Experiences of Christian clients in secular psychotherapy: a qualitative investigation

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EXPERIENCES OF CHRISTIAN CLIENTS IN SECULAR PSYCHOTHERAPY:
A QUALITATIVE INVESTIGATION

by

Carrie Cragun

A Dissertation
Submitted to the University at Albany, State University of New York
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the Requirements for the Degree of
Doctor of Philosophy

School of Education
Department of Educational and Counseling Psychology

2010
Dedicated to

my mother who calls me her “smart cookie” and

my father who came to my rescue during a bad Ithaca winter.
Acknowledgments

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Abstract

According to several authors, many Christians are skeptical of psychology and fear that their religious beliefs will be misunderstood, unappreciated, ridiculed, or eroded in secular therapy (King, 1978). The purpose of the present discovery-oriented study was to understand Christian clients’ phenomenological experiences in secular therapy.

Eleven Christians were interviewed in depth about the nature of their experiences with secular therapists. The narrative data were analyzed using the Consensual Qualitative Research method (Hill, Thompson, & Williams, 1997). The thematic results indicated that positive therapy experiences were facilitated by therapists’ incorporation of clients’ faith into therapy, openness to understanding clients’ faith, and giving clients control over how much, when, and how to discuss their religious beliefs. Clients who were dissatisfied reported that their therapists expressed opposing religious views and avoided incorporation of their faith into therapy. Most participants who had negative experiences indicated that the therapists’ mishandling of religious issues was only one of many reasons for their dissatisfaction. Regardless of the nature of their experiences, many participants reported feeling hesitant to discuss their faith due to uncertainty about their therapists’ reaction.

The qualitative results were triangulated with participants’ self-reports of their therapists’ social influence characteristics on the Counseling Rating Form - Short (Corrigan & Schmidt, 1983) and perceptions of the therapeutic alliance, as measured by the Working Alliance Inventory - Short Form (Tracey & Kokotovic, 1989). Results were largely consistent with the narrative data. All but one therapist was seen as fairly expert, attractive, and trustworthy; the alliance scores were more sensitive to
participants' evaluations of their therapy experience. That is, several participants rated their therapists favorably but had fairly low scores on the goals or tasks subscales of the WAI-S.

Implications for practice are provided, including the need for developing and assessing training programs to help therapists work effectively with the Christian population. Recommendations for future research are offered.
Chapter I

Statement of the Problem and Review of Literature

Historically, the field of psychology has held contrasting views towards religion. Prominent theorists such as Sigmund Freud (1961) and Albert Ellis (1980) voiced their opposition to religion in psychology. In some of his writing, Freud (1961) characterized spiritual experiences as pathological, and Ellis (1980) described religious belief as irrational thinking and as an emotional disorder related to poor mental health and well-being. In contrast, other early psychologists Gordon Allport (Allport, 1957), William James (James, 1902), and Carl Jung (Jung, 1936) recognized religion and spirituality as significant aspects of individuals’ experiences and viewed religious topics as relevant to psychological study.

The general purpose of the present study was to investigate the experiences of Christians in secular psychotherapy to gain information on what contributes to positive and negative experiences in psychotherapy. Generally, religion refers to an organizing system of faith, worship, rituals, and tradition (Worthington, 1988), whereas spirituality refers to practices involving an individual’s relationship with a higher being or the universe (Goldfarb, Galanter, McDowell, Lifshutz, & Dermatis, 1996; Grimm, 1994; Lukoff, Turner, & Lu, 1992). For some individuals, spirituality and religion are intimately connected whereas for others, spirituality and religion are distinct. Miller and Thoresen (2003) asserted that these constructs have both shared and idiosyncratic characteristics. Defining the two terms is difficult in that full agreement about terminology has not been reached (Fukuyama & Sevig, 1999; Pargament, 1999; Richards & Bergin, 1997, 2005). There has been some interest among psychologists to
define and operationalize these terms for research purposes, but some theorists speculate that for believers, this distinction is not relevant (Hill & Pargament, 2003; Miller & Thoresen, 2003). In this study, a decision was made not to distinguish religion and spirituality so as not to limit the explanations of participants’ experiences by narrow definitions.

Interest in religion or spirituality and psychotherapy has burgeoned in the past 30 years (e.g., Aten & Leach, 2009; Bergin & Jensen, 1990; Richards & Bergin, 2000; Hage, 2006; Kane & Jacobs, 2010; Shafranske & Malony, 1990; Smith & Orlinsky, 2004; Wothington & Sandage, 2001), as psychologists increasingly recognized that spiritual and religious beliefs are related to positive mental health (e.g., George, Larson, Koenig, & McCullough, 2000; Plante & Sharma, 2001). Researchers have found, for example, that espousing a religious belief is positively associated with reduced onset and greater likelihood of recovery or adjustment to physical and mental illness (George et al., 2000) and negatively associated with depression, anxiety, and substance abuse (Plante & Sharma, 2001). Additionally, frequent religious observance (e.g., attendance at church) has been related to greater subjective well-being and life and marital satisfaction, as well as fewer depressive symptoms, reduced risk of suicide, reduced delinquency, and decreased substance abuse (McCullough, Larson, & Worthington, 1998).

Religion and spirituality are particularly important for people who use religious methods to cope with difficulties in their lives (Koenig & Pritchett, 1998; Pargament, 1997). In two national polls, 90% of U.S. respondents reported believing in a personal God (Gallup Organization, 2005), and 90% professed some religious affiliation (Gallup Organization, 2001). These percentages suggest that therapists are likely to work
with religiously committed clients who use religious methods to cope with difficulties and who see their religious beliefs as an important part of their identity.

Psychologists have also begun to recognize religion and spirituality as important facets of culture and cultural identity (Constantine, Lewis, Connor, Sanchez, 2000; Fukuyama & Sevig, 1999; Sue & Sue, 2002; Worthington, Kuru, McCollough, & Sandage, 1996). Indeed, some theorists argued that religion “is a more potent social glue than the color of one’s skin, cultural heritage, or gender” (Shafranske & Malony, 1990, p. 564). Recognition of religion and spirituality as aspects of culture and identity is supported by the American Psychological Association’s Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (American Psychological Association; APA, 2003). These guidelines cite religion/spirituality as one of the several critical dimensions of cultural identity, and psychologists are encouraged to familiarize themselves with issues related to spiritual or religious identity in order to effectively assist their clients and competently train graduate students to become psychologists. Similarly, the Ethical Principles of Psychologists and Code of Conduct (APA, 2002) requires psychologists to obtain the training, experience, consultation, or supervision necessary to ensure competence when working with religious and spiritual diversity (Standard 2.01 b).

Clinicians’ Views about Religion and Spirituality

Surveys indicate that many psychologists are interested in religious and spiritual concerns, view religious and spiritual issues as relevant to psychotherapy, and work with clients who present with issues related to religion and spirituality (Shafranske & Malony, 1990). Shafranske and Malony (1990) surveyed 409 clinical psychologists on
their use of religious interventions and found that 91% took a religious history of their clients, 57% used religious content and language, 36% encouraged participation in religious organizations, 32% suggested religious/spiritual reading materials to clients, 24% prayed privately for their clients, and 7% prayed with their clients in session. It is important to note, however, that this survey had a 41% response rate, and psychologists who self-selected to participate may have been among the most religious of the population. Nevertheless, therapists’ attitudes towards discussing and addressing religious and spiritual issues also seem to be favorable. A survey of national internship training directors (Johnson & Hayes, 2003) found that 72% of respondents addressed spiritual concerns with their clients, and a study of 249 randomly selected college counselors (Weinstein, Parker, & Archer, 2002) found that over 70% were open to discussing religious and spiritual issues during therapy sessions.

Despite the growing interest in culturally sensitive therapy approaches that incorporate religious and spiritual issues, many therapists indicate feeling unprepared to work competently with religious material (McMinn, 1996; Shafranske, 1996; Shafranske & Malony, 1990) and having received minimal training, supervision, and coursework in this area (Brawer, Handal, Fabricatore, & Wadja-Johnston, 2002; Schulte, Skinner, & Claiborn, 2002). In a survey of APA members, Shafranske and Malony (1990) found that 83% of clinical psychologists reported having little or no training in addressing religious or spiritual issues in therapy and only 33% reported feeling competent to address these issues with their clients. Similarly, Kelly (1994) reported that fewer than 25% of counselor education programs covered religion or spirituality in any capacity. Other authors (Abernathy & Lancia, 1998; Weinstein et al., 2002) suggested that a lack
of training may cause therapists to avoid discussing clients’ spiritual or religious values, experiences, or concerns in treatment. In addition to a lack of training, some therapists may feel ambivalent about addressing religious or spiritual issues with clients, either to avoid imposing their own values or because they have personal struggles with religious or spiritual beliefs (Mack, 1994).

There are mixed results in the literature about secular therapists’ views on working with religious clients. Studies have shown that psychologists tend to view religious clients more pessimistically than non-religious clients (Gartner, Harmatz, Hohmann, Larson, & Gartner, 1990; Gerson, Allen, Gold, & Kose, 2000). However, more recently, Horn (2008) found that therapists (in an analogue study) showed no bias toward fundamental Christian clients, and other researchers (Houts & Graham, 1986; Lewis & Lewis, 1985; Wadsworth & Checketts, 1980) reported mixed results in analogue studies of therapists’ perceptions and empathy for fundamental Christian clients.

**Clients’ Preferences for Addressing Religious and Spiritual Issues in Psychotherapy**

Richards and Bergin (1997, 2005) suggested that clients “may not wish, or may not believe it is appropriate, to discuss [religious] issues in therapy” due to their awareness of the “religiosity gap” between psychologists and the general public (p. 124). According to these authors, the “religiosity gap” refers to therapists being generally less involved in organized religion than their clients. The “religiosity gap” belief is supported by surveys indicating that mental health professionals generally tend not to be involved in religious practice (e.g., Bergin, 1991; Bergin & Jenson, 1990; Shafranske, 1996) and prefer spiritual approaches that are not associated with organized religion (Shafranske, 1996). Indeed, one study found that 50% of psychologists indicated having no
religious preference, compared to 7% of the U.S. public (Shafranske, 1996).

Nevertheless, studies suggest that religious clients tend to prefer therapy that in some way includes their belief system, and they generally want their religious values and practices to be addressed in therapy (Quackenbos, Pribette, & Klentz, 1985). Rose, Westefeld, and Ansley (2001), for example, surveyed 74 participants (Christian and non-Christian) about the appropriateness of discussing religious and spiritual issues in therapy. Participants were recruited from university counseling centers, a psychology training clinic, a women’s center, and community mental health centers. The largely female sample included 40% of participants who reported no religious affiliation, yet 89% reported a belief in God or a higher power. The results showed that the majority of the participants believed religious concerns were appropriate for discussion in counseling and over 25% indicated that religion and spirituality were important to them and essential for their healing and growth.

More recently, Knox, Catlin, Casper, and Schlosser (2005) conducted a qualitative study with 12 participants to examine the role of religion and spirituality in clients’ lives and their experiences discussing religious and spiritual topics in secular therapy. Participants who were engaged, either presently or in the past, in individual therapy were predominantly Caucasian women; six were religiously or spiritually active but identified with no particular religious or spiritual group, three were Roman Catholic, and three had experiences with Buddhism, Hinduism, Judaism, paganism, and Unitarian Universalism. Participants were asked to identify three incidents: a time when religious and spiritual issues were addressed in therapy and it was helpful, a time in which religious and spiritual issues were addressed and it was not helpful, and a time in
which participants thought about but did not raise religious or spiritual issues for
discussion.

The data were analyzed using the Consensual Qualitative Research method (CQR;
Hill et al., 2005; Hill, Thompson, & Williams, 1997), and results indicated that helpful
discussions tended to be initiated by clients in the first year of therapy, were related to
clients’ presenting concerns, facilitated by therapists’ openness, and yielded positive
effects. Participants indicated that unhelpful discussions were equally likely to be raised
by them or by their therapists early in therapy; these unhelpful discussions made
participants feel that their therapists were judging them or imposing their own beliefs. For
example, one therapist reportedly told a participant that she was “too Catholic,” and
another therapist reportedly told another participant that she could not expect spiritual
help until she embraced the religion of her birth (Knox et al., 2005, p. 296). When
participants considered bringing up religious or spiritual issues but chose not to, they
attributed this decision to feeling uncomfortable. One participant felt discomfort because
of “differences between herself and the therapist,” and another participant believed that
her therapist would judge her religious and spiritual beliefs as “kooky” (Knox et al.,
2005, p. 296).

Taken together, these studies suggest that some clients want to address religious
and spiritual issues in psychotherapy and believe that these discussions are important for
treatment success (Knox et al., 2005; Rose et al. 2001). The next section focuses on
research examining Christians’ expectations and preference for Christian or secular
therapy and research examining whether strength of religious belief moderates
expectations for secular therapy.
Christians’ Expectations of Psychotherapy

Some research suggests that many Christians are skeptical of psychology (Almy, 2000) and fear that their religious beliefs will be misunderstood, unappreciated, ridiculed, or eroded in secular therapy (King, 1978). Worthington and Scott (1983) pointed out one concern of many Christians, that secular therapists “will not accept or work within the religious client’s values, or will try to change the client’s values to be less religious and more secular” (p. 318). Worthington and Scott further suggested that some Christians fear that therapists will ignore their religious and spiritual concerns and treat their beliefs and experiences as pathological.

Negative anticipations about therapy can prevent people from seeking therapy, resulting in treatment underutilization by Christians, especially highly religious Christians (Quackenbos, Privette, & Klentz, 1985; Worthington, 1986). Additionally, religious clients with negative expectations about therapists tend to be resistant to therapy and have high rates of premature termination (Lovinger, 1979, 1984; Worthington, 1986).

In calling for research with religious clients, Worthington (1991) pointed out that highly religious clients’ attitudes and expectations about therapy differ from those of moderately or low religious clients. Worthington (1988) developed a model for understanding the values of highly religious clients, those who score in the top 10% to 15% on measures of religious commitment. According to this model, highly religious people tend to view the world differently than less committed religious people or nonreligious people with regard to the importance ascribed to scripture or sacred writings, religious leaders, and belonging to a primary religious group.

A review of research on religion and therapy (primarily analogue studies)
by Worthington et al. (1996) found that high religious commitment predicted (a) preference for value-similar therapists, (b) pre-therapy expectations about therapy, (c) reactions to challenges of behavior, beliefs, and values, (d) estimation of client continuation in therapy after a challenge, and (e) perceptions of therapists. These results have been found with Protestant Christians (e.g., Keating & Fretz, 1990).

