting with (Barnett, 2016). These religious and/or spiritual problems may be contributing to stress, anxiety, or a number of other areas that are causing the patient concern. Another very important reason that religion and/or spirituality should be addressed in therapy is because religion and/or spirituality may be an important coping measure for client. It may give the client strength to complete tasks set up during therapy. Religion and/or spirituality may also open up other areas of treatment to the therapist allowing them to use various religious and/or spiritual interventions. If religion and/or spirituality is important to the patient, it may further help the therapeutic alliance if the therapist is also of a similar religious/spiritual belief. Similarly if the patient is not of a particular religious and/or spiritual belief, it may be helpful for that patient to be with a therapist with a similar lack of belief. Importantly the idea of religious congruence suggests an increased ability to bond with a patient; the increased bond would influence the working alliance.

One study, completed in 2011, found that anticipated working alliance between therapist and patient was impacted based on the level of religiosity of the patient and whether the patient was given an informed consent document that addressed religion (Shumway & Waldo, 2012). This study gives credence to evidence in support of the argument that incorporating or being aware of religion, for purposes of the therapeutic process, not imposed, but proffered or made accessible can in fact aid in a better therapeutic experience (Worthington & Sandage, 2001).

Although the link between mental health and religion may not seem vital to some practitioners, due to the strong beliefs people hold and their conviction that there is a higher power, it seems crucial that patients have access to therapists that will be sensitive

and informed to their religious values. Shumway & Waldo (2012) stated that “research on theistic clients’ attitudes toward attention given to religious/spiritual concerns in counseling suggests a stronger bond with counselors who are willing to address such concerns” (p. 86). Furthermore, studies have found that religious attendance and religious values aid in the healing process much like other healthy coping measures (Green & Elliot, 2010). The importance of religious congruence between therapist and patient is important in ultimately advancing the ability of mental health providers to offer their patients the best possible treatment because therapists that are more culturally sensitive to the patients’ values/beliefs appear to be less inclined to view the patient as experiencing psychopathology. Historically, general findings suggested that clinical judgments by therapists were more negative when therapist values and client values were incongruent. In fact, “prior [research] work” suggests “that some mental health professionals tend to view religious belief and behaviors as symptomatic of mental illness” (McGowan & Midlarsky, 2012, p. 660). However, since the recent trend has been to encourage multicultural awareness, it would seem that such past findings should no longer prove true. Indeed, one researcher has observed that this is indeed the case, stating that while in the past the mental health profession in general was disinclined to embrace addressing religion/spirituality during therapy, more recently there has been increased acceptance of religion/spirituality in the treatment process (Barnett, 2016).

Furthermore, as has been suggested previously, a therapist willing to assess whether religion and/or spirituality should be addressed in therapy in order to promote the overall welfare of the client can aid in strengthening the bond between the therapist and patient. In fact, research indicates that clients appreciate therapy that includes their

belief systems, with more than 78% of clients stating that spiritual and/or religious issues should be addressed in therapy (Eck, 2002).

## **Chapter 4**

### **Discussion**

#### **Implications for Practice**

Based on the present literature, empirical evidence makes it clear that the inclusion of therapeutic practices that are informed by the patient's culture can strengthen the relationship between the therapist and patient. Religion/spirituality has been tied to one's culture, thus the informed therapist should, at the very least, be willing to explore or address the patient's religious/spiritual beliefs. Importantly, possibly the best time for this assessment would be during intake (Eck, 2002). During intake, the client could assess whether religion and/or spirituality is a concept that the client might find helpful to discuss. If a client does appear to be a candidate, for religious and or spiritual interventions, the therapist should ensure that those therapeutic interventions are consistent with the client's goals. It also holds true that therapists need to be aware of the influence that general congruence has on the relationship between the therapist and patient. Congruence, in general, encourages a healthy working alliance, thus by being aware of the patient's disposition towards religion/spirituality or lack thereof, given the changing religious demographics here in the United States, will aid the therapist. Importantly, a therapist should be aware of any possible conflicts that are a result of the client's spiritual and/or religious beliefs and the therapist's own beliefs or lack thereof (Eck, 2002). If the therapist is not capable of these things, the therapist may wish to refer the client to a therapist that is generally a better fit congruently for the patient. Therapists implementing these suggestions will have an increased chance of forming a stronger working reliance and thus increasing the chances of a positive therapeutic outcome.

## **Areas for Future Study**

As with most reviews, there is more to be researched on the topic. For instance, future studies should seek to ascertain whether different religious denominations are more likely than others to benefit from therapists addressing religion/spirituality. Also, future research should address whether patients professing a certain religion would have a better therapeutic outcome if the therapist was also of that particular religion. Indeed, there is an implication that this may be true for certain religious people. Also, future research should examine whether the integration of religious/spiritual interventions into the practice of psychotherapy is something that should be incorporated into general practice for all mental health practitioners or whether such a task requires the formation of specialized practice requiring a state certificate of completion, thus becoming a specialization in the field. This seems very important given that only 10-30 % of therapist, in particular psychologists, report ever having completed any training in religious/spiritual issues (Hathaway, 2008). Also, future research should examine which religious/spiritual interventions work best and for which type of patients. Finally, future research should look at how age affects the relationship between patient and therapist religious congruence. This is certainly important given the changing demographics in the United States, with increasing numbers of younger people professing to have no particular religion or religious affiliation.

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