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All members of CAPS receive the JPC as one of the several benefits of membership. Annual CAPS membership dues are $80.00 for Regular Members and $40.00 for Associate Members (students, paraprofessionals, and retired). Library subscription rates are $50.00. Membership and subscription rates are for the calendar year. Information on membership may be obtained by contacting the CAPS Executive Director, P.O. Box 310400, New Braunfels, TX 78131-0400. (Telephone: (210) 629-CAPS; FAX (210) 629-2342.) All issues still in stock for a given year are sent to new members who join by May 31.

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Individuals and organizations who wish to advertise professional opportunities that are compatible with the purposes of CAPS and the editorial policies of the JPC should contact the Managing Editor at the address noted on the masthead for rates, publishing procedures, and deadline dates.
PUBLICATION POLICY OF THE
JOURNAL OF PSYCHOLOGY AND CHRISTIANITY

Material in the following areas will be considered for publication:

1. Theoretical and research articles focusing on issues in psychology, theology, sociology, marital and family studies, social work, and related fields which can be useful to academic and applied communities in those disciplines.

2. Theoretical and research articles which have bearing on the relationship between psychology and Christian faith, including the interface of psychology with theology and the psychology of religion.

3. Applied articles treating current issues in clinical practice, pastoral counseling, family and community services, and similar matters involving the helping professions.

4. Articles dealing with the application of psychological theory and data to the work of the church, missions, and other Christian organizations.

5. Responses to current or past journal articles.

6. Book and journal reviews in fields relevant to psychology and theology.

INSTRUCTIONS TO AUTHORS AND BOOK REVIEWERS

Manuscripts:
Manuscripts should be submitted in triplicate to Peter C. Hill, Department of Psychology, Grove City College, Grove City, PA 16127. A brief biography including research and/or professional interests of no more than five lines must be submitted on separate pages.

JPC utilizes a blind review system. Thus, authors’ names, institutions, and other identifying information should appear on only one of the three submitted copies. All manuscripts should be in accordance with the guidelines of the American Psychological Association Publication Manual, 4th ed. This manual may be obtained from the Order Department, American Psychological Association, 750 First St., N.E., Washington, DC 20002-4242. (A brief summary of the American Psychological Association guidelines, emphasizing common stylistic issues, may be obtained without charge by writing the JPC Editor at his address above. Please include a self-addressed, 9" x 12" envelope with $.78 postage affixed.) Manuscripts should be limited to 25 pages, double-spaced typing, except under unusual circumstances. This limit should include figures, tables, explanatory footnotes and references. Manuscripts normally will be evaluated within three months.

Book Reviews:
Book reviews should be submitted in duplicate to Rodney L. Bassett, Roberts Wesleyan College, 2301 Westside Dr., Rochester, NY 14624. Book reviews should not exceed two to three pages, double-spaced typing. Unsolicited book reviews are welcome. Book reviews submitted are subject to editing and not all will necessarily be published.

Disclaimer: The ideas and opinions published in the JPC are not necessarily those of CAPS or its Board of Directors but are the sole responsibility of the individual authors. The JPC is designed to be a forum of discussion and exchange of any and all ideas relevant to the psychological and pastoral professions, in keeping with the historic spirit of CAPS.
Editor's Page

Peter C. Hill

This past summer I had the superb privilege of guest-editing along with Duane Kauffmann of Goshen College a special issue of this journal on the topic of integration. Our one regret with that issue was our inability to schedule the founding editor of the Journal of Psychology and Christianity, J. Harold Ellens. Not surprisingly, Hal was already committed to a number of writing projects and these precluded his immediate involvement in that issue, despite a strong desire on his part to engage in the dialogue. With pleasure, I am able to include Hal's thoughts on current efforts in the integration enterprise as the opening article in this issue. His article stands on its own; however, the interested reader may want to look back at the Guest Editors' Page (p. 99) of the Summer, 1996 issue (Vol. 15, No. 2) to understand the context within which Hal's comments have been tendered. As many readers of this page are aware, my predecessor's in-depth analysis and intoxicating style sends the reader on her way with new riches, even if in disagreement. I can assure you that, once again, Hal does not disappoint.

Mark McMinn and his colleagues at Wheaton College provide survey results of CAPS members' beliefs and behaviors concerning ethical issues. The research team uncovered some results that surely will be of interest to many readers. Later in this same issue, the research team of Meeks and McMinn provides a critical analysis of current research trends regarding forgiveness. By arguing that forgiveness is more than simply a therapeutic technique, they suggest that a thorough understanding of forgiveness requires that its transforming power, propelled by religious faith, be recognized.

The son and father team of psychologists W. Brad Johnson and William L. Johnson favor us with an insightful discussion on salient issues in treating conservatively religious dads. Their analysis is joined by a discussion of activities fostering social skills among children with Attention Deficit Hyperactivity Disorder by Emery Twoey. As has become our custom, three columns designed for the clinician are included prior to the section of book reviews.

It is my profound pleasure to work with capable scholars such as these who comprise this slate of authors. My hope is that others may benefit from their work as much as I.
ANNOUNCEMENTS

ANNUAL CAPS BUSINESS MEETING SCHEDULED

The Annual Business Meeting (ABM) of the Christian Association for Psychological Studies, Inc. (CAPS) will be held on June 20, 1997 in Bellevue, Washington. It will be held during a special luncheon in the ballroom of the Red Lion Hotel, in conjunction with the 1997 CAPS Convention. CAPS is your association and thus our financial and membership data are published and open to discussion, especially during the ABM. Be there and make your voice heard in how CAPS is directed by your Board of Directors and other servants of our nonprofit, charitable corporation.

THERE IS STILL TIME TO RENEW YOUR CAPS MEMBERSHIP

Time is getting very short to renew your CAPS membership for 1997 without a late-dues penalty! As we celebrate our 41st Anniversary Year, your commitment to CAPS is deeply appreciated. Won’t you help us make 1997 our best year ever? When you renew now, you’ll help us put more of your membership dollars to work for you.

By renewing now, you will receive the *Journal of Psychology and Christianity (JPC)* without interruption, will be kept apprised of upcoming international and regional conventions (at which members benefit from greatly reduced registration fees and hotel costs), and will continue to qualify for the many other benefits of CAPS membership. (If the 1997 membership renewal form that was mailed to all 1996 members in October is not readily available, telephone CAPS at (210) 629-2277—collect, if you wish—or FAX at (210) 629-2342—and a replacement form will be mailed to you immediately.)

VACATION IN THE GREATER SEATTLE AREA IN JUNE, 1997 DURING THE CAPS CONVENTION!

Plan to attend the CAPS ’97 Convention by reserving the dates June 19-22, 1997 on your planning calendar now. This will be our 44th annual get-together for professional growth, spiritual enrichment, food, fun and fellowship.