Studies using Christian samples have investigated expectations about psychotherapy and preferences for therapists’ religiosity. For example, in one of the only non-analogue studies with Christians, King (1978) asked Evangelical Christians about their experiences in secular therapy and found that many were satisfied with the therapy they received and did not see it as a threat to their faith. In fact, 31% of participants stated that therapy actually helped strengthen or restore their Christian faith. However, of those who expressed dissatisfaction with therapy, 89% expressed concern that their faith was misunderstood, unappreciated, or ridiculed. It was also found that the more Christians agreed with conservative beliefs of the church, the less frequently they sought counseling (see also Worthington & Scott, 1983).

A subsequent study (Keating and Fretz, 1990) sampled Christian college students and Christian adults to examine expectations about therapists based on their (therapists’) religious orientation. Participants classified as either high religious or low religious, were asked to read vignettes about three types of therapists: secular, Christian, or religiously empathic. (The religiously empathic therapists were characterized as those who ask clients about their religious or spiritual orientation). Results indicated that both the high and low religious participants had negative anticipations about the secular therapist.

Further, the description of the religiously empathic counselor evoked less
negative anticipation for the low religious participants but not for the highly religious participants, indicating that strength of religious belief may indicate more negative anticipation about a non-Christian therapist. However, because the design did not control for age, it is unclear whether the results would generalize to non college students.

In a similar study, Guinee and Tracey (1997) sampled Christian college students to determine their willingness to seek help from secular, Christian, or religiously empathic therapists. Perceptions of the therapists’ social influence was assessed using participants’ ratings of therapists’ expertness, attractiveness, and trustworthiness on the Expectations About Counseling-Brief Form (EAC-B; Tinsley, 1982). Similar to Keating and Fretz’s results (1990), participants were classified as either high religious or low religious. Results indicated that, compared to the low religious group, participants in the high religious group rated the Christian therapist more favorably than either the secular or the religiously empathic therapist. However, in contrast to Keating and Fretz (1990) the high religious group did not differ from the low religious group on ratings of the secular or religiously empathic therapist. In other words, participants in the high religious group did not perceive the non-Christian therapists less favorably, and they were not less willing to seek help from these therapists. The authors concluded that their study yielded different results from previous studies about anticipation about non-Christian counseling because their sample was of college students, who may have more positive exposure to the field of psychology and to psychotherapy.

Belaire at al. (2005) found similar results in an examination of Christians’ expectations for counseling. In an analogue study, participants were randomly assigned to read 1 of 2 therapist descriptions: a Christian therapist or a therapist whose
religious beliefs were unknown. Participants rated their expectations for the therapist’s attitude towards their religious beliefs and the use of religious behaviors in therapy (e.g., use of scripture, prayer). Results indicated that participants expected both the Christian therapist and the therapist whose beliefs were unknown to display pro-religious attitudes and to integrate some religious behaviors into therapy.

In sum, results of studies examining participants’ expectations of counseling with non-Christian therapists are mixed. Some investigators found that Christian individuals prefer Christian therapists (Keating & Fretz 1990; King, 1978) but other studies did not replicate these results, raising the question of whether most Christians prefer Christian therapists (Belaire et al., 2005; Guinee & Tracey, 1997). Further, results have been mixed with regards to whether strength of religious belief influences clients’ negative anticipations about counseling. For example, Keating and Fretz (1990) found that participants with relatively stronger religious beliefs had more negative expectations about psychotherapy. On the other hand, Guinee and Tracey (1997) did not find a difference between low and high religious clients on willingness to see a secular therapist.

Further, most studies were analogue experiments with non-clients. Therefore, it is not known whether most Christian clients tend to have negative experiences in therapy or feel misunderstood or judged because of their religious beliefs.

**Relevance of Social Influence Theory to Psychotherapy with Religious Clients**

Social influence theory (Strong, 1968; Strong & Matross, 1973) was the theoretical foundation for the present qualitative investigation of Christians’ experiences in therapy. According to social influence theory, client change is a result of a
persuasion process that occurs between client and therapist in two stages.

First, therapists establish themselves as a useful resource, that is, as expert, attractive, and trustworthy. Therapists gain influence due to clients’ perceptions that these resources will help them solve their problems (Strong & Matross, 1973). These perceptions in turn generate dependence and responsiveness on the part of the client, which facilitate the second stage of therapy.

In the second stage, therapists promote change through communicating messages to clients that are discrepant from the clients’ previous views (Strong, 1968; Strong & Matross, 1973). This process creates cognitive dissonance, which is eventually decreased through attitude change. Theoretically, if therapists’ interpretations or understanding of clients’ situations are not discrepant from clients’ perceptions of their situation, change will not occur (Claiborn, 1982; Strong, 1968; Strong & Claiborn, 1982). In this second stage, therapists use questions, reflections, test interpretations, self-disclosures, feedback, confrontations, and interpretations to introduce ideas that are discrepant from clients’ ideas.

Much of the research on social influence theory has focused on factors that may affect clients’ perceptions of therapist expertness, attractiveness, and trustworthiness (Heppner & Claiborn, 1989). For expertness, verbal and nonverbal therapist behaviors have been examined. Studies found that frequent, consistent, and responsive nonverbal behaviors such as touching, smiling, head nodding, and leaning forward were related to perceived therapist expertness (Barak, Patkin, & Dell, 1982; Hackman & Claiborn, 1982). With regard to verbal behaviors, narrative analogies and empathic responses (Suit & Paradise, 1985) and positive (rather than negative) self-involving statements
(Anderson & Anderson, 1985) resulted in higher ratings of therapist expertness. Representative studies suggest that evidence of training (Angle & Goodyear, 1984), positive reputational cues (Littrell, Cafrey, & Hopper, 198), status (McCarthy, 1982), and therapist self-disclosure (Anderson & Anderson, 1985) tend to facilitate positive perceptions of attractiveness. With regard to trustworthiness, nonverbal and verbal behaviors have been examined. Credible introductions and reputational cues (Littrell, et al., 1987), responsive nonverbal behaviors (Hackman & Claiborn, 1982), verbal and nonverbal cues associated with confidentiality (LaFromboise & Dixon, 1981), and positive self-involving statements (Anderson & Anderson, 1985) seem to facilitate perceived trustworthiness.

Additionally, there is a wealth of (primarily analogue) research indicating that client-perceived therapist attractiveness, expertness, and trustworthiness are important predictors of positive therapeutic process and outcome (Corrigan, Dell, Lewis, Schmidt, 1980; Heppner & Claiborn, 1989). Clients’ perceptions of their therapists’ expertness, attractiveness, and trustworthiness are associated with client satisfaction with therapy (Heppner & Heesacker, 1983; McNeill, May, & Lee, 1987) and client self-concept (Dorn & Day, 1985). Dorn and Day (1985) found trustworthiness to be the best predictor of change. The generalizability of these studies is questionable, however, as results were based on brief vignettes examining participants’ initial impressions rather than the impressions of actual clients in therapy.

**Significance of the Study**

Given the scant empirical research on therapy with Christian clients, the present study explored factors that contribute to Christian clients’ experiences in secular
therapy. Little is known about factors that facilitate Christian clients’ perceptions of therapist attractiveness, trustworthiness, and expertness or other factors that contribute to therapeutic change. It was reasoned that Christian clients who experience positive outcomes in psychotherapy and are satisfied with treatment are likely to (a) perceive their therapists as attractive, trustworthy, and expert and (b) report having a strong working alliance (Bordin, 1979) with their therapists.

In this study, secular therapists were defined as therapists who do not specialize in work with Christian clients and who do not consider themselves to be “Christian therapists.” Self-identified Christians were interviewed in depth to uncover the factors that contribute to positive and negative therapy experiences. A qualitative approach, which provided depth and richness of understanding, was used because qualitative methods are appropriate for areas in which little research has been done (Hill, et al., 1997). Measures of the therapeutic alliance and perceived therapist characteristics (expertness, attractiveness, and trustworthiness) were administered to participants for triangulation purposes.

The present study was expected to contribute to the sparse but growing body of research on integrating religion and spirituality and psychotherapy. Until now, almost all of the research with Christians has been analogue, with potential clients rather than actual clients. Thus, the study expanded on previous research by providing a richer perspective of Christian clients’ perceptions of their secular therapists and their therapy experience. Further, the study contributed to the application of social influence theory to psychotherapy beyond clients’ initial impressions, as has tended to be the case in analogue studies.
Because of the paucity of research examining the experiences of Christians in therapy, obtaining a better understanding of these clients’ perspectives was expected to help therapists who treat individuals for whom Christian religious and spiritual beliefs are integral to their worldview. The results of this study were also expected to provide nuanced understanding of what actually occurs in therapy with Christian clients who identify their experiences as particularly positive or negative. This information is particularly important because previous research suggests that highly religious Christians tend to fear being misunderstood by therapists (Keating & Fretz, 1990; King, 1978) and have high dropout rates (Lovinger, 1979, 1984; Worthington, 1986). Gaining an understanding of what contributes to Christian clients’ strong therapeutic relationships and positive experiences could contribute to better treatment outcomes.

The results of this study were also expected to have provide information for therapist training. Religion and spirituality fall under the rubric of multicultural competence (Constantine, Lewis, Connor, Sanchez, 2000; Fukuyama & Sevig, 1999; Sue & Sue, 2002; Worthington, Kurusu, McCollough, & Sandage, 1996), but many therapists report receiving little training in working with religious and spiritual clients (Brawer, Handal, Fabricatore, & Wadja-Johnston, 2002; Schulte, Skinner, & Claiborn, 2002). Literature on the factors that contribute to positive therapy experiences for Christians is particularly relevant for training, since many therapists report feeling ill-prepared to address religious and spiritual issues with their clients (McMinn, 1996; Shafranske, 1996; Shafranske & Malony, 1990).
Chapter II

Method

Participants

A purposive sample of 11 Christians (nine women, two men) participated in this study. Volunteers were invited to participate if they met all of the following criteria: (a) self-identified as Christian, (b) were 18 years of age or older, and (c) had seen a secular counselor for at least three sessions within the past year but were no longer in treatment.

The study was originally designed to compare two samples: Christians with highly positive secular therapy experiences and Christians with highly negative experiences. In the recruitment procedure, volunteers were sought who had either a highly positive or highly negative experience in therapy. For purposes of this study, a highly positive experience was defined as one that the participant experienced as especially helpful, that had a positive impact on his or her life, or that led to improvement in his or her problems. A highly negative experience was defined as one that the participant experienced as unhelpful or harmful and that did not lead to improvement in her or his presenting issues. However, few individuals who had had solely negative experiences responded to the recruitment advertisements. Thus, it was decided not to compare two samples. Rather, regardless of whether volunteers identified having had either a positive or a negative experience, they were included in the sample if they met the other inclusion criteria.

All 11 participants self-identified as Caucasian and ranged from age 20 to 62 years \( M = 32.18, SD = 11.94 \), and their education levels varied from some college to having a graduate degree. In this regionally diverse sample, participants resided
in California, Maryland, Minnesota, Mississippi, and Virginia. Four participants were doctoral students in a Christian-based clinical psychology program.

Participants were a diverse group of Christian clients, who self-identified as Assemblies of God (n = 1), Baptist (n = 3), Christian (n = 3), Lutheran (n = 1), Methodist (n = 1), Protestant (n = 1), and non-denominational (n = 1) (see Table 1). Based on their scores on the non-denominational measure, the Religious Commitment Inventory – 10 (Worthington et al., 2003; described below), three participants met or exceeded the cutoff score for highly religious; based on a one $SD$ difference from this cutoff score, of the 8 remaining participants, 7 could be considered as moderately religious. With regard to church attendance in the past year, nine participants reported attending church weekly and two reported attending occasionally.

At the beginning of the interview, each participant was asked to identify his or her religious identity or faith and explain its personal meaning. Eight participants described their Christian faith as a “personal relationship with Jesus Christ,” nine identified their faith as a “guide” or the “meaning” of their life, and seven stated that their faith was the “main or high priority” in their life.

The therapy experiences described by participants took place in independent practice, hospitals, university counseling centers, and community mental health clinics. Therapists were one pre-doctoral intern, one social worker, two master’s level clinicians, two psychologists, two psychiatrists, and three unknown. Four participants indicated having had a generally negative therapy experience, and seven indicated having had a positive therapy experience.
Table 1

*Participant Demographics*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Marital status</th>
<th>Education</th>
<th>Current denomination</th>
<th>Times in therapy over lifetime</th>
<th>Time spent in this therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Male</td>
<td>34</td>
<td>single</td>
<td>graduate degree</td>
<td>Christian</td>
<td>3</td>
<td>1 year</td>
</tr>
<tr>
<td>2 Female</td>
<td>34</td>
<td>single</td>
<td>some graduate school</td>
<td>Non-denominational</td>
<td>2</td>
<td>6 wks</td>
</tr>
<tr>
<td>3 Female</td>
<td>36</td>
<td>never married</td>
<td>college student</td>
<td>Christian</td>
<td>10+</td>
<td>9 wks</td>
</tr>
<tr>
<td>4 Female</td>
<td>27</td>
<td>living together</td>
<td>degree</td>
<td>Protestant</td>
<td>2</td>
<td>1 year</td>
</tr>
<tr>
<td>5 Female</td>
<td>30</td>
<td>divorced</td>
<td>some graduate school</td>
<td>Baptist</td>
<td>2</td>
<td>7 months</td>
</tr>
<tr>
<td>6 Male</td>
<td>20</td>
<td>single</td>
<td>some college</td>
<td>Baptist</td>
<td>1</td>
<td>3 months</td>
</tr>
<tr>
<td>7 Female</td>
<td>20</td>
<td>single</td>
<td>some college</td>
<td>Methodist</td>
<td>1</td>
<td>5 wks</td>
</tr>
<tr>
<td>8 Female</td>
<td>23</td>
<td>single</td>
<td>degree</td>
<td>Christian</td>
<td>1</td>
<td>4 months</td>
</tr>
<tr>
<td>9 Female</td>
<td>41</td>
<td>married</td>
<td>degree</td>
<td>Lutheran</td>
<td>5</td>
<td>1.5 yrs</td>
</tr>
<tr>
<td>10 Female</td>
<td>62</td>
<td>married</td>
<td>associate’s degree</td>
<td>Baptist/attends inter-denominational church</td>
<td>5</td>
<td>4 yrs</td>
</tr>
<tr>
<td>11 Female</td>
<td>27</td>
<td>living together</td>
<td>degree</td>
<td>Assemblies of God</td>
<td>5</td>
<td>4 yrs</td>
</tr>
</tbody>
</table>
Design

Qualitative methods are appropriate for areas in which little research has been conducted (Creswell, 2003), as they allow researchers to examine a phenomenon from the perspective of those involved in it (Taylor & Bogdan, 1984). In addition, qualitative methods are well-suited for examining complex phenomena, such as psychotherapeutic processes.