We will assemble in Bellevue, WA in the beautiful and comfortable Red Lion Hotel Bellevue, which is in the greater Seattle area. The area is naturally refreshing, especially as summer commences, and marvelously entertaining. Expand your attendance at the convention into a family (or personal) time of vacation.

You have already received publicity and a “Call for Papers.” Registration information and more publicity will continue to follow, through this Spring. However, start planning now to attend. In addition to reserving the dates June 19-22, 1997 now, think about participating in the program with a paper, or seminar, forum, workshop, interest group or poster session. See you there!
The Interface of Psychology and Theology

J. Harold Ellens
University of Michigan

Abstract

This article discusses the semantic issues in such terminology as the integration and interface of psychology and theology and defines principles for their interdisciplinary relationship as sciences. It suggests models for theology illuminating psychology and vice versa. This project is illustrated by observations upon the efforts of CAPS to wrestle with these issues. This inevitably unfolds some of the story of the author’s fifteen-year pilgrimage as Editor of JPC and Executive Director of CAPS and his endeavor to relate the sciences of psychology and theology, psychological experience and spirituality, emotional health and biblical faith. It claims that the relationship of psychology and theology is less a matter of integration of the two into each other’s framework, scientifically or intuitively, and more a matter of their interface for mutual illumination as sources of insight in which God’s truth is revealed.

Responding to the invitation to write this article on the interface of psychology and theology, I do so with three purposes in mind. I wish to present an articulate perspective upon the relationship between the disciplines of psychology and theology. In that connection I will describe in some degree my personal odyssey in the pursuit of this interface of sciences and their applications during my forty years of work in both scientific theology and clinical psychology. This latter inevitably requires me to comment upon that part of the interdisciplinary pilgrimage of American scholarship which was pursued by the Christian Association for Psychological Studies over the first forty years of its existence, and particularly during my fifteen years as the Executive Director and as the Editor of the Journal of Psychology and Christianity, including the years it was known as the CAPS Bulletin.

In that regard, it is the first claim of this article that psychology and theology, as discreet disciplines, are both sciences, in an equivalent sense, through which it is possible and necessary to discern the world of created reality. Thus, they are equivalently windows through which to read God’s self-revelation in the material world of humans and things. So both are essential scientific lenses through which the transcendent world of God’s reality may be discovered. Therefore, no one can claim to be serious about his or her scientific endeavors in these two fields if the investigative enterprise does not assume and involve an exhaustive process of illuminating psychological models and perspectives with the scientific insights of theology and illuminating theological models and perspectives with the scientific information of psychology.

The second claim made here is that the scientific underpinnings of theology, such as biblical interpretation, text analysis, linguistic studies, cultural data, literary-historical evaluations, archaeological investigations, and philosophical reflections, all of which are scientifically crucial to theology-formation, is an enterprise upon
which all the tools of human inquiry must be brought to bear in order to distill from the text the full range of cognitive and affective import, which the text carries and offers the inquirer. Among these tools are historical criticism, literary criticism, form criticism, redaction criticism, and textual criticism proper. Lately, some scholars such as Howard Clark Kee have attempted to bring sociological perspectives to biblical studies as the primary source of theology. Gerd Theissen has written on the psychological aspects of Pauline thought. The science and models of psychology must be employed as a lens through which to see any text, sacred or secular, and the theological concepts which they drive. Inevitably that will afford fresh and productive new dimensions of insights.

When the Christian Association for Psychological Studies was established forty years ago, it was the clear intent of its founders that the believing community should explore in a systematic way the manner in which our actual ontological relationships with God, as well as our psychological perception, experience, or projection of that relationship interfaces with our state of health. The assumption which I believe lay behind that concern was the conviction that the interface was definitive for our psychological and spiritual well-being as humans, together with the suspicion that that interface might also have much to do with our physical well-being. Moreover, it became clear from the kinds of papers which were read at the convocations of CAPS during its first two decades that it was the mind of the association that sometimes the nature of our personal religion or spirituality, our posture before the face of God, creates or expands psychological pathology and spiritual disfunction, while frequently our real or perceived relationship with God, the Bible, our faith tradition, and/or theology enhances health in body, mind, and spirit.

It was not the concern of the founders to drag the psychologically aware community, or indeed any part of the communities of faith and science, into questionable processes of mysticism, subjective pietism, para-psychology, spiritism, or the occult. It was very much the opposite; namely, to explore why it seemed to be at least heuristically and perhaps even empirically evident that wholistic health involves the self-actualization of the full range of grand potentials for growth with which God has invested humans by creating us in God’s own image in body (soma), mind (nous), psyche (psyche), and spirit (pneuma).

There was a corollary implication at the center of this charter for the scientific psycho-spiritual pilgrimage of CAPS. It was the notion, less formally defined perhaps than the first motivation for establishing such a community of inquiry, that if we could understand how religious faith interfaces with human health, theology with psychology, we would also see, conversely, how the psychological insights we have about the dynamics of human health and illness illumine the messages in the text of the Bible and hence should contribute to the content and shape of theology. In retrospect, that seems to have been a fruitful set of objectives and intuitive assumptions, which have become the focus of inquiry for a wider world of scholarship today. In any case, it was largely that two-sided trajectory of CAPS’ pilgrimage which became the channel for my personal and scholarly quest for the majority of my life and work.

**Exposition**

When I came to the position of Executive Director of The Christian Association for Psychological Studies in 1974 the scene was verdant, in both the evangelical and the progressive or mainline Christian communities, with a luxuriant growth of
models for exploring and conceptualizing the relationship between our faith and work, our religion and our profession, our theological and psychological sciences, our confessions and our careers as practitioners in the social sciences and clinical arts. On the one hand, such evangelical psychologists as H. Newton Malony, John Carter, Bruce Narramore, and others were beginning to write on these issues. On the other hand, such progressive scholars as Seward Hiltner, Don Browning, James Lapsley, LeRoy Aden, Colin Brown, Wayne Oates, Liston Mills, and others were producing a spate of sturdy volumes treating the interface of psychology and religion. Anton Boisen had, in many generative ways, parlayed his own serious psychoses into a series of models and proposals regarding the interface of psychology and theology which had sturdily set the stage for these later scholars. The work of William James had, of course, provided a useful framework of thought in the context of which to do the kind of work we were seeking to do. Whether one worked in his light or against his notions, he was the unavoidable rock to which one anchored or on which one was honed to a finer edge.