In this exploratory study, a qualitative method was chosen in order to gain a rich and nuanced understanding of the phenomenological experiences of Christians in secular therapy. The data were analyzed using the Consensual Qualitative Research method (CQR; Hill et al., 1997, 2005), an approach that is frequently used to investigate therapists’ and clients’ perspectives in general, and has previously been used to study religious and spiritual clients’ experiences in particular (Knox et al., 2005). CQR was developed to investigate complex phenomena in counseling psychology and involves the use of open-ended questions in semi-structured interviews, which allows for the analyses of data across participants as well as an in-depth examination of individual experiences.

Two quantitative measures were used to triangulate the qualitative results. That is, all participants completed the Counselor Rating Form - Short (CRF-S; Corrigan & Schmidt, 1983) the Working Alliance Inventory - Short Form (WAI-S; Tracey & Kokotovic, 1989). Also, as mentioned above, the RCI-10 (Worthington et al., 2003) was administered for descriptive purposes, i.e., to identify the level of participants’ religious commitment.

Inclusion of these measures allowed for comparison of the qualitative themes with individuals’ responses, thus providing a rich view of the phenomena under
Instruments

_Counselor Rating Form – Short_. The Counselor Rating Form – Short Form (CRF-S; Corrigan & Schmidt, 1983; see Appendix A) is a shortened version of the original Counselor Rating Form (CRF), which was developed by Barak and LaCrosse (1975) to test Strong’s (1968; Strong & Matross, 1973) theory that clients’ perceptions of their therapists’ trustworthiness, expertness, and attractiveness are important predictors of treatment success. The CRF-S consists of three subscales (Trustworthiness, Expertness, Attractiveness), each of which has four unipolar items: friendly, likable, sociable, warm (Attractiveness); experienced, expert, prepared, skillful (Expertness); and honest, reliable, sincere, and trustworthy (Trustworthiness). All items are rated on 7-point Likert scales (1 = not very descriptive, 7 = very descriptive), and scores for each subscale can range from 4 to 28 (total scores range from 12 to 84), with higher scores indicating more favorable perceptions of the therapist.

In shortening the CRF, Corrigan and Schmidt (1983) reported inter-item reliability coefficients for the three subscales ranging from .82 -.94. Split-half reliabilities range from .82 to .94, $Mdn = .91$ (Corrigan & Schmidt, 1983). Coefficient alphas for the subscales, ranging from .76 to .89, were reported by Epperson and Pecnik (1985).

The CRF-S total score represents a positive evaluation factor which reflects the extent to which the therapist is seen in a favorable light (Tracey, Glidden, & Kokotovic, 1988). Confirmatory factor analysis (Tracey et al., 1988) revealed a general satisfaction factor, represented by the total score for all 12 items. Tracey et al. (1988) reported internal consistency estimates of .93, .92, .92, and .95 for the Expertness,
Trustworthiness, Attractiveness, and total scores, respectively. Guinee and Tracey (1997), who summed the subscale scores to obtain an overall score, reported a Cronbach alpha of .89 and a correlation of .83 for two-week test-retest. Additionally, Constantine (2007) reported a Cronbach’s alpha of .96 for the total score.

Although the three CRF-S subscales can be used individually, several researchers (e.g., Guinee & Tracey, 1997; Harari & Waehler, 1999; Kokotovic & Tracey, 1987) recommended that the total score be used as a global measure of perceived therapist competence due to the high interscale correlations. In this study, the total score as well as the three scale scores were calculated and reported for each participant.

**Working Alliance Inventory- Short Form.** The Working Alliance Inventory-Short Form (WAI-S; Tracey & Kokotovic, 1989; see Appendix B) was used to assess participants’ perceptions of the therapeutic alliance. Repeatedly, client-rated therapeutic alliance ratings have been found to be predictive of therapy outcome (Horvath & Symonds, 1991). The WAI-S is a shortened version of Horvath and Greenberg's (1989) 36-item Working Alliance Inventory (WAI), which is based on Bordin's (1979) theory of goal agreement, task agreement, and bond development. Items for the short version (WAI-S) were obtained from a factor analysis of the WAI; Tracey and Kokotovic (1989) selected the four highest loading items from each of the three WAI subscales: Bond, Tasks, and Goals.

Each of the subscales has four items that are rated on 7-point Likert scales (1 = never, 7 = always). Bond refers to the positive attachment formed between client and therapist (e.g., “My therapist and I trust one another”); Tasks refers to the behavioral and cognitive processes that occur during sessions (e.g., “My therapist and I agree
about the things I will need to do in therapy to help improve my situation’’); Goals refers to mutual endorsement by client and therapist on the desired therapeutic outcomes (e.g., “My therapist and I are working towards goals that we both agree on”).

WAI-S total scores can range from 12 to 84, and higher scores are associated with more positive perceptions of the therapeutic working alliance (Tracey & Kokotovic, 1989). In previous studies, the WAI-S has demonstrated high internal consistency reliability, \( \alpha = .98 \), and test-retest reliability coefficient of .83 across a 2-week time period (Tracey & Kokotovic, 1989). Additionally, Fuertes et al. (2006) and Constantine (2007) reported coefficient alphas of .94, .84, respectively. Because the subscales tend to be highly intercorrelated (Tracey & Kokotovic, 1989), the total score was reported as well as the three subscales.

**Religious Commitment Inventory – 10.** The Religious Commitment Inventory – 10 (RCI-10; Worthington et al., 2003; see Appendix C), was used to describe the level of religious commitment of participants. This 10-item scale measures “the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living” (Worthington et al., 2003, p. 85). All items are rated on 5-point Likert scales (1 = *not at all true of me*, 5 = *totally true of me*), with higher scores indicating greater commitment to one’s religion. According to Worthington et al., a full-scale score of 38 or higher indicates a person as being highly religious. Sample items include “My religious beliefs lie behind my whole approach to life” and “I often read books or magazines about my faith.” The RCI-10 has demonstrated high internal consistency reliability, \( \alpha = .92 \), and a test-retest reliability coefficient of .87 across a 3-week time period (Worthington et al., 2003). Additionally, Wade, Worthington, and Vogel (2007) reported a coefficient
alpha of .96. The RCI-10 has shown evidence of construct validity, being strongly correlated with other measures of religious commitment, beliefs, and spirituality (Worthington et al., 2003). The RCI-10 has two subscales, the interpersonal and intrapersonal scales, which are highly intercorrelated. Scores on the full-scale range from 10 to 50. Only the full-scale score was calculated and reported as recommended by Worthington et al. (2003). The standard deviation used to determine moderate religious commitment was 10.3, as reported by Worthington et al.

**Demographic questionnaire.** A demographic questionnaire (see Appendix D) asked participants for their age, gender, race or ethnicity, current religious/spiritual orientation, the religious/spiritual orientation in their family of origin, highest educational level, and marital status. Participants were also asked to indicate the number of times they were in therapy, approximate time spent in each therapy experience, the professional specialty of their therapist (i.e., psychologist, social worker, psychiatrist), and the therapy setting (i.e., independent practice, university counseling center, hospital) that related to the therapy experience they discussed in the interview.

**Interview Protocol.**

The interview protocol (see Appendix E), was a semi-structured set of open-ended questions designed to allow participants to generate responses freely. All participants were asked the same standard set of questions, and the interviewer pursued new or additional areas that arose from participants’ responses. The questions on the interview protocol were based on the literature and previous qualitative studies examining psychotherapy and religion and spirituality.

The interview protocol began with a series of general and contextual
questions about participants’ religious affiliations and the role of religion and spirituality in their lives (e.g., “How do you define religion and spirituality for yourself?”). As explained above, these questions were intended to obtain a description about participants’ Christian faith, regardless of whether they defined it in terms of identification with a specific religious denomination or primarily spiritual.

Questions about participants’ experience discussing religious and spiritual issues in therapy followed. During the second portion of the interview, clients were asked about a specific incident, or turning point, that occurred in the therapy that resulted in their feeling either especially positive or negative about the overall experience. Additionally, participants were asked to discuss their general satisfaction with the therapy and their relationship with their therapist. The interview concluded by asking clients to add any information that they thought was pertinent that was not already discussed.

**Procedure**

Volunteers were recruited at a state university in the midwestern U.S. and from various Christian groups, organizations, and churches, and through a professional listserv, as well as word of mouth. Facebook was also used to advertise the study on web pages of Christian organizations. Flyers (see Appendix F) and internet postings provided basic information about the study (i.e., eligibility criteria, participation requirements, contact information for the investigator, and monetary incentive). The research was described as “a study to gain information about what Christians find most helpful and unhelpful about psychotherapy with a secular therapist.” Volunteers were invited to a specific website to read the consent form (see Appendix G) and complete the demographic questionnaire and measures. The website explained that clicking “next” after the consent form page
indicated consent to participate in the study. Volunteers received $25 as incentive to participate.

After participants completed the demographic form and the three quantitative measures on the website, they were contacted by the investigator to arrange a telephone interview. Participants were interviewed for approximately one hour. The investigator audiotaped the interviews and transcribed them verbatim (except for minimal encouragers, silences, and stutters). To ensure confidentiality, all identifying information mentioned during the interviews was omitted from the transcripts. Transcripts were assigned code numbers for confidentiality and matching purposes.

**Qualitative Analyses**

The transcribed interviews were analyzed using the CQR method (Hill et al., 1997, 2005), which involves consensual decision making about the meaning and categorization of the data by a team of judges and an auditor who reviewed the team’s decisions. Three major steps are involved in CQR methodology: developing domains, constructing core ideas, and developing categories to describe consistencies across cases (Hill et al., 1997, 2005). The consensus process is central to the CQR methodology and helps circumvent the bias of any single judge (Hill et al., 1997, 2005). The domains, core ideas, and categories are derived from analysis of the data through a negotiation process. That is, the judges evaluate the data independently and then come together to discuss their ideas about the domains, core ideas, and categories until a consensus is reached. At each step, the auditor reviews the judge’s decisions and offers feedback as needed.

Domains are general topic areas that are used to group or cluster data. The judges independently read through the first two transcripts and assigned a domain to
each block of data (i.e., anything ranging from a phrase to several sentences related to the same topic). After the judges coded all of the text into domains, they met to discuss the domains that were generated and arrived at consensus.

The next step involved summarizing the content of each domain into core ideas, i.e., summary statements. The goal of this step was to succinctly summarize participants’ responses. Similar to how the domains were developed, the judges identified the core ideas independently and then met to arrive at a consensus regarding the content and wording of the core ideas within each domain in each transcript (Hill et al., 1997, 2005).

After the data from each transcript were sorted into domains and the core ideas were abstracted, the auditor reviewed the text to ensure that it was appropriately sorted into domains and abstracted accurately and completely. The auditor provided feedback to the judges, who considered the feedback and decided whether or not to incorporate it.

After the domains and core ideas were developed, the process of interpreting the data began. During this next stage, the judges independently examined all the transcripts to identify similarities across cases. The team then jointly developed titles for the categories and the placement of the core ideas under each category. The primary auditor consulted with a secondary auditor, a PhD level counseling psychologist with extensive qualitative research experience, and the two auditors jointly refined the categories and core ideas.

After all of the core ideas were categorized, the cross-case analysis was conducted. That is, the frequency of each category across all cases was determined. As recommended by Hill et al. (1997, 2005), a general label was assigned to categories that were represented in all 11 cases or all but one of the cases, a label of typical was
designated to any category that applied to 50% or more of the cases, i.e., 5-9, and a
variant label corresponded to any category that was represented by at least two cases but
fewer than 50%, i.e., 2-4. Categories that applied to only one case were dropped. After
the cross-case analysis was performed across all domains, the auditors reviewed the
results and provided feedback to the team (Hill et al., 1997, 2005).

**Research team.** Three graduate students served as the judges, and the
investigator served as the auditor. The judges (two Caucasians, one Korean American)
were two female Ph.D. students in counseling psychology and one male Ph.D. student in
sociology, aged 26, 28, and 30. One judge had prior experience working within a
Christian church and identified as a Christian, another was raised Catholic and identified
as agnostic, and the third judge was raised in the Catholic church and identified as an
“avowed atheist who maintains multicultural tolerance for people who have religious
beliefs.” All judges had experience conducting qualitative research, and two judges had
specific experience with CQR.

In terms of the expectations for the research study, one judge believed that
participants would uniformly have positive experiences due to a belief that therapists are
trained to match the needs of clients with their techniques and approaches, and therefore
would be able to recognize the needs of their clients in terms of religion and spirituality
and respond to them appropriately. Another judge expected that participants may have
felt uncomfortable and judged discussing religious issues with their therapists and that the
best outcomes would have been achieved when counselors communicated warmth and
positive regard and created a non-judgmental environment. Another judge expected that
clients who worked with therapists who attended to multicultural issues (in this
case, religious and spiritual issues) and actively incorporated culturally sensitive interventions would be satisfied with therapy. Further, because of this judge’s knowledge of common factors, it was expected that therapists who worked to develop a strong therapeutic alliance and conveyed empathy, positive regard, and genuineness would produce more positive therapy experiences.

The investigator, a doctoral candidate in counseling psychology, does not espouse any religious beliefs. However, one of her parents self-identifies as Evangelical Christian, and the investigator had similar religious beliefs throughout her adolescence. In college, however, she moved away from these beliefs and stopped attending church and religious activities. Thus, the investigator considers herself both an “insider” and “outsider” with regard to Christianity. As an insider, she is familiar with the religious beliefs of Evangelical Christians and understands the fears many Christians have about therapists being unable to help them or understand their worldview. As an outsider, she no longer holds these religious beliefs and is aware of how different her views are from the religious group to which she used to belong. Additionally, she is a co-investigator of an unpublished qualitative study in which several participants, all therapists, identified Christians as the most difficult type of religious client with which they worked. The investigator expected that positive therapy outcomes would result when clients felt comfortable enough to discuss their faith and when therapists’ incorporated their clients’ faith into therapy; conversely, negative therapy outcomes would be likely when therapists misunderstood the degree to which the clients’ faith influenced their worldview.

The judges were trained in CQR by reading and discussing Hill et al. (1997, 2005) and two other studies that used the CQR methodology. As recommended for
consensual qualitative research (Hill et al., 1997, 2005), the judges and the auditor discussed their experiences with the topic and potential biases or expectations about the study prior to conducting the analysis. The purpose of recording and discussing expectations was to identify preconceived ideas so as to decrease their potentially biasing influence on the data analysis (Rennie, Phillips, & Quartaro, 1988).
Qualitative Results

On the basis of criteria established by Hill et al. (1997, 2005) themes were described as *general* if they applied to all or all but one of the cases (10-11 cases), *typical* if they applied to more than half and up to the cutoff for general cases (5-9 cases), and *variant* if they applied to at least two cases and up to the cutoff for typical (2-4 cases).

Findings that emerged from single cases were not reported. Table 2 shows the frequency of cases for each of the categories and subcategories within the domains. As seen in Table 2, five themes, or domains, emerged that were used to organize the data: Client Preferences, Religious/Spiritual Topics in Relation to Assessment, Religious/Spiritual Topics Discussed in Therapy, Positive Experiences, and Negative Experiences.

**Client Preferences.** Within this domain, six categories emerged, relating to clients’ preferences for either secular or Christian therapy and preference for content discussed in therapy. Typical and variant themes were found relating to preference for a secular therapist and seeing a secular therapist due to unavailability of a Christian therapist, respectively. Several participants indicated having sought out a secular therapist, someone outside of their faith community, to avoid feeling judged and to have a sense of control over the content of the sessions. One participant (#11) stated:

“I think that might be one of the reasons that I did not want a Christian counselor. If they happened to be a Christian and did not tell me, that is fine.”
Table 2

Domains and Categories

<table>
<thead>
<tr>
<th>Domain: Client Preferences</th>
<th>Variant</th>
</tr>
</thead>
</table>
| Preference for secular therapist | Wanted secular therapist, someone outside of faith community, so would not feel judged  
|                              | Wanted secular therapist, someone outside of faith community, so would have control over whether or not issues of faith were raised  
|                              | Client expected secular therapist to be non-judgmental regarding faith  
|                              | Client preferred secular therapist who could incorporate r/s a little bit  |
| Preference for Christian therapist | Thinks that Christians prefer Christian therapists because they seem “safer”  
|                              | Prefers Christian therapist for guidance about theological questions and doubts  
|                              | Prefers Christian therapist for marriage counseling  |
| Unavailability of Christian therapist | Saw secular therapist because could not find Christian therapist  |
| Preference for Christian therapist | Typical |
| No preference for Christian therapist | No preference based on positive experience with secular therapist in past  
|                              | Sought secular therapist because didn’t need to address r/s issues in depth  
|                              | Aware of and ok with therapist’s limitations in providing religious or spiritual guidance  |
| Preferred content | Typical |
| Therapist understanding of religious beliefs | Variant |
|                              | Wanting therapist to understand church teaching that depression is failure  
|                              | Wanting therapist to understand religious beliefs  
|                              | Wanting therapist to understand that talking about faith is important  |
| More Christian content | Variant |
|                              | Would have wanted to discuss how was using faith to cope (e.g., pray, read bible, church)  
|                              | Would have wanted therapist to ask about God or prayer to open the door to talk about faith  
|                              | Praying in session-if had been a Christian therapist  
|                              | Christian feedback-if had been a Christian therapist  
|                              | Encouragement to read bible-if had been a Christian therapist  |

table continues
Table 2, cont.

Domain: R/S Topics in Relation to Assessment

<table>
<thead>
<tr>
<th>At intake</th>
<th>Variant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client discussed family upbringing</td>
<td></td>
</tr>
<tr>
<td>Client stated that talking about faith would be important</td>
<td></td>
</tr>
<tr>
<td>Client mentioned being in a Christian organization</td>
<td></td>
</tr>
<tr>
<td>Client mentioned not drinking for religious reasons</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In relation to coping</th>
<th>Variant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist asked what had been helpful in the past to cope</td>
<td></td>
</tr>
<tr>
<td>Therapist asked what would be helpful now to cope</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In relation to presenting issue</th>
<th>Typical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband of same faith abused client</td>
<td></td>
</tr>
<tr>
<td>Effect of Christian upbringing</td>
<td></td>
</tr>
<tr>
<td>The impact of daughter’s abortion on client’s Christian family</td>
<td></td>
</tr>
<tr>
<td>Adjustment to other Christians’ beliefs that differed from client’s own</td>
<td></td>
</tr>
<tr>
<td>Depression related to not feeling like a good enough Christian</td>
<td></td>
</tr>
</tbody>
</table>

Domain: R/S Topics Discussed in Therapy

<table>
<thead>
<tr>
<th>Specific focus on R/S</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited focus</td>
<td>Typical</td>
</tr>
<tr>
<td>Faith was discussed some but was not the focus of therapy</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deliberate focus</th>
<th>Variant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addressed r/s issues as integral part of therapy</td>
<td></td>
</tr>
<tr>
<td>Client prayed out loud at the beginning of every session</td>
<td></td>
</tr>
<tr>
<td>Client “tested the waters” when initially discussing faith</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Negative emotions related to beliefs</th>
<th>Variant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guilt and shame for faith not being strong enough</td>
<td></td>
</tr>
<tr>
<td>Anger at God</td>
<td></td>
</tr>
<tr>
<td>Fear that God was angry with client</td>
<td></td>
</tr>
<tr>
<td>Low self-esteem</td>
<td></td>
</tr>
</tbody>
</table>

table continues
Table 2, cont.

Domain: Positive Experiences

Therapist’s accepting attitude
Typical
Open and non-judgmental attitude made client feel comfortable with r/s
Conveyed respect of r/s beliefs
Signs in therapist’s office (e.g., religious books)
Therapist’s desire to understand what faith meant to client
Therapist had differing beliefs but client felt respected nonetheless
Client did not have to justify religious beliefs
Client felt vulnerable with disclosure of faith but got easier over time because trusted therapist
Therapist expressed understanding of the importance of faith for client
Therapist expressed humility about not understanding client’s faith and asked questions

Therapist’s behavior related to client’s beliefs
Typical
Did not avoid topic of faith when raised by client
Discussed faith as a coping strategy
Explored how r/s related to other issues
Use of prayer and imagery
Admitted when he did not have competence in s/r issues and offered referrals
Client-driven approach (little pressure, client raised issues)
Created a safe place where client could be mad at God

Domain: Negative Experiences

Therapist mishandling of r/s issues
Typical
Disrespected client by calling God “she”
Client felt judged for her religious beliefs
Expressed disagreement with client’s religious beliefs
Addressed surface level r/s issues but not in depth
Did not seem comfortable discussing client’s religious beliefs and abuse
Client did not trust therapist’s techniques (i.e., imagery)
Misunderstanding/confrontation about client’s religious beliefs
Initiated discussion of r/s when not preferred focus for client
Client felt judged and defensive when told her beliefs were too rigid
Client did not feel listened to
Therapy was already going poorly and therapist’s approach to r/s made it worse
Did not appear to understand importance of faith

Table 2, cont.
Client avoidance of s/r topics

Typical

Due to therapist’s avoidance of r/s topics
  Therapist appeared hesitant or avoided addressing r/s issues

Variant

Due to fear or uncertainty
  Fear of judgment
  Fear of beliefs being misunderstood
  Belief that therapist would not see r/s as relevant to counseling
  Unsure if allowed to talk about r/s in secular counseling
  Fear that therapist would over-focus on negative aspects of Christianity and ignore her issues
  Fear of portraying Christianity negatively
  Fear that therapist would minimize concerns related to religious beliefs

Because therapist’s beliefs differed
  Client avoided some issues because not sure if therapist’s values would match client’s values
  Due to therapist’s unknown or secular identity
  Previously saw secular therapist who inferred that Christianity was problematic
  Previously saw therapist who said that if she wanted to discuss r/s she should see pastor
  Did not feel that they spoke the same language

Note: General = category endorsed by all 11 participants or all but one; Typical = category endorsed by 5-9 participants; Variant = category endorsed by 2-4 participants.

R/S = religious or spiritual.
I needed to know that I wasn’t going to be judged and that religion would only come into the story when I brought it in.”

This participant also wanted a secular therapist because she did not anticipate that a Christian therapist would be helpful for her at the time. She explained:

“\[I grew up in the church and I know the church can be a really supportive place but I really just did not want one more person to tell me that God was going to help me. (laughs) Because I was struggling and that’s what Christians tend to say to each other and I was afraid that a Christian therapist would come at me with Bible verses and platitudes and I really didn’t want that.\]”

This participant also stated that she wanted a secular therapist to have an “impartial party” to talk to. She said:

“\[It was the first time in my life that I needed to do something that wasn’t completely centered around the church. I needed the opinion of an impartial party. And by not knowing her belief system, she was a completely impartial party. And it freed me up to be exactly who I was and to talk about whatever I wanted. About my faith: the good, the bad, and the ugly. And I am not sure I could have done that with a Christian counselor.\]”

This participant reported having a positive experience and stated that she had expected that a secular therapist would be “open-minded enough to deal with it [her Pentecostal religious beliefs].” She further stated that she would have been surprised if a secular therapist would have told her, “You know, I am not comfortable dealing with these faith issues.”

On the other hand, some participants preferred a Christian therapist but
had to see a secular therapist because a Christian therapist could not be found due to insurance reasons or lack of availability in the area (variant theme). Most of these participants, however, reported that in the end, they had a generally positive experience with their secular therapists.

Preference for a Christian therapist was a variant theme. Some of these participants wanted guidance about theological questions and doubts and encouragement to use Christian methods to cope. For example, when asked why she initially wanted to work with a Christian therapist, one participant (#3) stated:

“Mainly because I thought they [Christian therapists] would be able to encourage me in my faith and to look to God for solutions instead of just giving me what they thought. I would be encouraged to rely on God and seek Him and pray.”

This particular participant did not see a Christian therapist because her insurance did not cover it but described having a positive therapy experience with her secular therapist nonetheless.

Participants also discussed seeking a Christian therapist who seemed “safer.” One participant (#10) disclosed:

“I think sometimes in evangelical circles we have this separation: like there are Christians and non-Christians. Christians are good and non-Christians are bad. We have to be friends with Christians and date Christians and marry Christians and that is sort of the best. So I think that people who have grown up in evangelical families and churches have that sort of belief. That is part of it. I wonder if there is any piece of it that has something to with it. That the Christian [therapist] is better or safer.”
Some participants indicated that while they preferred a secular therapist for individual work, they preferred a Christian therapist for couples counseling. One participant explained her rationale for this by saying, “Christian therapists understand that bond [marriage] and the importance of that bond a little differently than a secular counselor would.”

A typical theme emerged about participants’ lack of preference or indifference for a secular or Christian therapist. Participants indicated not having a preference due to having had positive experiences with secular therapists in the past, not needing to address religious or spiritual issues in depth, and being aware of secular therapists’ limitations in regard to assisting with religious and spiritual matters. One participant (# 8), who initially sought out a Christian therapist but had a positive experience with his secular therapist stated:

“I guess in some ways I had the expectation that the counseling wouldn’t be able to really cover that part of my life [client’s faith and relationship with God]. So in some ways, I saw it as counseling for just kind of like, everyday life. And over the summer and in this past Fall I went to a different counselor [a Christian therapist] that I trusted more in those deeper areas of my walk with God. And I found her to be more helpful in those areas.”

Two subcategories emerged for preferred therapy content: therapist’s understanding of participants’ religious beliefs (typical theme) and more Christian content included in therapy (variant theme). Participants indicated that they wanted their therapist to understand their religious beliefs, specifically to recognize that talking about their faith was important for therapy success, and to understand the church
teaching that depression signifies failure. On participant (#11) explained:

“I am not sure that she really understood that I felt like I had failed by being depressed. So if I am depressed, the church tells me that I am not supposed to be depressed so I must have failed somehow. And I must have done something to cause me this pain. And if I touched on that, that was something that she didn’t quite get.”

In regard to wanting more Christian content in session, a few participants acknowledged that while they did not expect it from secular therapy, that receiving encouragement to pray, go to church, and read the bible would have been comforting and helpful. One participant (#4), who had sought counseling for depression and had initially wanted to see a Christian therapist, wished that she could have received some encouragement from her therapist to use Christian coping mechanisms. She explained:

“Had he been a Christian counselor, I felt like he would have prayed with me and that would have given me a lot of comfort. And maybe encouraged me to get in the Word. Cause sometimes when you are really feeling down its hard. It’s hard to even pray and especially to study your Bible. And do the things you know because you are not functioning normally at all, and sometimes just getting up is hard enough and doing the things you just have to do.”

Another participant (#11), who described having a highly positive therapy experience, reported that she nonetheless missed having some Christian encouragement. She said:

“I think that when you are in a small group, and you tell them that you are feeling depressed, it is nice that you can have them pray with you. I was struggling so much and not many people knew my secrets. And she wasn’t able to push me and
pray with me and guide me in a way that at the time I probably needed to be. So as much as she let me be myself and let me be a Christian and all that kind of stuff, she wasn’t able to push me the way a Christian might have been able to.”

Another participant (#4) stated that she was having some doubts about her faith and that it would have been helpful to have someone with whom to discuss her doubts. She stated:

“I know I believe, but right now, I mean… I am going through some doubt and having a lot of whys about things. I think that had I had a person that I could really sit down with and know where I was coming from, and my thinking about that [it would have been helpful].”

Some participants discussed wishing that their therapist would have asked about their faith more so that they could have discussed how to use faith to cope with their difficulties. For example, one participant (#3) reported:

“I had mentioned being involved in a Christian organization. Had she asked me if I had used the Christian organization to help figure out my struggles or to help myself… had she asked, I would have told her that I do. That I pray about it and that I had talked to my Bible study leader about it. Which could have opened up an entire different conversation. But she seemed to just avoid it.”

**Religious/spiritual topics in relation to assessment.** Participants indicated that the topic of religion or spirituality arose at the intake session (typical theme) and when discussing coping methods (variant theme) and presenting issues (typical theme). Clients’ faith was discussed at intake sessions in the context of discussing family upbringing, being a member of a Christian organization, and not using alcohol or drugs for religious reasons. One participant also indicated that she completed
paperwork at the intake and endorsed that spirituality was important to her. In addition, one participant explained to her therapist at the first session that talking about her faith would be important to her and asked if this was something with which the therapist was comfortable. This participant (#11) reported:

“\[I\] was really up front with her and told her that my faith was a huge part of my life and if that was something that made her uncomfortable, I would find another therapist. Even though I didn’t want to talk to a Christian counselor, I knew that talking about my faith had to be okay. She was really great with that.”

Some participants also reported discussing their faith in response to therapists’ inquiry about how they had tried to cope in the past and what would be helpful presently. Participants reported talking to their therapists about using prayer, the church, and scripture to cope. One participant (#6) who had a particularly positive therapy experience stated:

“He asked at the very beginning different questions about coping skills and religious activities and self-care. Your normal intake questions. So he got a gauge of that from the beginning and I guess when he saw that it was important to me he just kinda rolled with that as an aspect of therapy for me.”