There were two interesting negative characteristics in that phase of the inquiry which I have spent my professional life endeavoring to heal. The first was that the evangelical community did not speak to or read the works of the progressive, then referred to as the liberal, community. Neither did the mainline scholars read the evangelicals or dialogue with them. Moreover, the second problem was that the evangelicals generally came to this inquiry into the relationship between theology and psychology from the side of scientific psychology, having been trained primarily as professional psychologists, mostly at the doctoral level. On the other hand, the progressives came to the inquiry from the side of scientific theology, having been trained primarily as professional theologians teaching in pastoral care departments at seminaries. Therefore, the evangelicals did not trust the progressives because they thought they did not know scientific psychology and were working mainly with an intuitive popularization of the field. The progressives did not trust the evangelicals because they thought they did not know scientific theology and were working mainly with an intuitive and primitive Sunday School religion, or the dogmatic categories and language of fundamentalism.

They were both in error, of course. Actually such scholars as Seward Hiltner, Don Browning, Peter Homans, and the like, were heavily trained in psychoanalytic and psychodynamic psychology. Moreover, Professor Malony is an ordained Methodist minister with a standard theological education who spent most of his teaching life addressing the issue which the evangelicals called the integration of psychology and spirituality. His evangelical colleagues were mostly well-informed persons who, even if they had little formal theological training, were biblically and spiritually reasonably well-informed and at least consummately honest. Moreover, it must be said for the evangelicals that they began to read the positions of and take seriously the dialogue with the progressives before the latter began to take them seriously. Don Browning was one of the progressives who by 1980 recognized that his colleagues needed to be reading the evangelical publications as thoroughly as the evangelicals had begun to read theirs. Today, it seems to me, the dialogue between the two communities runs on apace so that the names, evangelical and progressive, which once distinguished them, are becoming less and less useful at the levels of academic, clinical, and research operations.

However, there was a central problem in the framework within which the evangelical community generally tended to conceptualize the relationship between faith and
practice and between theology and psychology, and in the language used to express that relationship. Evangelical scholars have tended even to this time to describe the problem as that of the integration of theology and psychology. Two aspects of this language and its implied conceptual model are problematic. First, to think of the issue as that of integration suggests that the two components to be integrated in a unified model are in some way inherently disparate. Second, the categories of theology and psychology must be conceived of as being commensurate as scientific enterprises, not merely as a discussion between psychology and religion. Regarding the latter, it must be noted that religion is a psychospiritual practice which has a cultural character and cultic expression. It is a sociological process as well as an expression of a philosophico-theological worldview. Psychology and theology, on the other hand, are scientific and academic disciplines which express themselves, as sciences, in academic, clinical, and research operations.

Thus the religious counterpart of the discipline of psychology is the science of theology. So even if the issue were to be formulated as a problem of integration, it should at least be structured as the integration of theology and psychology as scientific disciplines and of psychological and theological worldviews. Addressing such matters as the integration of faith and life, of pastoral care and clinical practice, or of one’s religion and vocation are different though not unrelated matters.

Nonetheless, the word integration remains problematic because it suggests a model in which two disparate entities, psychology and theology, essentially alien to each other, must be lined up or force-fitted to each other in order to insure decent or responsible work in the helping professions or in theological understanding. There is a difference, of course, between the science of theology and that of psychology. Each has its own universe of discourse, each its own paradigms, arena of inquiry, database, objectives, and controls within the framework of scientific inquiry. Both depend upon empirical and heuristic data and methods. Each has its own forming and informing history, and each depends upon theory formation which must respond with integrity to the scientific constraints upon theory development and testing, and each must respond with integrity to its respective database. However, as science, both psychology and theology operate with essentially the same general models of method, coherence, and objectivity.

My perception has been consistently that what we really have always sought in the quest to understand the relationship between the scientific disciplines of psychology and theology, together with the relationship of their applied arts and the worldviews they afford us, is an interface of mutual illumination. This I argued with some vigor in my Finch Lectures in 1980 and in my 1982 publication, *God's Grace and Human Health* (pp. 19-36, 94-115). The question whether integration or interface of mutual illumination is the better term is an epistemological problem on the theoretical science level, a structural problem on the applied science level, and a problem of psychodynamic dissonance or harmony on the experience level.

There is also a theological problem which may be implied in the integration paradigm and for many evangelicals lurks only slightly below the surface of conscious thought; namely, that the truth value of data produced by psychology has a lesser valence than the truth value of the insights of theology or the message of the text of the Bible. To put it simply, there may be the assumption or the claim that the truth of the Bible is more truthful than the truth of psychology; more important divine revelation. I have vigorously contested this position, as have the scholars from the progressive community generally, largely on the theological grounds that
God reveals the divine self in nature and in grace, in Scripture and in creation, in faith and in work; and with equal valence since all truth is God’s truth and God does not speak with a forked tongue.

The Reformed tradition, for example, in which I have always stood, consistently has held out for the notion of God’s two books of creation and the Bible, even though the tradition used the terms of general and special revelation, respectively. Under the rubrics of this spiritually and scientifically rich Calvinist tradition, scientific inquiry into theology and spirituality stands on equal footing with scientific inquiry into the natural and social sciences, and vice versa. Both are seen as equivalent inquiries into God’s self-revelation. The world of truth is not conceived schizophrenically as divided into sacred and secular, in that sense. The immanent and transcendent categories of reality are not seen as alien to each other or in any sense discontinuous. Most of all, this material world is not seen, as it generally is in fundamentalism, as alien to God’s life but rather as God’s dwelling place, God’s home with us, God’s own design, domain, and delight.

Perhaps there is, therefore, a second theological problem implied in the integration model; namely, the notion that the revelation in creation is not merely different in value from that of Scripture, but that what we see through the science of theology and what we see through the science of psychology represent two radically different realms of ontological reality, specifically the world of the natural and of the supernatural. These terms have become largely nonfunctional in the thought world of the progressive community, though there has been an increase in such terminology as “material and transcendent worlds” and the like, as the positivism of enlightenment thinking has come under fire in recent decades. The rise of transcendental psychologies and the resurgence of transcendental theologies in the progressive community is a corollary to this post-enlightenment mindset.

The insights of the postmodern era regarding the impossibility of achieving a valueless scientific objectivity are crucial here, namely, the realization that all scientific theory development is born, in the first place, out of assumptions which are to some degree driven or shaped by one’s religious, theological, or value-laden predisposition. All the data one acquires, therefore, are not strictly speaking empirical data or objective rationality but rather the formulations of Reason Within the Bounds of Religion (Wolterstorff, 1976).

A Model of Mutual Scientific Illumination

To speak of a model of interface between two scientific enterprises or operational categories which offers mutual illumination between them is to suggest what may be called a perspectival model. This way of looking at the matter and of speaking of it would have found agreement from Seward Hiltner and most of the progressive community of scholars. There are three principles, I think, which such a model must reflect if it is to be a thorough-going expression of scientific and psycho-spiritual integrity.

First, theology and psychology are both sciences in their own right, stand legitimately on their own foundations and, when read carefully, are two equivalent sources of illuminating truth. Speaking theologically or religiously, they are two equivalent sources of God’s self-revelation in creation and Scripture, as I noted above. Conversely, speaking psychologically, they are two equivalent subjects of scientific study, assessment, and description. They are not alien in any inherent sense. When they seem at odds, paradoxical, or disparate in some way it must always be
because of a dysfunction on one of three counts. Either we have failed to do scientific theology well enough or we have failed to investigate the science of psychology thoroughly enough. Or, second, we have distorted the science of the theological or natural world by arbitrary dogmatism, not properly constrained by sound investigation of God's word/scientific truth in creation or in the Bible. Or, third, we have drawn erroneous conclusions in either of those investigations and not allowed each of the scientific disciplines to illumine the other adequately, honestly, or thoroughly.

Wherever truth is found, it is truth, God's truth, having equal warrant with all other truth. Some truth may have greater weight than other truth in a specific situation, but there is no difference in its warrant or valence as truth (Ellens, 1982, p. 24). If you have just been hit by a car and are bleeding from the jugular, the truth about blood pressure and arterial closure may be significantly more important at that moment than any product of theological science. There are undoubtedly other circumstances in which the opposite is the case. In any case, truth is truth, regardless of who finds it, where, or how.

Egbert Schuurman, at that time a professor of philosophy at Eindhoven Institute of Technology and lecturer at the Free University of Amsterdam, published in 1980 a work entitled Technology and the Future: A Philosophical Challenge and in that same year another book, Reflections of the Technological Society. These were only slightly preceded by the work of the distinguished Benedictine priest, Stanley L. Jaki, The Road of Science and the Ways to God (1978) and soon followed by Jaki's (1980) Cosmos and Creator. In these seminal works the authors developed the claim that, given the nature of human mind and personality, it is imperative to recognize that the mutual illumination of all scientific disciplines is essential to a full-orbed and honest achievement in any of them. These signal volumes were followed rapidly by a rich flow of useful interdisciplinary studies during the last decade and there seems to be no indication that this fecund quest will in any way abate in the century, indeed millennium, before us.

Second, the criterion of soundness in theory development or operational application of the illumination the sciences of psychology and theology bring to each other is not the effectiveness with which our psychological insights fit in with our theological worldview or our theological insights fit in with our psychological worldview, but rather whether they make discernible claims upon each other in a way that either requires modification of the other or makes the thoroughgoing understanding of the other more evident. Perhaps one could say that it has to do with the way in which one enlarges or resolves problems in the internal coherence of the other. Psychological data, insights, paradigms, or worldviews may be helpful in illumining a biblical text and/or theological proposition by enlarging the perception of the internal coherence of the text or proposition, resolving problems in the coherence of the text or proposition, or disturbing the supposed coherence of the text or proposition in a way that leads to an enlarged understanding of what the coherent message of the text or proposition is; as well as illumining the degree to which all of these conform to and account for the data about God and humans which arises in the database.

Comparably, theological data, insights, paradigms, or worldviews may be helpful in illumining the internal coherence or lack thereof in the living human document; namely, the patient in the clinical process or under research analysis, in a way that will discernably enhance the formulation of psychological models and propositions, clinical procedures, and the healing progress of that patient; as well as illumining
the degree to which the psychological project coheres with the imperatives of the data about humans (and God) which arises in the database. Such theological illumination may resolve problems or impasses in the process of the therapy, or may disturb the presumed progress only to lay bare deeper needs, coherence, or incoherence in the living human document (Gerkin, 1984). Similarly, theological light may illumine the process of theoretical work in psychology, enhancing the understanding of the living human document about which both sciences are concerned to take accurate account.

Third, the responsible function of the perspectival model of that interface which provides mutual illumination between the psychological and theological sciences requires an incarnational posture on the part of the scientist or practitioner. That is, for the illumination to take place, the person who brings the lights of psychology to theology and the biblical text or those of theology to psychology and the living human document must believe that each respective science has legitimate light to bring to bear and that that light is the light of truth incarnated in the understanding possessed by the scholar. This implies that the scholar perceives herself or himself as a midwife of the truth not merely a manipulator of insights or data.

In describing the operational application of these three principles to the enterprise of bringing theological illumination to the science and practice of psychology in my above-mentioned book, I enunciated eight biblical insights significant to the full understanding of the living human document: the patient in therapy (1982, pp. 27-36). These were the biblical theology of 1) human personhood, of 2) alienation, of 3) sin, of 4) discipline, of 5) grace, of the 6) wounded healer, of 7) mortality, and of 8) celebration.

These I followed with twelve practical applications of biblical theology to the psychotherapeutic setting. This is neither the time nor situation to explicate these in detail, but I list them for the sake of the completeness and symmetry of this article. They have to do with the biblical illumination of the 1) identity of the patient before God, the 2) certification of the patient's destiny as self-actualization of the Imago Dei, the 3) assurance the patient can derive from the radical nature of grace, the 4) inherent dignity of the patient as a creature of God despite his or her illness, the 5) assurance of the therapist that his or her task is not to take ultimate responsibility for the patient but to incite a finite growth process, the 6) affirmation of the patient's self-esteem in his or her certification as person before the face of God, the 7) permission to give up situation inappropriate or neurotic anxiety in a world where grace and providence reign, the 8) affirmation of transference and countertransference as sources of energy that can be employed for healing, 9) God's inviolable goodwill and not threat as the context of all of life in health or illness, 10) growth as the objective and purpose of existence, 11) freedom from the need on the part of the therapist and the patient to play God in therapy or in life, and the 12) recognition that mortality is acceptable, that is, that theology offers the opportunity for relief from the ultimate panic that stands as a specter behind all pathology. Because God is God and grace is grace, it is perfectly acceptable, even delightful, to age, wrinkle, watch one's youthfulness fade, and embrace the finitude of life; the messages of our culture to the contrary, notwithstanding!

**A Formal Model of Scientific Interface**

The biblical story is a paradigm of the human psychological odyssey and as such asserts an inherent union of experience in our history and, metaphorically at
least, in God’s history (see Miles, 1995). This idea has been explicated helpfully as well by John Cobb (1969, 1982) and the process theologians. The import of this centers in the realization that life for God, as Spirit, however mythically or ontologically we conceive of it, and the life of the human psyche cut across each other at such substantive levels as to effect the description and definition of both. Presumably the only thing we can know about God or the meaning and content of our God-talk is what we can understand through the perceptions and projections of the human person. So any theology about God, us, and the world is heavily dependent upon the cognitive and affective apperceptive processes of human beings. Thus to employ theology for insights regarding any reality requires the employment of a useful and warrantable anthropology and, therefore, a sound psychology. Conversely, to employ a proper psychology in the pursuit of truth also requires a useful and warrantable anthropology and, therefore, I claim, a sound theology.