Finally, participants also discussed their faith or religious issues in the context of their presenting issues. Examples of presenting issues included physical abuse from husband who was a pastor, impact of daughter’s abortion on the participant’s Christian family, adjustment to moving to a part of the country where others’ religious beliefs were different than participant’s beliefs, and depression related to feeling inadequate as a Christian.
**Religious/spiritual topics discussed in therapy.** A general category emerged which applied to all participants: a specific focus on religious/spiritual issues. This category was further subcategorized into two categories: limited focus on spiritual and religious issues in therapy (typical theme) and deliberate focus on spiritual and religious issues in therapy (variant theme). Several participants reported that their faith was talked about some during their therapy sessions but that it was not the main focus of therapy. While their faith was not the main focus of therapy, all of these participants indicated that talking about their faith (e.g., as a way of coping, as part of their identity) was very important and contributed to their satisfaction with therapy.

The second subcategory pertained to participants’ deliberate focus on spiritual and religious issues in therapy (variant theme). For example, one participant (#10), who sought therapy for anxiety and depression and who did not seek out a Christian therapist described her therapy experience as positive and as a “good fit” because she felt like she could talk about her faith and that it was “interweaved as part of the work we did.” This participant described talking with her therapist about using prayer and Christian imagery to address anxiety and discussing issues of low self-worth, shame, and guilt for feeling like her faith was not strong enough. Another participant (#1), who did not seek a Christian therapist and who had a negative therapy experience, reported that she prayed out loud at the beginning of every session asking God to guide the session.

Participants also indicated “testing the waters” to see if therapists were open to discussing religious issues. One participant (#10) explained:

“Umm…let’s see…I think in therapy, with many topics, we sometimes tend to test the waters before you bring up something that is difficult. Not that religion is
difficult to talk about. But in the past, when I have talked about faith or religion…I am remembering one therapist in particular that said, ‘Don’t talk about that, I’m not really an expert in that-go talk to your pastor.’ Or, sort of along the lines that Christianity is, not so much bad, but shaming or guilt producing. I think that in the past I have gotten some negative messages about that. So I think initially as I talked about it with this therapist I didn’t get either of those responses. It was a willingness to say, ‘Tell me what your faith means to you and how do you define that.’ And she was just really accepting of whatever I said. And really kind of interweaving that into the work we did. It’s hard to explain, it’s more from, I was my own expert about my own faith so it was like exploring it more than her telling me or guiding me.”

This participant further discussed how she “tested the waters”:

“For me, it was actually easier to talk about abuse history [than her religious conflicts]. But when she said, ‘Is there anything currently that is going on that makes you feel bad?’ Then I said, ‘Well, sometimes I don’t feel like I am a good enough Christian or that God is angry with me.’ That was my way of testing the waters to see what she would say.”

A third subcategory comprised of participants’ negative emotions related to their religious beliefs (typical theme). For example, participants discussed feeling anger at God, worrying about God being angry, feeling like living a dual life with having both Christian and non-Christian friends, and experiencing guilt imposed by church and family. One participant (#7) reported:

“Part of the thing I had talked about was guilt. When I was growing up in my
church and my best friend became pregnant when we were in high school. And how a lot of people in the church looked at me negatively after that. And I felt that in some way my family did as well. So I had a lot of guilt about that even though I hadn’t done anything and I wasn’t the one to get pregnant.”

**Positive experiences.** Two typical categories emerged that describe the factors that contributed to participants’ positive therapy experiences: therapist’s accepting attitude (typical theme) and therapist’s behavior (typical theme). Several participants reported that their therapist’s open, non-judgmental, and respectful attitude made them feel comfortable discussing their faith. One participant (#7) reported:

“**I think the non-judgmental attitude [made me feel comfortable]. I felt that she was very attentive and paid attention to what I was saying. And I never felt like she was putting down my beliefs or criticizing. So I think that was helpful.”**

This participant further described feeling vulnerable the first time she talked about his faith but stated that it got easier over time due to her therapist’s attitude. Another participant (#5) stated:

“**I felt like when I was in session with him I didn’t feel like he was judging me for what I believed in. And at no time did he ever challenge me on that or say, ‘Oh well are you sure about that?’ He would never sidestep any question or anything related to that. There was never a time when I felt like, gosh, if I say this, he is going to be like, this guy is crazy because he is a Christian.”**

Participants also reported appreciating the therapist’s genuine desire to understand their faith. One participant (#8), who described having a positive experience (even though he had initially wanted to see a Christian therapist), discussed that while his
therapist only understood about “50%” of his faith, that his therapist’s genuine desire to understand him was meaningful. He said:

“I would say he understood 50% of it [client’s faith]. I think he really understood the mind of it but the heart: I think he was about half way there. And I guess as I think about what he understood about me, it wasn’t an understanding like oh, I need to make sure I understand him. It felt like there was a desire from him to understand where I was coming from and what I was experiencing.”

Another participant (#11), who told her therapist up front that talking about her faith would be important, reported that her therapist often did not understand her religious beliefs but respectfully asked her about them. She explained:

“She treaded very gently. She did what most therapist do - which is, you know, let the patient do the talking and let the patient teach you. She would ask me questions…like, I believe in speaking in tongues and at one point it came up, I don’t know how, and I told her what I felt that that means. And one thing that came up over and over was going up to the alter at church and praying. And she didn’t understand that at all, so I had to break it down for her and tell her why that was important and why it was emotional for me.”

This participant further described other aspects of her faith that she explained to her therapist:

“Honestly, I think there were lots of times when she was confused and she wasn’t very good at hiding it either (laughs). But with the simple stuff like prayer and why church is important to me. Like for instance, a big issue for me was that I stopped going to church when I was depressed. I was struggling and I didn’t want
to be around, again, the platitudes and the same words over and over again. And plus my motivation to go to church kinda disappeared too. So that was a big issue: that I wanted to get back into church and I knew that was something God wanted me to do. So that was something that came up and I think that she didn’t understand that but she still supported me. She still worked with me like, ‘Okay, what can we do to get you going back to church? What do you need to do in your life to get you going back there?’

This participant described her therapist as being “respectful and humble” in the way she asked questions about her faith. She stated:

“She was good about asking questions when I used terminology that she wasn’t familiar with. She was respectful and humble too, actually. I distinctly remember one time when she was like, ‘I really don’t understand all of this so you are going to have to explain this to me. What did you mean by this?’ It’s a pretty humble thing for a professional to do. To say they have no clue about what you are talking about.”

Another theme that emerged in the positive experiences domain is therapists’ behavior related to clients’ religious beliefs. Several participants reported appreciating that their religious beliefs were incorporated into their treatment and discussed as a way to cope with difficulties. Some participants discussed finding it helpful when therapists reinforced behaviors such as prayer and church attendance. One participant (#6) reported that her therapist encouraged her to use her faith and prayer, in addition to other coping methods, to cope with anger. She reported:

“He brought it up [her faith] as a coping skill because I did bring up that I was
spiritual and that I felt that I could call on God and talk to Him. He asked me, ‘Do you feel that you have been able to call on Him during this time?’ And we talked about how I did feel like I could but I still didn’t feel like my anger was going away. So we talked about the reality of having to work through the anger. That anger takes time. So we talked through that and he brought up the coping strategies of not only the exercising, the deep breathing, and progressive muscle relaxation, but also prayer during that time. So even though he was secular he brought that up as maybe a coping skill for me.”

This participant further discussed how incorporating her faith in therapy was positive. She stated:

“It was very positive. To use something that was normally a strength for me anyways, and to have the therapist bring that out as something I could use as a strength for me, as a coping skill for me, it was a very positive experience.”

Another participant (#10) discussed an effective way that she and her therapist incorporated imagery:

“The imagery part was something that she initiated, and it was my own way to define it. So someone else might imagine Buddha or some compassionate being. But she talked about, when you envision unconditional love, or when you envision this caring, loving all knowledgeable presence…For me, that was Christ and for someone else that might be something else. So in a general way she initiated it but the specific Christian application came from me.”

Participants also reported appreciating the way therapists handled religious material when raised. One participant (#5) expressed satisfaction that his
therapist did not avoid the topic of faith when he [the client] raised it, and that he let the participant lead the discussion. He explained:

“

“I was very satisfied. Like I said, I didn’t go into therapy to ask him to pray with me or pray for me. It [my faith] was something that I felt very open discussing because in a lot of cases I had difficulty discussing those issues in school and with the people I went to school with. It actually became an issue. So with him, I didn’t feel any of the pressures. He wasn’t asking me, ‘So, what are your thoughts on this?’ It was very much left in my court that if I wanted to talk about it I could, and if I didn’t, then I didn’t have to. So I felt very comfortable discussing any spiritual matters with him.”

Another participant reported that his therapist expressed an inability to help him with some of his spiritual issues and that his therapist did this in a way that was positive and validating. This participant (#8) stated:

“

“At one point we were talking about how my relationship with God does factor into the way that I live life. And he said, ‘I would love to give you some input here, but I am just not qualified.’ He said, ‘I can’t help you with this, but it is important, and I am sure someone can really help you a lot more than I can. It is not my role.’ And it felt very comfortable as he said it. After he said it, I said, ‘Yeah, I agree with you, that makes sense.’ It didn’t feel awkward.”

Negative experiences. Two major themes emerged for negative experiences: therapists’ mishandling of religious/spiritual issues (variant theme) and client avoidance of religious/spiritual issues (typical theme). Participants reported several ways in which their therapists mishandled religious/spiritual issues that lead to feeling judged,
disrespected, and not listened to. One participant, (#2) reported feeling disrespected by her therapist when her therapist referred to God as “he or she.” The client described how she felt after this incident: “I had been thinking for a while that it [therapy] wasn’t going as well as it could be at that point I really thought that she didn’t get me at all. And she didn’t relate.” This participant also explained that her therapist calling God “he or she” was a critical incident in the therapy that made her feel closed off to further discussions about her faith. She stated that “once she said little things like ‘he’ or ‘she,’ in my mind we couldn’t go back there.” This participant went on to say that her therapist vocalized disagreement with her religious beliefs, which made her feel judged and not listened to. This participant also indicated feeling defensive when her therapist told her that “believers are too rigid,” which she took personally. She stated:

“She kinda pushed her beliefs too much. When you have a secular psychologist you don’t need their beliefs pushed on you. Even if they are a Christian psychologist, [you don’t need their beliefs pushed on you]. It is not ethical anyways. I just mean, as a psychologist, you are not supposed to put any kind of judgment on your client. Help them find their own way, guide them, but not too much. I didn’t feel like she was really listening to me! I don’t expect a therapist to totally agree with everything, that is not the point of therapy. But to let some things be if you don’t agree with them.”

This participant also did not like that her therapist repeatedly brought up the issue of her faith because it was not her desire to talk about it. In sum, this client reported that her therapist was “talking at me, judging me, and not respecting me.”

Another way in which participants felt their therapists mishandled their
religious issues was by not going into depth about religious issues, but rather skimming the surface. For example, one participant believed that her therapist felt uncomfortable discussing the issue that brought her into therapy, which was that her husband, who was of the same faith and a pastor, was physically abusing her.

Many participants also felt that their therapist did not understand their religious beliefs. One participant (#1) stated that her therapist “over-spiritualized everything based on what she knew about Christians.” She described a guided imagery exercise that her therapist asked her to do every week. She explained:

“One thing that I realized while being in the counseling is that every week she wanted me to go into this…close my eyes and go into this ‘fear of the light.’ And at first I felt like this is the Holy Spirit, wow. And I really felt like God was ministering to me and it was great. And then I realized that every week we are going into this fear of the light. I am looking for something natural not supernatural. And maybe you’re trying to give me something based on what you think. I think sometimes people have that impression of Christians: that we want to be spiritual all of the time. It’s like, we are normal people! We want to talk, just like everybody else. We want to rationalize.”

She added that she [the participant] prayed out loud before every session and thought that this may have affected her therapist’s decision to engage her in the “fear of the light” every week. She stated:

“I would ask every time, ‘Lord, please just take over and use this time. I believe in the message that you are going to bring and not so much the messenger.’ You know, I wanted it to be spirit-led. And maybe, this is just…what I was thinking
was that I don’t want to do this every time. I don’t want to close my eyes and do this hocus pocus bullshit. It didn’t help. And I felt like every week we were talking about something trippy spiritual and I am not going to be in the mood every week. Let’s just talk in the natural.”

This participant joked about the impact that her praying may have had on the therapist. She stated, “I felt like maybe that put some pressure on her (laughs) to be spiritual. If you are saying to the Lord in front of this woman, ‘Lord, this is your time…’ she probably is thinking, good Lord what do I do with this?”

This participant indicated that her therapist did not seem to understand her religious beliefs as evidenced by the “fear of the light” exercise and because she did not refer to Christian scripture. For example, she stated:

“This is something else that makes me believe that maybe she didn’t really understand Christianity. She never once mentioned the forgiveness of God for making a mistake and being washed in the blood. None of that! Which would come from having a conversation, right, about feeling guilty or knowing it was the wrong thing to do [allowing her daughter to have an abortion].”

This participant reported that overall her therapy experience was poor and that engaging in the “fear of the light” exercise made her feel “absurd, uncomfortable, and embarrassed.” She discussed feeling that she could not trust her therapist’s techniques or talk about her faith or the issues that brought her into therapy because of her therapist’s “agenda.” However, she felt good about terminating and “being able to discern what was happening and say, ‘I appreciate everything that you have done but I think this is going to be my last session.”
The other category in the negative experiences domain was client avoidance of religious/spiritual issues (typical theme). This category was further divided into three subcategories. The first subcategory was participants’ avoidance of religious/spiritual issues due to the therapists’ avoidance of such issues. Some participants discussed noticing that their therapists did not feel comfortable, for whatever reason, discussing such matters and changing the subject when participants discussed their faith. One participant (#3) stated, “I would assume that she would be really hesitant to bring it [religion or faith] up with any client. That is how it seemed. That wasn’t part of her job and wouldn’t make it part of her job.” Another participant (#4) stated that in response to her [the client] saying anything faith-related, her therapist would not give her any feedback and “sorta moved on.”

The second subcategory was participants’ avoidance of religious/spiritual issues due to fear or uncertainty. This included participants’ fear of being judged or misunderstood for their religious beliefs and uncertainty about whether the therapists would see religious matters relevant to counseling or something they were “allowed” to talk about. Participants also indicated hesitance to bring up religious issues for fear of how therapists might handle the topic: either minimizing religious concerns or over-focusing on negative aspects of Christianity and ignoring the issues raised by clients. Finally, some participants had difficulty expressing true distress and worried about portraying a negative image of Christianity.