Psychology and theology are, thus, inevitably interlinked regardless of what the immediate focus or concern of either is. Hence, whether we are exploring a biblical document or the living human document, the mutual illumination of psychology and theology is imperative because a properly enlightened anthropology is required for both. Moreover, the mutual illumination undoubtedly takes place precisely in the anthropology which is formed or forming in, which functions in, and which informs each discipline. Since both disciplines deal with the psycho-spiritual domains, either of these which ignores the other is not adequately serious about itself.

So one must come at each of these two disciplines with an eye to the other. This is likely to be true regarding the science which explores any other facet of the cosmos, as well, of course. Theology is barren without a comprehensive appreciation of creation, and creation ultimately can only be understood theologically, that is, in terms of its ultimate transcendent source, nature, meaning, and destiny. The natural and social sciences must inquire finally of theology and theology must listen and speak to the natural and social sciences in order to make sense of itself.

Psychology and theology exercise the stewardship of their mandates by collecting data, formulating theories for accounting for the data, and applying the interpreted data to operational concerns in their respective disciplines. Theory development in this process depends upon the weltanschaung, the pou sto from which one comes to the scientific enterprise. That means that behind the theory development and data collection or interpretation is a faith assumption, a belief regarding the nature and function of reality (see Wolterstorff, 1976). Thus, all scientific activity from data collection to theoretical or operational interpretation of the data has significant theological or spiritual as well as psychological import.

To this end, CAPS, from its outset forty years ago, began to publish its own work in the form of the annual Proceedings of the CAPS conventions. These volumes are still of great value and indicate the profundity of the investigations undertaken by the participants in that dialogue in those early years. Frequently, I note that studies done more recently for CAPS conventions or published in JPC are not alert to that early work and replow the same ground, often in less profound ways. In 1974 we moved from the publication of the Proceedings and began to bring out a quarterly magazine style journal known as The CAPS Bulletin. As founding editor of that organ, I continually looked forward to the time when a more standard professional journal could be established and the opportunity came for that in 1982. By decision of the National Board of CAPS, I was instructed to begin publishing the Journal of Psychology and Christianity which is endowed and has flourished since then,
under my editorship until 1988 and since then from the hand of the very able academic and research psychologist, Dr. Peter Hill of Grove City College.

The consistent objective of these endeavors has been to develop working models of the interface of the sciences of psychology and theology at both the theoretical and operational levels. Thus I attempted to give conscious circumspect leadership to the CAPS community in developing a formal model of what we were trying to do in our search for a more complete understanding of how these disciplines work in their interaction in the faith, professional work, and life of concerned Christian scientists. In 1982 I published such a proposed model and have continued to refine it since then in such works as *The Church and Pastoral Care* (Aden & Ellens, 1988), *Christian Counseling and Psychotherapy* (Ellens, 1987), *Counseling and the Human Predicament* (Ellens, 1989), and *Christian Perspectives on Human Development* (Aden, Benner, & Ellens, 1992).

In this process it has seemed increasingly clear to me that there are four levels at which scientific and operational disciplines interface. These are the levels of theory development, research methodology, database development, and operational application (see Figure 1).

![Figure 1](image)

The first three categories do not differ in their function from one discipline to the next. The fourth category is similar in function for all disciplines but the arena in which the function is executed differs from the 1) psychological clinic to the 2) pastoral care setting to the 3) formulation and teaching of theological or psychological constructs in the academy to the 4) research labs and libraries. The crucial issue regarding the interface and mutual illumination which psychology and theology afford each other in this model is the recognition that each of these disciplines comes to the work at each of the four levels with its own independent parlance, prerogatives, perspectives, and purposes, but all encounter each other at each level of the model in the anthropology which is functioning or forming at that level in the mind and worldview of the scientist.

In fact, one can go a step further and demonstrate that it is in the theological or psychological personality theory which is functioning or forming in that anthropology that the interface and mutual illumination takes place (see Figure 2). It is in that
notion of the nature and function of the human person who does science, experiences conceptualization of aspects and functions of the cosmos, and relates to God that the various disciplines meet to bring their illuminating insights to bear on all the others. It is that sense of the operative nature of humanness, particularly the

**Figure 2.**
The anthropological concept that is forming or functioning in each locus of intersection is the actual junction element that constitutes the cite of intersection.

**Figure 3.**

notion of the nature and function of the human person who does science, experiences conceptualization of aspects and functions of the cosmos, and relates to God that the various disciplines meet to bring their illuminating insights to bear on all the others. It is that sense of the operative nature of humanness, particularly the
epistemology operating in one’s anthropology and theory of the human person, which is at stake in how theology illumines the psychological address to the living human document and psychology illumines the theological address to the biblical document or theological proposition. Our anthropology, properly illumined affords us our understanding of how God is and speaks to us. In sum, therefore, I see theology and psychology as different perspectives or frames of reference, with differing fields of discourse, dealing with the same subject matter; namely the function of the living human document which is sometimes described in the textual documents of the Bible (see Figure 3). In this living human document and its cosmic context can be seen the reflections of the face and heart of God. The illumination which psychology can bring to theology, thus, is the light it offers about the nature and function of the living human document as author, context, initial audience, interpreter, subsequent audience, and modifiable object of theological concepts. The illumination theology can bring to psychology is the light it offers about the nature and function of the theological data as modifier, context, in that sense author, audience, and interpreter of the living human document.

A Look Toward the Future

A continuing fruitful struggle to understand and employ the potential of the sciences and practice of psychology and theology for mutual illumination is imperative for at least two concrete reasons. First, the recent data regarding the etiology of psychopathology is moving us more and more toward the inevitable conclusion that at least 80% of everything we see in the clinic derives from genetic and/or biochemical sources rather than environmental influences. When that is combined with the government statistics on the generally relative ineffectiveness of its own costly prison rehabilitation programs and attempts to train the so-called hard-core unemployed, one is forced to ask to what extent these latter conditions are driven by the former. If there should prove to be some significant correlation between biochemical-based psychopathology and the limits of a person’s potential for rehabilitation or social function, as I think we shall find, we are faced in the field of psychology with an enormous problem of both a theological and ethical nature. The theological problem is the classical problem of determinism and personal freedom. The ethical problem is that of whether the state or some external entity such as the medical profession can or should, for example, take responsibility for such forced medication of the persons involved as to render them amenable to rehabilitation and social function, for their own good and that of society. Thus it is clear that theology and psychology are thrown inextricably together in this applied and operational arena as well as in that of theoretical scientific investigation.