Some participants discussed worrying that they would feel judged or misunderstood for their religious beliefs. One individual, who described having a positive therapy experience stated, “I never felt like she was putting down any of my
beliefs or criticizing.” She further explained that this had been a fear of hers:

“I think that especially in psychology, sometimes people look down on faith and religion, so there is a little bit of risk to expose that part of your person. But for me, that is part of who I am, so it was important for me to be open with everything.”

Another participant explained that she felt embarrassed talking about religious issues with her therapist because of her awareness of Christian stereotypes. She mentioned at the beginning of the interview that she did not like to use the term “religion” when talking about her faith and preferred to use the terms faith or spirituality because “religion generally has a bad connotation to non-religious people, or just in the secular world.” This participant stated that she tried to be “really open” with her therapist because she wanted therapy to help with her anxiety, but her faith was the “only thing I can think of that I was reluctant to talk about.” This participant (#3) explained how she felt when she raised an issue related to her faith:

“When I did bring up that up [feeling guilt, for living in ‘two worlds,’ i.e., having Christian and non-Christian friends] I almost felt, not embarrassed, but I guess felt the way I always feel talking about the Christian organization with someone who wasn’t Christian or who doesn’t really have a faith. It’s almost like I didn’t want to talk about it too much because I didn’t want her to get any impression of me that isn’t correct. I guess I just didn’t really feel comfortable talking about it with her. Or even that it was necessary because I just assumed that she wouldn’t really understand or care as much about it I guess.”

Despite having a negative experience with this counselor, this participant
indicated that in the future she would be hesitant to see a Christian therapist but would want a secular therapist who is “comfortable incorporating my faith a little bit.”

Participants also reported being hesitant to discuss their faith due to uncertainty about whether therapists would consider religious matters relevant to counseling and uncertainty about being “allowed” to discuss their faith in therapy. One participant stated:

“He never talked about it [client’s faith]. Maybe he wasn’t allowed to, I don’t know (laughs). It did not seem to be a big part of his life or a part of his counseling. It was like this [her faith] was a separate thing because it was almost like this is not an acceptable part of therapy. I mean, he gave me that feeling that he was not a Christian counselor, so he wasn’t going to input on that. He listened to me and what I had to say and all that: church and my faith, trying to be in church and with Christians, even when I felt like I couldn’t do anything else. He would just nod his head but then go on to something else.”

This participant reported having a poor therapy experience and noted that she was “reluctant to talk to him about the things that had to do with faith.”

Another participant (#3) was unsure if secular therapists were “allowed” to discuss faith. She reported having a generally negative therapy experience and not feeling comfortable talking to her therapist about her faith. When asked if there was anything her therapist could have said or done to help her feel more comfortable discussing her faith, she answered:

“I guess if she would have brought up God, I would have elaborated a little I think. Yeah, had she brought up God, I probably would have talked about it a little and maybe even she could have used it to try to help myself. I mean, I did it
on my own and I would have shared with her that I was praying, things I was doing on my own...had she brought it up. Can she do that? Bring up God?”

When asked why she was unsure if her therapist could “bring up God,” she stated that she had mentioned early in therapy that she was a member of a Christian organization but her therapist “seemed to just avoid it.”

Some participants also indicated a hesitance to bring up religious issues for fear that therapists would over-focus on negative aspects of Christianity or minimize their religious concerns. One participant (#7) described feeling vulnerable when discussing her religious upbringing with her therapist. She stated:

“I grew up in a more, I guess you can say fundamental church. So there were a lot of rules about what you did and didn’t do. So feeling a little bit more vulnerable sharing that information because a lot of times when people hear fundamental, they stiffen up and they cringe a little bit. So I was bracing myself for-okay, is she going to go off on a tangent on how bad this is? I worried if she would throw it off and say, ‘It’s no big deal. You don’t need to feel guilty about that. That is ridiculous for you to feel that way.’ I never felt like that from her. She was more like, ‘Oh wow, I can understand what that would be like.’ She was aligning herself with me, being more understanding.”

Some participants reported being hesitant to admit having psychological distress and being cognizant of not wanting to portray a negative image of Christianity. One participant (#11) stated that this hesitance did not prevent her from discussing issues, but that she sometimes worried about this after her sessions. She reported:

“I will say that there were moments when it was hard to walk away from the
office, and I would say, gosh what kind of image must she have of Christianity after dealing with me? Christians are supposed to be perfect and have it all figured out. We are supposed to have sun shine down on us at all times. And I said things and behaved in ways that Christians should not behave. And if we are supposed to be a light in the darkness, well, it is hard to do that when you are depressed and when you are sharing your deepest, darkest secrets with someone. And I was doing things that you are not supposed to do. I would certainly would never try and witness to a person by telling them those things!"

She further explained the kinds of things she discussed with her therapist:

“"I get that we are not perfect and that we don’t have to be perfect all the time. And I think that she gets that too. But there were moments when I thought, my goodness, what kind of image must she have of Christianity? You know, because you are talking about your family, talking about your friends at church and the way that they treat you. And all the skeletons in the closet come out. And you and I both know that Christianity isn’t perfect. There are things in the church that are just as flawed as in the world. But we don’t like to talk about those things.”

Another participant (#2), who had a negative experience with her therapist, stated that she felt like she “always had to be on my game with her.” She further stated:

“"I was never totally relaxed. And my issue is that I feel like I always have to be perfect anyways! And I did feel like I had to be perfect because she was looking at me through rose colored glasses because I was a Christian and I make mistakes.”

Another participant discussed a similar concern when asked if there was anything
she was hesitant to discuss with her therapist. She stated:

“Yeah, there were a few things [she was hesitant to discuss]. Getting into more personal issues there was hesitation. So talking about specific religious beliefs. Like I had mentioned earlier, the feeling that there is always a risk. So there was some hesitation with that. And then also being more open and really saying, ‘Hey, I am really struggling right now’ rather than saying ‘Oh, everything is fine, and I can handle it.”

The third subcategory in this domain was participants’ avoidance of religious/spiritual topics due to their therapists’ beliefs differing from their own. One participant reported that she did not feel that she and her therapist “spoke the same language,” and another participant (#3) stated that not knowing her therapist’s religious beliefs made her hesitant to discuss her faith:

“Because I did not know her thoughts about it [Christianity] or what her background or anything was, I didn’t really want to talk about it. I guess I just didn’t really feel comfortable talking about it with her.”

Yet another participant (#10) stated that she was hesitant to discuss her faith because of having bad experiences with secular therapists in the past. She explained:

“I didn’t see this person [secular therapist] very often because I got the sense of, ‘No, I am not that. I am not someone that can help you with those issues, have you thought about talking to your pastor?’ Which I had already done. So just the way she said it and the way she handled it was a negative turn off for me. It was like, ‘I can’t help you’ kind of thing. And the other situation was that I had been seeing this counselor for a while and it [client’s faith] came up and I sort of got
the message of, ‘Do you ever think that Christianity is part of the problem or contributing to your depression?’ And I was like, ‘What do you mean?’ And she was like, ‘Well, sometimes fundamental Christians have all these rules to follow, and we can never measure up to that. Is that part of the problem?’ That may have been my interpretation and not what she had meant at all.’"

When asked how she felt when her therapist replied in this way, she replied:

“Well, it made me feel worse! It made me feel… I guess it made me really wonder… well, I had always felt like being a Christian was a good thing, and it made me feel like maybe it is not a good thing. I think I knew it wasn’t that simple, but I think it made me think, is this [client’s faith] a bad thing? Is this not helping? Is this part of the problem?”

This participant, who had a positive experience with her secular therapist, hypothesized that her Christian maturity may have had something to do with experiencing other secular therapists whom she saw in the past negatively. She explained:

“Part of that were her responses but also part of it was my own maturity in my faith. Because the first two therapists I mentioned I had only been a Christian for 2-3 years, and the other one was during young adulthood, before I had figured out a lot of my own beliefs. So I think that probably made a big difference. I feel like my faith was more mature and thought through.”

Another participant stated that he was reluctant to discuss a particular struggle he was having because he was unsure if his therapist’s values and morals would match his own. He explained:

“Sometimes I was overwhelmed with lust and how to walk with God through
being single and God’s gift of sexuality. In some ways, I didn’t know how to connect with him [client’s therapist] on that level because I didn’t know what his expectations were. If he would say, ‘Really what you are concerned with, or the things you don’t want to do, they are okay because I think they are okay.’ I didn’t know if that would come about, so I didn’t probe in that area of my life with him.”

He went on to describe some confusion he faced when his therapist encouraged him to consider another point of view regarding dating:

“At the time I was dating someone from church and we hadn’t done anything physical. And at one point I brought that up in my sessions. And he brought some views to the table. He said that my morals that I had were great and sex is something to definitely be cherished and physical intimacy and that whole realm is a gift, but don’t be so quick to shut it off completely. And I guess I didn’t know what to do with that. Because I wanted to listen to him and maybe the way I was hearing it, I was too controlled. But at the same time I was scared to listen to something that I couldn’t measure in terms of the quality. I didn’t know if he was speaking in a godly way or speaking in a way that was wise unto the world.”

**Triangulation with Quantitative Results**

For purposes of triangulation, participants’ scores on the WAI - S and the CRF - S were compared with the qualitative results to examine congruence with the narratives. These results are displayed in Table 3 (CRF - S) and Table 4 (WAI – S).
Table 3

*Participants’ Scores on the CRF-S*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Therapy Experience</th>
<th>Total Score</th>
<th>Attractiveness</th>
<th>Expertness</th>
<th>Trustworthiness</th>
</tr>
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</table>

*Note.* CRF-S = Counseling Rating Form - Short (Corrigan & Schmidt, 1983). Total scores range from 12 to 84, and subscale scores range from 4 to 28.
Table 4

Participants’ Scores on the WAI-S

<table>
<thead>
<tr>
<th>Participant</th>
<th>Therapy Experience</th>
<th>Total Score</th>
<th>Goals</th>
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<td>Positive</td>
<td>57</td>
<td>21</td>
<td>20</td>
<td>22</td>
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</tbody>
</table>

Note. Therapy experience was self-reported during the interviews. WAI-S = Working Alliance Inventory-Short Form (Tracey & Kokotovic, 1989). Total scores range from 12 to 84, and subscale scores range from 4 to 28.
The results indicated that the alliance measure was more sensitive than the CRF-S to participants’ reported therapy experiences. As shown in table 3, with one exception (Participant #3) all participants saw their therapists as high on expertness, attractiveness, and trustworthiness regardless of their description of the experience as positive or negative. There was variability in how participants rated the therapeutic alliance (see Table 4). The WAI-S total and subscale scores indicated that participants who described having had a generally positive experience rated the alliance relatively higher ($Mdn = 63$) than did those who reported having a generally negative experience ($Mdn = 42$). (Recall that WAI-S total scores can range from 12 to 84 and subscale scores can range from 4 to 28.)

Table 3 shows that the total CRF-S scores reported by participants who had a positive therapy experience were higher than the total scores of participants who reported a negative experience. There were two exceptions, however, (Participants 2 and 4), who reported negative experiences in therapy. Participant #2 described her therapist as “disrespectful, pushy, and judging” but rated her highly on the CRF-S (total = 68, attractiveness = 22, expertness = 22, and trustworthiness = 24). Additionally, Participant #4, whose total CRF-S score was 70 (25, 18, and 27 on attractiveness, expertness, and trustworthiness, respectively), described her therapy experience as a “waste of time” and her therapist as “unhelpful and impersonal.”

Despite these two inconsistencies, other participants’ scores on the CRF-S were generally consistent with their stated views of their therapy experiences. For example, Participant #3, whose total score was 43 (14, 14, and 15 on attractiveness, expertness, and trustworthiness, respectively), was quite clear in her interview that she did not
have a positive therapy experience: “I wasn’t happy or satisfied with my time with her. Which is kinda why I ended it. I just didn’t like her, to be honest, and I didn’t appreciate some of the comments or the way she approached things.” Another participant, whose total score was 76 (23, 27, and 26 on the attractiveness, expertness, and trustworthiness scales, respectively), who reportedly had a positive experience, described her therapist as “respectful and validating” and stated that she liked that she “let the patient do the talking and let the patient teach you.”

Interestingly, two participants (#4 and #8) rated their therapists high on attractiveness and trustworthiness and low on expertness, suggesting that perhaps they viewed their therapists positively as people but not as skilled in incorporating faith into therapy. For example, Participant #4 stated:

“From early on I felt like his answers were one size fits all. He would say things that didn’t relate. He would just sometimes say, ‘Well, you know, that is to be expected.’ He would sympathize. In his face I saw sympathy and empathy but he just gave me no…no feedback as far as anything pertaining to Christianity.”

Participant #8 explained:

“At one point we were talking about how my relationship with God does factor into the way I live life. And he said, ‘I would love to give you some input here, but I am just not qualified.’ He said, ‘I can’t help you with this, but it is important. I am sure someone can really help you a lot more that I can. It is not my role.’ And it felt very comfortable as he said it. After he said that I said, ‘Yeah, I agree with you. That makes sense.’ It didn’t feel awkward.”

Consistency was found between participants’ scores on the WAI-S and
the narratives. For example, Participant #8, who scored 69 on the WAI-S total score and 25, 24, and 25 on the tasks, bond, and goals scales, respectively, reported a strong bond with his therapist: “It felt like there was a desire coming from him to understand where I was coming from and what I was experiencing. It felt like a whole lot more understanding because of the warmth that he had.” Another participant (#6), who scored 65 on the total score and 23, 26, and 24 on the tasks, bond, and goals scales, respectively, said, “I felt very comfortable talking with him...so our rapport was immense.” She described the therapist as “very professional, empathic, warm, and caring” and expressed satisfaction with his incorporation of her faith into therapy.

In contrast, Participant #1, who scored 11 on the tasks subscale stated, “It [therapy] wasn’t helpful. It was like, are we going to do this [imagery exercise] again this week because I just can’t get in that mode every week. I am not some strange hippie. That is not Christianity.” Participant #4, who had a relatively high bond score (20) but low task (11) and goal (12) scores, described disappointment with the goals but not her feeling towards the therapist: “He was a nice person and very friendly but he was not giving me any…he wasn’t helping me set any goals…he wasn’t helping me to realize why I felt the way I felt.”
Chapter IV

Discussion

According to several authors, many Christians are skeptical of psychology (Almy, 2000) and fear that their religious beliefs will be misunderstood, unappreciated, ridiculed, or eroded in secular therapy (King, 1978). Worthington and Scott (1983) pointed out that many Christians fear that secular therapists “will not accept or work within the religious client’s values, or will try to change the client’s values to be less religious and more secular” (p. 318).

In order to provide culturally competent care to Christian clients, research is needed with this population to determine what contributes to positive therapy experiences. Most studies with Christians, however, have been analogue experiments with non-clients (e.g., Guinee & Tracey, 1997; Keating & Fretz, 1990). Given the scant research on therapy with actual Christian clients, the purpose of the present discovery-oriented study was to understand Christian clients’ phenomenological experiences in secular therapy. Based on the social influence theory literature (e.g., Strong, 1968; Strong & Matross, 1973), this study examined the factors that facilitate or hinder these clients’ perceptions of their therapist’s attractiveness, trustworthiness, and expertise, as well as the therapeutic alliance.

Results of the qualitative analysis suggested various factors that contributed to positive and negative therapy experiences for participants. Interestingly, many participants’ therapy experiences were not uniquely positive or negative and were rather mixed, despite having been asked to endorse either a positive or negative therapy experience on the demographic questionnaire. For example, one participant
indicated having had a positive experience but described her therapy experience in the interview as very poor. When asked about this discrepancy, the participant explained that it was positive because had assertively told the therapist that she would be terminating treatment because it was not helpful.

The thematic results suggested therapeutic attitudes and behaviors that were seen as contributive to positive and negative therapy processes and outcomes. With regard to therapist attitudes, participants discussed finding it helpful when their secular therapists took a “humble” approach toward their religious beliefs. Participants appreciated when their therapists were open to learning about what their faith meant to them or asked questions when their religious practice or beliefs were not understood (e.g., speaking in tongues, going to the altar). In contrast, participants who had negative therapy experiences described their therapists as “talking at clients (Participant #2)” rather than asking or allowing them to explain what their faith meant to them. Participant #2 explained that she felt judged when her therapist “talked at” her and “imposed her own religious beliefs.”

Participants also reported that having control over of how much, when, and how to discuss their religious beliefs was important. In fact, some participants reported having chosen to see a secular therapist so as not to feel pressured to discuss their faith and to have control about when and how much to discuss. Participants reported appreciating therapists who let them decide when to discuss their faith, rather than having an “agenda.” In contrast, one participant who had a highly negative therapy experience indicated being frustrated that her therapist kept raising the issue of her faith, which was not her preferred therapy focus. Another participant, who was also dissatisfied,
reported that her therapist had her own “agenda” in terms of how to incorporate
Christianity in therapy. This participant indicated being highly dissatisfied with her
therapist’s approach of “going into the fear of the light” and believed that her therapist
used this technique out of ignorance.

Whereas some participants wanted autonomy discussing their faith, others wanted
their therapists to bring up their faith in order to open the door for a discussion of beliefs.
For example, one participant indicated that if her therapist had simply “brought up God”
or asked her about the Christian organization she mentioned being a member of that she
may have felt more comfortable discussing her use of faith to cope with her struggles.
This participant, along with another participant, reported being unsure if secular
therapists were even “allowed” to talk about religion in therapy. They reported
wondering about this norm when their therapists ignored or changed the subject of
Christianity. Other participants indicated being hesitant because they worried that their
therapists would not think faith was relevant to therapy or would minimize their religious
concerns.

Similarly, some participants discussed feeling “vulnerable” when mentioning
their faith due to uncertainty about their therapists’ response. These individuals indicated
a fear of being judged or misunderstood for their religious beliefs. For this reason, they
“tested the waters” to see how their therapists would respond to religious material. One
participant mentioned that it was easier sharing her abuse history than talking about her
faith. Another participant discussed fearing that her therapist might emphasize the
negative aspects of Christianity rather than focus on the concerns that brought her into
treatment, which had happened to her in the past.
Many of the participants who reported having a positive therapy experience indicated that their therapists included their faith in the treatment. These participants reported appreciating their therapists’ “interweaving” of their faith by referring to it and inquiring about it. Also, many participants reported finding it helpful when their therapists asked how they might use their faith to cope and encouraged them to use faith as a coping mechanism (e.g., praying, going to church). By contrast, most of the participants who had a negative experience mentioned having wanted more incorporation of faith; they also specifically indicated wishing that their therapists had encouraged them to use their faith to cope.

The four participants who reported having negative therapy experiences were quite clear that their experiences were negative. Other than stating that their therapist was a “nice person,” these participants generally had little else to say about their therapists. Interestingly, all of these participants mentioned that their therapists’ mishandling of their religious issues was only one of many reasons for their dissatisfaction, suggesting that the quality of the therapy for these participants may have been poor in other respects as well. One participant (#2) explained that therapy was already not going well and that “when religion was thrown in, it got all the more weird.” These participants’ reasons for their negative feelings ranged from being disrespected (e.g., when the therapist referred to God as “he or she”) or challenged (e.g., about the rigidity of the client’s beliefs) to their therapists ignoring their faith. Some participants avoided talking about their faith, even though they wished to, having sensed their therapists’ discomfort, as evidenced by changing the topic or not pursuing the topic.

It is important to note that despite exhaustive efforts to recruit individuals
who had had either a positive or a negative therapy experience, it was particularly
difficult to recruit participants who had negative experiences. One can only speculate as
to why participants did not easily come forward. Perhaps these clients were reluctant to
be interviewed by someone in the field of counseling psychology. Another possibility is
that, overall, fewer Christian clients have had negative experiences with secular
therapists, as compared with those who have had generally positive experiences.

The narratives were also informative about participants’ preferences for a
Christian therapist. Some participants saw a secular therapist out of necessity, i.e., due to
insurance reasons or unavailability of Christian therapists. In general, participants who
wanted to work with a Christian therapist wanted to receive religious guidance and
encouragement to use their faith to cope with their struggles. Of the five participants who
would have preferred a Christian therapist, four indicated that their therapy experience
was a positive one, despite their therapists’ limitations in terms of discussing religious
issues. One participant, for example mentioned that his therapist respectfully explained
his lack of qualification to help him with his religious questions. This participant
understood his therapist’s reasoning and felt validated nonetheless. This participant’s
reaction contrasted with that of another participant, (#10) who described feeling
invalidated by a secular therapist who said that she could not help her and suggested that
she speak with a pastor.

The quantitative data provided another perspective on the research questions and
generally were consistent with the narrative themes. Results showed that the WAI-S was
more sensitive than the CRF-S to participants’ general therapy experiences. That is,
whereas all but one participant rated their therapists highly on expertness,
attractiveness, and trustworthiness, there was greater variability in therapeutic alliance scores. Specifically, two participants who described having negative experiences rated their therapists relatively high on expertness, trustworthiness, and attractiveness but saw the alliance as poor. It may be that these participants viewed their therapists favorably, in general, but as inadequate in relating to their specific needs.

The quantitative results also shed light on social influence theory (Strong, 1968; Strong & Matross, 1973). The results indicated that participants who had a positive therapy experience reported that their therapists were non-judgmental, open to incorporating their religious beliefs into treatment, and discussed faith as a coping strategy, which suggests a strong personal connection. Further, several participants stated that this bond developed from the intake when they shared with their therapists the important role of faith in their lives and received validation. Taken together, the CRF-S and WAI-S results indicate that therapists can be seen as having positive characteristics even when the working alliance is not strong due to major differences in perspectives.

Comparison with Previous Research

The present results support previous research that suggests that therapists who work with clients whose issues include religion and spirituality (Shafranske & Malony, 1990), tend to be open to discussing these issues in therapy (Johnson & Hayes, 2003; Weinstein et al., 2002). Nonetheless, as was found in other studies (McMinn, 1996; Shafranske, 1996; Shafranske & Malony, 1990), the present participants often saw their therapists as unprepared to work competently with religious material. Indeed, a number of participants reported noticing their therapists’ discomfort with issues related to faith and perceived that their therapists avoided the topic. This avoidance is consistent
with Mack’s (1994) point that some therapists avoid religious discussions in therapy or are ambivalent about having such discussions either to avoid imposing their own values or because of personal struggles with religious or spiritual beliefs.

Richards and Bergin (1997, 2005) suggested that clients “may not wish, or may not believe it is appropriate, to discuss [religious] issues in therapy” due to their awareness of the “religiosity gap” between psychologists and the general public (p. 124). In contrast, similar to Quackenbos et al. (1985) and Rose et al. (2001), the present religious participants wanted to discuss religious issues, but some were unsure if therapists were “allowed” to discuss religious issues or if the therapists would view such discussions as relevant. In fact, inclusion of religion was a distinguishing factor in that participants with positive experiences expressed appreciation for the inclusion of their faith in treatment, whereas participants with negative experiences expressed wanting more discussion of their faith, even if “just a little bit.”

Many participants in the current study reported expecting secular therapists to be able to “handle” religious material and work effectively within this worldview. This expectation is consistent with Belaire et al.’s (2005) analogue study, which found that participants expected Christian therapists as well as therapists whose beliefs were unknown to integrate some religious discussion into therapy.

Similar to the results of Knox et al. (2005), who interviewed clients (not specifically Christians) about their therapy with secular therapists, helpful discussions regarding faith were facilitated by therapists’ openness. Unlike Knox et al.’s findings, however, the current results indicated that helpful discussions about faith were initiated by both clients and therapists. Participants explained that their therapists raising
the issue of faith was helpful as it indicated to them that the issue was appropriate for therapy. Similar to the results of Knox et al., unhelpful discussions led participants to feel judged and occurred when therapists imposed their own beliefs.

Knox et al. (2005) reported that their participants did not bring up religious issues even though they wanted to, due to a fear of being judged and due to discomfort based on perceived religious differences with their therapists. Some of the present participants also described fearing being judged and being uncertain about how their secular therapists would react to discussions of faith. However, participants in the current study also avoided bringing up their faith due to (a) perceiving their therapists’ avoidance and discomfort with religious issues, (b) fearing being misunderstood, (c) not knowing if such discussions were allowed or seen as relevant by therapists, (d) fearing that the therapist would minimize religious concerns or emphasize the negative aspects of Christianity, and e) experiencing negative reactions from their previous secular therapists. These results are also similar to King’s (1978) study with Christians, which found that clients were skeptical of counseling and feared that their religious beliefs would be misunderstood, unappreciated, ridiculed, or eroded in secular therapy.

Some researchers (e.g., Keating & Fretz, 1990) found that relatively more religious Christians tend to be more negative in their anticipations about non-Christian therapists. Other researchers (e.g., Belaire et al., 2005; Guinee & Tracey, 1997) found, however, that the strength of religious belief does not moderate expectations for secular therapy. Specifically, Guinee and Tracey asked non-client participants to rate potential therapists, both secular and Christian, on qualities such as expertness, attractiveness, and trustworthiness. Results indicated that participants, despite their level of
religiosity, did not rate secular therapists more unfavorably than Christian therapists. Interestingly, these findings echo the present results in that participants, even those who had negative therapy experiences, generally rated their therapists positively in terms of the social influence characteristics.

**Implications for Practice and Training**

It was anticipated that examining the experiences of Christians who had participated in secular therapy would provide clinically useful information for secular therapists. Further, the results were expected to have implications for training, which is an area that is less developed (Brawer et al., 2002; Schulte et al., 2002).

It is reasonable to expect that some Christian clients who present for secular therapy may be reluctant to work with a secular therapist, but this is not uniformly the case. As the present study demonstrated, some participants intentionally seek out secular therapists because they prefer a less biased perspective and want to control how much to incorporate their faith into treatment. Further, some Christian participants wish to have their faith interwoven into the treatment, whereas others prefer or expect it to play a minor role. Nonetheless, all participants in this study wanted their faith to be included somehow as it is an important part of their identity. These results suggest that it would be beneficial for therapists to ask clients about their expectations for discussing religious beliefs.

A broader issue is how to make clients feel comfortable discussing their faith, as many participants described being reluctant to share this aspect of themselves, even though they wanted to. Results suggest that creating safety for clients to discuss their religious identity and beliefs could begin upon intake. Therapists could ask about
clients’ coping methods or specifically about religion and spirituality. If clients discuss faith, it seems most important to follow up with specific questions in order to gain deep understanding of a client’s faith and its role in her or his life. In addition to providing information about the client, this questioning would convey to clients that they are allowed to talk about their faith and that it is relevant. Doing so seems particularly important for clients who are highly religious. Because some clients may “test the waters” to see if it is safe to discuss their faith, it would be beneficial for therapists to follow up when the issue is raised and inquire explicitly about the client’s faith.

Results also suggest that a delicate balance needs to be made between giving clients autonomy to decide how much and when to discuss their faith and raising the issue of faith for discussion. It appears to be helpful to let clients take the lead in raising issues for discussion, but it is equally important to convey an openness to discussing clients’ faith. Because some clients may not know if these discussions are acceptable or appropriate, therapists should follow up when clients make even oblique reference to Christianity, such as mentioning being a member of a Christian organization. As Griffith and Griffith (2002) suggested, therapists should listen for the use of words or phrases with religious undertones such as “I felt so at peace,” “I deserve this punishment,” or “It’s in God’s hands” and then gently and respectfully inquire about the meaning of such statements.

The primary reason the present clients gave for wanting to see a Christian therapist were to obtain religious and spiritual guidance, and particularly to receive encouragement to use their faith to cope with difficulties. Further, the current results suggest that therapists’ encouragement to “use” their faith is especially important.
Therefore, therapists can facilitate the therapeutic alliance by encouraging clients to use their faith (e.g., by praying, going to church, talking to a trusted friend or religious leader) to cope with their personal difficulties.

Naturally, many therapists may find themselves unable to assist their clients with religious or spiritual questions. One participant in the current study explained that his therapist conveyed being unable to help him with his religious issues but did so in a way that was respectful, validating, and non-shaming. This participant was satisfied with therapy, despite his therapist’s limitations in the religious area of his life.

Regardless of having had a positive or negative experience, some participants mentioned having had a hard time telling their therapists that they were struggling. Additionally, some participants discussed being concerned about the image they may have portrayed to their therapists about Christianity. Being aware that clients may be filtering, or may be tempted to filter what they say, may help therapists understand why their clients are holding back. In some cases, it may be appropriate to ask a client if he or she is concerned about portraying a negative image of Christianity. Having such candid discussions would likely affect the therapeutic alliance positively.

Finally, the results of this study have implications for training. Although the profession has begun to acknowledge religion and spirituality as one aspect of multiculturalism, many clinicians receive minimal training, supervision and coursework in this area (Brawer et al., 2002). Knox et al. (2005) wrote:

“As we train students to incorporate other multicultural factors in therapy effectively (e.g., race, age, socioeconomic status, sexual orientation), we need also to educate them to explore the impact of clients’ and therapists’ religious-
spiritual orientation on therapy content and process.”