Second, the converse of this interface for mutual illumination, namely, the light psychology can bring to theology, is just as crucial and perhaps more tractable. Psychology has been able to develop a number of standardized paradigms for understanding the living human document and these paradigms have proven useful cross-culturally. Therefore, it may be assumed that they are also applicable cross-generationally and from one millennium to another. That is, our current models for understanding human beings are likely to be applicable when we use them to view persons from a thousand years ago or from biblical times, provided we can secure a substantial amount of information about those persons.

One might be able, for example, to note that Tertullian was a lawyer by training and that he was meticulously preoccupied with the precise and subtle nuances of
the meaning of words and expressions, that he tolerated no variance or margin of flexibility in the denotation or connotation of the words he used in formulating his early Christian creedal statements, that he was inordinately legalistic in his theological and church political notions, and that when the church of North Africa moved toward vesting its authority in the bishops and their Apostolic Succession instead of following his rigid formulations and proposals, he left the Orthodox Church for the Montanists (Jackson & Gilmore, 1950, pp. 305-308). Having noted these things and presumably developing a similar but more extended body of knowledge about him, his history and function, we could successfully employ our diagnostic categories of today, with their implied psychological models for understanding the living human document, and draw appropriate conclusions regarding Tertullian’s health and pathology. We might conclude, for example, that he was suffering from at least a mild case of compulsivity and paranoia. In such a case, it would be important to have made this psychological assessment in order to understand what he wrote, intended, and meant by his theological works; and how we should take them, and perhaps even how seriously we should take them as part of the early formulations of what has become the Christian tradition.

Similarly, it is possible today to bring the insights and models of psychology to bear upon a biblical text or theological construct, assessing the nature and function of the author, of the implied or stated intended audience, of the real audiences in the church’s history which interpreted the text, together with their interpretations, and thus assess the reasons, healthy or pathological, for the constructs that were expressed in the text and in subsequent theological uses of it. That is to say, in addition to all the other text-critical paradigms which are legitimately applied to the text of Scripture and of theological traditions, surely we must apply the paradigms for understanding how humans function, what they tend to say, why they say what they say the way they say it, and what messages mean as seen through standardized psychological paradigms when applied in a given context. Psychology is another lens through which it is possible to see any text and understand dimensions of it and the way it reflects the living human documents behind it and, therefore, reflects and interprets God who stands behind and created the living human document. Neither humans nor God can be adequately understood if one does not employ this lens.

Conclusion

I have made the claim and CAPS has spent forty years in quest of the trust that psychology properly done before the face of God will reveal that face through living human documents and thus illumine theology in essential ways. I have made the further claim, also confidently pursued for four decades by CAPS, that theology properly done before the face of God will reveal that face in the text of Scripture and thus have light to bring to psychology. I make the final claim that as each is a lens to see deeply into its own scientific arena, so each in bringing light to the other discipline is a lens to assist in seeing the face of God in that other science more clearly, by seeing the face of that science’s own living human documents more clearly, in the clinic or behind the biblical-theological text.

Without such bifocal spectacles properly adjusted on our seeking scientific eyes, looking at both psychology and theology, we shall have our view of God distorted and thus inevitably our view of humans and humanness as well. Conversely, if we
have our theological or psychological anthropology distorted because we have not properly illumined each with the other, we shall not see God rightly in creation or in the Scripture, to our great and unnecessary confusion and loss.

References


Author

J. Harold Ellens completed his Ph.D. in Communications Psychology at Wayne State University in 1970, and is currently finishing a second Ph.D. in Biblical Studies and Christian Origins at the University of Michigan, Department of Near Eastern Studies. In addition to being the Executive Director Emeritus of CAPS and the Founding Editor of The Bulletin of CAPS and of the *JPC*, Dr. Ellens has written prolifically in both the field of psychology and of theology and their interface. He is also a psychotherapist in private practice in Farmington Hills, Michigan.
Beliefs and Behaviors among CAPS Members Regarding Ethical Issues

Mark R. McMinn  Katheryn Rhoads Meek
Barrett W. McRay
Wheaton College

Abstract

A survey was conducted of the ethical beliefs and behaviors of 498 Christian counselors, using the same 88-item instrument used in previous surveys of psychologists (Pope, Tabachnick, & Keith-Spiegel, 1987) and counselors (Gibson & Pope, 1993). Seventy-seven of the respondents were members of the Christian Association for Psychological Studies (CAPS). Generally, CAPS members appear to have high regard for and high compliance with prevailing professional ethical standards. Response patterns from the overall sample were simplified with factor analyses, resulting in two scales of ethical beliefs and four scales of ethical behaviors. Scale scores were used to compare CAPS members with non-members and licensed therapists with unlicensed in a 2 x 2 analysis of variance. Similarly, scale scores were compared, based on CAPS membership and membership in other professional organizations, in a second 2 x 2 analysis of variance. Although CAPS members did not differ significantly from other Christian counselors, those with professional licenses and those belonging to non-religious professional mental health organizations were less inclined to report multiple role relationships and more inclined to report sexual countertransference feelings than other respondents. The implications of these findings and possibilities for future research are discussed.

A commitment to ethical standards is an important distinctive of all mental health professional organizations (American Association for Marriage and Family Therapy—AAMFT, 1991; American Counseling Association—ACA, 1988; American Psychological Association—APA, 1992; Christian Association for Psychological Studies—CAPS, 1992, National Association of Social Workers—NASW, 1993), and systematic research is an essential part of establishing ethical standards by which a profession regulates itself. Since 1987, three large-scale survey research projects have been reported which provide information about the specific ethical beliefs and behaviors of counselors. In 1987, Pope, Tabachnick, and Keith-Spiegel reported the results of a survey of professional psychologists. Four hundred fifty-six members of Division 29 (APA) responded to the 83-item survey. The results provided an important "real world" look at what psychologists think and do in the context of professional psychological services. Six years later, Gibson and Pope (1993) reported the results of a similar survey with a more diverse mental health population. They sampled 579 counselors certified by the National Board for Certified Counselors. Their results provided additional practical information about the beliefs and behaviors of mental health practitioners. McMinn and Meek (1996)

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recently reported results of a similar survey of 498 members of the American Association of Christian Counselors (AACC). Of those 498 respondents, 77 were also members of the Christian Association for Psychological Studies (CAPS). In addition to these large-scale surveys, Oordt (1990) used the same survey instrument with a small sample of Christian psychologists.

AACC, an organization experiencing rapid and recent growth, has established a law and ethics committee and is in the process of developing an ethics code for its members, but most AACC members have not yet seen a preliminary version of the code. CAPS, in contrast, has had an ethics code in place since 1986. Thus, one might speculate that CAPS members are more aware of prevailing ethical standards and more cautious to adhere to those standards than AACC members. The purposes of the present study were to describe the ethical awareness of CAPS members, and to investigate the extent to which membership in an organization with a published code of ethics affects ethical beliefs and behaviors.

Method

Participants
Participants for the study were randomly selected from the 11,000 members of the AACC. Three hundred with doctoral degrees, three hundred with master’s degrees, and three hundred with no graduate degree were selected. Of the 900 individuals to whom surveys were sent, 29 returned personal responses explaining why they could not complete the survey (e.g., retirement, not currently practicing), and five were undeliverable. Of the 866 who could have responded, 498 returned completed or partially completed surveys, resulting in a return rate of 58%.

Materials
The survey questionnaire was based upon the survey instrument used by Pope, Tabachnick, & Keith-Spiegel (1987), and was divided into three main sections. First, participants responded to a list of 88 behaviors by reporting how often they engaged in the behavior and whether or not they believed it was ethical. Pope et al.’s (1987) list included 82 behaviors, with one item being repeated to allow for a reliability check. Gibson and Pope (1993) added five behaviors at the end of the original 83 and replaced the repeated item, resulting in a total of 88 items. These same 88 items were used in this survey, except that we retained Pope et al.’s (1987) repeated item (#66 and #82: “Being sexually attracted to a client”) rather than using Gibson and Pope’s (1993) replacement item for #66 (“Advertising accurately your counseling techniques”). Frequency of engaging in the behavior was rated on a five-point scale: 1=never, 2=rarely, 3=sometimes, 4=fairly often, or 5=very often. Participants also had an option of reporting that a behavior was not applicable to their counseling practice. Beliefs about the ethics of the behavior were also rated on a five-point scale: 1=unquestionably not, 2=under rare circumstances, 3=don’t know / not sure, 4=under many circumstances, and 5=unquestionably yes. A general analysis of the response patterns on these 88 items, including differences based on sex, age, highest degree, and professional license, is reported elsewhere (McMinn & Meek, 1996).

Second, participants evaluated the usefulness of 14 resources for providing direction and regulation of their practice. These included resources such as graduate training, internship, state ethics committees, and so on. Usefulness for each
was assessed on a five-point scale: 1=terrible, 2=poor, 3=adequate, 4=good, and 5=excellent. Participants also had the option of reporting that a resource was not applicable to their situation. Information from the second part of the survey is reported elsewhere (McMinn & Meek, in press).

Third, participants reported demographic and professional information including their sex, age, primary work setting, major theoretical orientation, organizational memberships, highest degree held, and number of professional journals received. They also rated the prevalence of several different psychiatric disorders among those for whom they provide services—information that was used as part of another study (McMinn & Wade, 1995).

**Procedure**

Surveys were mailed in March, 1994 with a cover letter describing the purpose of the study, and participants were asked to put their completed survey in an inner envelope which, in turn, was placed in an outer postage-paid envelope. The outer envelope was sent to a psychologist in Oregon who separated the inner and outer envelopes and then sent them to the primary investigators in Illinois. The outer envelopes had a code to identify who had returned the survey, but since the inner envelopes had been previously separated, none of the survey responses could be traced to individual respondents. This assured confidentiality for those completing the survey. Those who had not yet returned the survey after three weeks were sent a reminder postcard. After two additional weeks, they were sent another questionnaire packet.

**Results**

The demographic characteristics of the respondents are described in Table 1. Most respondents were male, had graduate degrees, were not licensed, worked in clinic or church settings, and were not members of CAPS.

The overall response pattern of all respondents, and of CAPS members is reported in the Appendix. To simplify interpretation of this large response set, we implemented a series of principle components factor analyses, using varimax rotation. Because what one believes sometimes differs from what one does, we computed separate analyses for belief and behavior ratings. Also, to confirm the factor structure, we randomly divided the sample into two subsets. The larger subset included 398 respondents and the smaller included the remaining 100 respondents. Thus, we computed four factors analyses: ethical beliefs—large sample (exploratory), ethical beliefs—small sample (confirmatory), ethical behaviors—large sample (exploratory), ethical behaviors—small sample (confirmatory). In each case we included only factors with eigen values of 1.5 or greater in order to simplify the numbers of factors produced. Items with factor loadings of .45 or greater were used to create factor scales.1

Those factors that appeared in both the exploratory and confirmatory factor analyses were considered for subsequent analyses. Only items that loaded on the same factor for both samples were included in the scales. For ethical beliefs, two large scales emerged: blatant ethical violations and multiple roles. For ethical behaviors, four smaller scales emerged: Multiple roles, confidentiality, sexual countertransference, immoral violations. The final scales and their internal consistency (coefficient alpha) ratings are listed in Table 2.
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Category</th>
<th>TOTAL SAMPLE</th>
<th>CAPS MEMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
<td>302</td>
<td>62.5</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>181</td>
<td>37.5</td>
</tr>
<tr>
<td></td>
<td>Not reported</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>Age</td>
<td>Under 30</td>
<td>8</td>
<td>1.6</td>
</tr>
<tr>
<td></td>
<td>30-45</td>
<td>182</td>
<td>36.9</td>
</tr>
<tr>
<td></td>
<td>46-60</td>
<td>217</td>
<td>44.0</td>
</tr>
<tr>
<td></td>
<td>Over 60</td>
<td>86</td>
<td>17.4</td>
</tr>
<tr>
<td></td>
<td>Not reported</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Degree</td>
<td>No grad degree</td>
<td>72</td>
<td>15.2</td>
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<tr>
<td></td>
<td>Master's</td>
<td>229</td>
<td>48.4</td>
</tr>
<tr>
<td></td>
<td>Doctorate</td>
<td>172</td>
<td>36.4</td>
</tr>
<tr>
<td></td>
<td>Not reported</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>Work Setting</td>
<td>Private Office</td>
<td>165</td>
<td>36.7</td>
</tr>
<tr>
<td></td>
<td>Clinic</td>
<td>40</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>Hospital</td>
<td>14</td>
<td>3.1</td>
</tr>
<tr>
<td></td>
<td>University</td>
<td>13</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td>Church</td>
<td>149</td>
<td>33.2</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>68</td>
<td>15.1</td>
</tr>
<tr>
<td></td>
<td>Not reported</td>
<td>49</td>
<td>6</td>
</tr>
<tr>
<td>Licensure</td>
<td>No</td>
<td>345</td>
<td>69.3</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>153</td>
<td>30.7</td>
</tr>
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</table>