Some therapists report feeling unprepared to work competently with religious material (McMinn, 1996; Shafranske, 1996; Shafranske & Malony, 1990). The results supported this finding, as a number of participants acknowledged that they could sense their therapists’ discomfort with the topic. This finding suggests that graduate student training should include how to discuss religious issues with clients and the importance of doing so for many Christian clients.

Limitations

A limitation related to internal validity is that this study, as all qualitative studies, may be influenced by subjectivity of the research team. However, the use of multiple judges and an auditor who came to consensus during the data analysis process assisted in reducing bias.

Another limitation of this study is that it relied on client self-report rather than observation of actual behavior in therapy. It is possible that participants were unable to recall details of their experiences. Effort to mitigate memory problems was made by only including participants who had been in therapy within the past year, but it is nonetheless possible that participants may not have been able to remember their experiences accurately. Accuracy of this study is further limited because only clients’ perspectives of the therapy was examined, not the therapists’ perspectives, which may be quite different.

In terms of the sample, there was little diversity, inasmuch as all participants were Caucasian, and all but two individuals were women. Further, four participants were doctoral students in a Christian-based clinical psychology program, which could have biased the sample. Their perspectives are likely to be quite different from
individuals who do not have specialized professional training. Additionally, the sample lacked diversity in terms of educational level, as all participants reported having at least an associate’s degree. It is unknown whether Christian clients with higher educational attainment are more open to seeking secular therapy.

Research with Christian individuals is inherently difficult given the diversity in which individuals define their faith. While religious denominations provide a guiding framework, individuals may interpret their religious denomination’s creeds uniquely. In the present study, the call for participants was for “Christians” which drew a diverse sample of Christian individuals. Given the qualitative design of this study, a more homogenous Christian sample may have been preferable, by specifically recruiting Evangelical Christians. Nonetheless, the participants’ narratives suggest that all but one participant was moderately or highly religious and attended church services weekly; moreover, descriptions of their faith and its meaning in their lives indicated similarity in (a) the role they ascribed to Jesus Christ, i.e., as a guiding force, and (b) religion as a priority in their lives.

Finally, despite an effort to interview two equal samples of participants, those who had had negative and those who had had positive experiences in secular therapy, the sample contained almost twice as many individuals who had had positive experiences. Although the within-sample comparisons were inherently consistent, supporting the validity of the themes, conclusions based on these comparative analyses should be considered cautiously.

Directions for Further Research

Given that the present study only examined clients’ perspectives on
positive and negative aspects of therapy experience, future research could examine therapists’ perspectives, particularly because some therapists seem to avoid addressing religious material in therapy. Mack (1994) suggested that therapists may feel ambivalent about addressing spiritual issues with clients, either to avoid imposing their own values or because they have personal struggles with religious or spiritual beliefs.

Several of the participants who described having a primarily negative therapy experience reported noticing their therapists’ discomfort with discussions about faith, which led to avoidance of these topics. It would be useful to conduct future research that helps develop and assess training programs to help therapists effectively work with the Christian population.

Finally, because of the limited gender and racial diversity in the present sample, it would be important to examine what facilitates positive therapy experiences for men and for Christians of color. Future research is also needed to investigate diversity within Christianity in terms of degree of conservativism (i.e., the extent to which individuals view the Bible as literal) in relation to preference for and experiences in secular therapy. At present, there is little consensus in the literature about defining Christian religious orientation. Specifically, many studies defined their samples as “Christian” or “Conservative Christian” but failed to specify how the authors determined their participants’ degree of conservatism. Having a clear definition of Christian self-identification is important for future research along these lines, given some evidence that strong agreement with the doctrines of the Evangelical Christian church is associated with a lower likelihood of seeking psychotherapy (King, 1978). Also, as Christianity in the U.S. has evolved in the past 30 years since King’s study, research examining
King’s findings about Christians’ help seeking behaviors is important to conduct to determine if the findings still hold true today given the implications for practice and training.
References


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research, practice. New York: Guilford Press.


Unpublished test manual, Department of Psychology, University of Florida.


Appendix A: Counselor Rating Form – Short Form

Instructions: Each characteristic is followed by a 7-point scale that ranges from “not very” to “very”. Please circle the point on the scale that best represents your therapist.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Not very</th>
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<th>3</th>
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<th>5</th>
<th>6</th>
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Appendix B: Working Alliance Inventory – Short Form

Instructions: As you read the sentences, mentally insert the name of your therapist in place of ______ in the text. If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

1. ______ and I agree about the things I will need to do in therapy to improve my situation.

   Never   Rarely    Occasionally    Sometimes    Often    Very often    Always
   1       2            3            4             5           6            7

2. What I am doing in therapy gives me new ways of looking at my problem.

   Never   Rarely    Occasionally    Sometimes    Often    Very often    Always
   1       2            3            4             5           6            7

3. I believe ______ likes me.

   Never   Rarely    Occasionally    Sometimes    Often    Very often    Always
   1       2            3            4             5           6            7

4. ______ does not understand what I am trying to accomplish in therapy.

   Never   Rarely    Occasionally    Sometimes    Often    Very often    Always
   1       2            3            4             5           6            7

5. I am confident in ______’s ability to help me.

   Never   Rarely    Occasionally    Sometimes    Often    Very often    Always
   1       2            3            4             5           6            7

6. ______ and I are working towards mutually agreed upon goals.

   Never   Rarely    Occasionally    Sometimes    Often    Very often    Always
   1       2            3            4             5           6            7

7. I feel that ______ appreciates me.

   Never   Rarely    Occasionally    Sometimes    Often    Very often    Always
   1       2            3            4             5           6            7
8. We agree on what is important for me to work on.

   1  2  3  4  5  6  7
   Never Rarely Occasionally Sometimes Often Very often Always

9. ______ and I trust one another.

   1  2  3  4  5  6  7
   Never Rarely Occasionally Sometimes Often Very often Always

10. ______ and I have different ideas about what my problems are.

   1  2  3  4  5  6  7
   Never Rarely Occasionally Sometimes Often Very often Always

11. We have established a good understanding of the kinds of changes that
    would be good for me.

   1  2  3  4  5  6  7
   Never Rarely Occasionally Sometimes Often Very often Always

12. I believe the way we are working with my problems is correct.

   1  2  3  4  5  6  7
   Never Rarely Occasionally Sometimes Often Very often Always
Appendix C: Religious Commitment Inventory – 10

Instructions: Please rate the following items on a 1 to 5 scale, in relation to Christianity.

1 = not at all true of me
2 = somewhat true of me
3 = moderately true of me
4 = mostly true of me
5 = totally true of me

1. I often read books and magazines about my faith.
2. I make financial contributions to my religious organization.
3. I spend time trying to grow in understanding of my faith.
4. Religion is especially important to me because it answers many questions about the meaning of life.
5. My religious beliefs lie behind my whole approach to life.
6. I enjoy spending time with others of my religious affiliation.
7. Religious beliefs influence all my dealings in life.
8. It is important to me to spend periods of time in private religious thought and reflection.
9. I enjoy working in the activities of my religious organization.
10. I keep well informed about my local religious group and have some influence in its decisions.
Appendix D: Demographic Questionnaire

1. Gender: Male___ Female ___

2. Age: ___ years

3. Race/ethnicity:
   - Asian, Asian American/Pacific Islander ___
   - Hispanic or Latino(a) ___
   - White, not Hispanic/ Latino(a) ___
   - Black, African American ___
   - Native American ___
   - Multiracial (please specify) ______________________
   - Other (please specify) __________________________

4. Marital status: ___ Single ___ Never married ___ Cohabitating with a partner ___
   - Separated/divorced ___ Married ___ Remarried ___ Widowed

5. Highest education level:
   - ___ Some high school ___ High school diploma ___
   - Some college or technical school ___ Associate’s degree ___ Bachelor’s degree ___
   - Some graduate school ___ Graduate degree ___ Other

6. State of residence: __________________________________________________

7. Religious denomination:

   __________________________________________________

8. Church attendance in the past year:
   - ___ daily ___ weekly ___ monthly ___ occasionally ___ never

9. Religious denomination of your family of origin:

   __________________________________________________

10. Number of separate times you sought therapy over your lifetime:

    ______________________

   The following questions refer to the therapy experience you will talk about for this
   study. That is, the highly positive or highly negative experience you had with a
   secular therapist within the past year.
11. Overall, how would you describe your therapy experience?

___ Highly Positive ___ Highly Negative

12. Approximate amount of time spent in the therapy experience you will discuss for this study: ___ years ___ months or ___ weeks

13. Primary reason for seeking this therapy (briefly describe):

______________________________

14. Professional specialization of your therapist:
   Master’s level counselor ___
   Psychologist ___
   Psychiatrist ___
   Social Worker ___
   Nurse ___
   Other (please specify) ________________

15. Setting of the therapy: ___ private practice ___ hospital ___ community clinic ___ university counseling center ___ Other (please specify) ________________
Appendix E: Interview Protocol

General and contextual questions about participants’ religious affiliation and the role of religion and spirituality in their lives.

1. How do you define religion and spirituality for yourself? Do you identify with a particular religious group?
2. What role does your religion or spirituality play in your life?

General experience addressing religious and spiritual issues in therapy.

3. How were you referred to your therapist?
4. How long ago was your first session?
5. How many sessions did you have?
6. What kind of setting did your therapy occur?
7. Did you look for a Christian therapist or did it not matter?
8. What brought you into therapy?
9. Can you please describe the primary issues addressed in therapy?
10. Did you know what your therapist’s religion was? (If yes, how did you know? If no, did you have any impression of his or her religion?)
11. Were there any religious/spiritual issues discussed in therapy? If yes, please describe.
12. What are your thoughts on discussing religious or spiritual issues in therapy? Was it important/not important for you to discuss it, and why?
13. What was your general experience talking about religious or spiritual issues in therapy?

Critical incident that resulted in feeling either highly positive or highly negative about therapy.

14. Please describe a critical incident, or a turning point that occurred with your therapist that resulted in your feeling either highly positive (or highly negative) about your experience? Or was it the experience as a whole that resulted in feeling either especially positive or especially negative about your experience?

Relationship with therapist/therapist characteristics.

15. Can you describe in as much detail as possible your relationship with your therapist? How would you describe your therapist?
16. How open was your therapist to discussing religious or spiritual issues in therapy? What leads you to this conclusion?
17. Do you think your therapist understood your religious or spiritual beliefs? What makes you think this?
18. Do you think your therapist understood the impact of your religious background on your presenting issues and concerns?

Satisfaction with therapy.
19. Please discuss the extent to which you were satisfied or dissatisfied with the ways that you and your therapist addressed your presenting concerns and issues.
20. Please discuss the degree to which you felt satisfied or dissatisfied discussing your religious or spiritual issues in counseling.
21. Is there anything that you were reluctant to discuss with your therapist? Was it because of your religious beliefs or in any way related to your therapist’s religious beliefs or affiliation?
22. How/why did you leave therapy?
23. Is there anything else that you would like to add that you haven’t mentioned?
Appendix F: Solicitation flier


- Participation involves filling out a brief survey and being interviewed by phone for 30 mins to 1 hour about your therapy experience.

- To thank you for your participation, I will send you a check or money order (your preference) for $25.

- PARTICIPATION IS CONFIDENTIAL

- WHY PARTICIPATE? Your participation will contribute to the field of counseling—specifically giving counselors a better understanding of what is helpful and unhelpful when working with Christian clients.

- You are eligible if:
  - You saw a secular therapist (not Christian counseling) at least three times within the past year.
  - You are no longer in therapy with this therapist.
  - You are 18 years of age or older.

- If you would like to participate in this research study, please go to https://www.psychdata.com/s.asp?SID=125073 or contact Carrie at cragun2@gmail.com
Appendix G: Consent Form

Positive and Negative Experiences of Christian Clients in Psychotherapy:
A Qualitative Investigation

Carrie Cragun
University at Albany, State University of New York

Hello!

My name is Carrie and I am a doctoral candidate in the Counseling Psychology program at the University at Albany, State University of New York. I am writing to ask for your help with my dissertation research, which is a study of positive and negative therapy experiences of Christians. I would greatly appreciate your participation, if your experience in individual psychotherapy was either very positive or very negative and was completed within the past year.

I am defining a positive experience as one that a person experienced as especially helpful that led to positive changes in his or her life. A negative experience is one that a person experienced as unhelpful or that had a negative impact on his or her life. If your experience with therapy fits either of these descriptions and you are interested in participating, please press “continue” at the end of this document to indicate your consent to take part.

After pressing “continue,” you will be asked to complete a brief survey online. Once you complete the survey, I will e-mail or call you to set up a telephone interview.

The interview will focus on questions about your experience in therapy and will last approximately one hour. The interview will be audiotaped and transcribed, with all personal identifying information about you deleted. I will send you a copy of the transcript afterward to be sure that it conveys what you intended to express and for you to include additional thoughts you may have had after completing the interview. I will incorporate any comments you offer into your transcript. At a later point, I will send you the results of my study to see if you have any feedback. Giving feedback is completely optional. To thank you for your participation in this study, I will pay you $25 (either check or money order—your choice).

Your participation in this project is voluntary. Even if you agree to participate or sign the informed consent document, you may withdraw from the study at any time. There is no penalty for withdrawing. I do not anticipate any risk in your participation, but in order to minimize any possible discomfort, you may choose not to answer any question for any reason. The benefit of participating in this study is the opportunity to reflect on your past therapy experience. It is my hope that publication of the general results of the study will provide helpful information to therapists working with Christian clients.
Your confidentiality will be protected. The only identifying information will be your signature on this consent form. In order to preserve confidentiality, I will use the code number you create, rather than your name, to match your interview transcript with the questionnaires you fill out. All information obtained in this study is strictly confidential unless disclosure is required by law. In addition, the Institutional Review Board, the sponsor of the study, and University or government officials responsible for monitoring this study may inspect these records.

Should you have any questions, you can contact me at (518) 598-6264 or by e-mail at cragun2@gmail.com. You may also contact my faculty advisor for this project, Dr. Myrna Friedlander, by phone at (518) 442-5049 or at mfriedlander@uamail.albany.edu. If you have any questions concerning your rights as a research participant that have not been answered by the investigator or if you wish to report any concerns about the study, you may contact the Office of Research Compliance at (518) 437-4569, 800-365-9139, or orc@uamail.albany.edu. One copy of this document will be kept together with the research records of this study.

I sincerely thank you for taking the time to participate in this study.

If you agree with these statements and consent to participate, please click on the 'Continue' button below.