Next, we were interested in seeing the effects of professional identity on ethical beliefs and behaviors. Two series of analyses of variance (ANOVA) were computed, with the dependent variables being the sum of ratings on the scales derived in the factor analyses. The first series of ANOVAs used CAPS membership and professional identity as independent variables in a 2 x 2 design. Those who reported being a psychiatrist, psychologist, licensed or registered social worker, or national certified counselor were considered to be licensed counselors, and others were considered to be non-licensed counselors. The average scale scores for each group are reported in Table 3. The main effects included the tendency for non-licensed counselors to engage in more multiple role behaviors than licensed (non-licensed were also more likely to believe multiple role relationships are acceptable), and the tendency for licensed counselors to report greater sexual countertransference than non-licensed counselors. There were no main effects for CAPS membership. A significant interaction emerged with multiple role behaviors. Non-licensed counselors were less cautious than licensed counselors in multiple role behaviors, but only among those who were not CAPS members. CAPS members, whether licensed counselors or not, appeared to be more cautious than non-licensed, non-CAPS members responding to the survey. Perhaps this is
due, at least in part, to the different membership requirements in AACC and CAPS (CAPS requires a graduate degree or professional certification and AACC does not).

The second series of ANOVAs used CAPS membership and membership in another professional organization as independent variables in a 2 x 2 design. Those who reported membership in the American Psychological Association (APA), the American Counseling Association (ACA), the National Association of Social Workers (NASW), or the American Association of Marriage and Family Therapy (AAMFT) were considered members of an organization with a professional ethics code. The average scale scores for each group are reported in Table 4. The same main effects were found, with members of professional organizations reporting greater caution regarding multiple role beliefs and behaviors, and greater sexual countertransference. There were no main effects for CAPS membership, and no interaction effects were found.

Discussion

Caution should be exercised in interpreting these survey results for several reasons. First, although the 58% return rate is good for survey research, it is possible that those not returning the survey differ from those who did. Second, the beliefs and behaviors of CAPS members who also belong to AACC may differ from other CAPS members who were not included in this survey. Third, the diversity of the sample, which reflects the various types of Christian counselors, make the results more difficult to interpret than the previous surveys of more homogeneous professionals (Gibson & Pope, 1993; Oordt, 1990; Pope, Tabachnick, & Keith-Spiegel, 1987). Fourth, one's reported behavior may not always be an accurate reflection or an objective appraisal of actual behavior.

Rare and Common Behaviors

A number of behaviors appear to be very rare for CAPS members. Fewer than 10% reported ever using sexual surrogates with clients, making custody evaluations without seeing the child, accepting a client's decision to commit suicide, leading nude therapy groups, becoming sexually involved with a current or former client, kissing a client, engaging in erotic activity with a client, giving a gift worth $50 to a client, engaging in sex with a clinical supervisee, receiving payment for referring clients, going into business with a current or former client, allowing a client to disrobe or disrobing in the presence of a client, borrowing money from a client, discussing a client by name with friends, signing for hours a supervisee has not earned, doing therapy under the influence of alcohol, or disclosing the name of a client to a class. Other behaviors are very common, occurring at least occasionally among 90% or more of the CAPS respondents. These behaviors include hugging a client, using self-disclosure in therapy, breaking confidentiality to report child abuse, addressing a client by first name or having a client address the therapist by first name, accepting a gift worth less than $5 from a client, and offering or accepting a handshake from a client. These rare and common behaviors are quite similar to those observed among psychologists (Pope, Tabachnick, & Keith-Spiegel,
### Table 2
**Final Scales Derived from Factor Analysis, and Internal Consistency Ratings (Coefficient Alpha) for Each Scale**

<table>
<thead>
<tr>
<th>SCALE</th>
<th>ITEMS</th>
<th>RELIABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>ETHICS BELIEFS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blatant Errors</td>
<td>31, 39, 41, 47, 49, 50, 54, 55, 56, 58, 60, 61, 62, 67, 68, 69, 70, 71, 72, 74, 75, 78, 84, 85, 86</td>
<td>.97</td>
</tr>
<tr>
<td>Multiple Roles</td>
<td>1, 3, 21, 33, 37, 44, 51, 53, 57, 59</td>
<td>.87</td>
</tr>
<tr>
<td>ETHICS BEHAVIORS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple Roles</td>
<td>1, 3, 33, 44, 53, 57, 59</td>
<td>.77</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>18, 27, 32</td>
<td>.86</td>
</tr>
<tr>
<td>Sexual Counter transference</td>
<td>66, 75, 82</td>
<td>.88</td>
</tr>
<tr>
<td>Immoral Violations</td>
<td>15, 39, 54</td>
<td>.83</td>
</tr>
</tbody>
</table>

**Note.** Scales are comprised of items that appeared in similar factors in both the exploratory and confirmatory factor analyses. Scales with fewer than three items were not considered.

### Table 3
**Average Scale Ratings for CAPS and Non-CAPS Members, Licensed and Non-Licensed Counselors**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Scale Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scale</td>
<td>CAPS Members</td>
</tr>
<tr>
<td>Scale</td>
<td>Licensed N=33</td>
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<tr>
<td>BELIEFS</td>
<td></td>
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<tr>
<td>Blatant Errors</td>
<td>31.29</td>
</tr>
<tr>
<td>Multiple Roles</td>
<td>23.03</td>
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<tr>
<td>BEHAVIORS</td>
<td></td>
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<tr>
<td>Multiple Roles</td>
<td>12.06</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>9.18</td>
</tr>
<tr>
<td>Sexual Counter transference</td>
<td>5.61</td>
</tr>
<tr>
<td>Immoral Violations</td>
<td>3.18</td>
</tr>
</tbody>
</table>

**Note.** a=main effect for licensed vs. non-licensed (p<.05)  
b=main effect for CAPS member vs. non-CAPS member (p<.05)  
c=interaction effect (p <.05)
Sexual Behavior

Questions regarding Christian counselors’ sexual behavior have been raised in recent years. For example, Craig (1991) noted that only 10% of AAMFT members are clergy practitioners, yet 75% of those whose memberships are revoked are clergy practitioners. By implication, Craig suggests that these revocations are largely due to inappropriate sexual behavior. In this sample of Christian counselors, it appears that respondents are very sensitive to the importance of maintaining strict standards with regard to sexual contact with their clients. However, there is one finding that stands out and needs further investigation. Pope et al. (1987) reported that 11% of the psychologists in their survey believed being sexually attracted to a client was always unethical. Another 11% believed it was only ethical under rare circumstances. Gibson and Pope (1993) had only two options (Yes or No) rather than the 5-point scale used here and by Pope et al. (1987), and found 37% of counselors believed being sexually attracted to a client was unethical. In the present survey, however, we found (among the total sample of Christian counselors) a surprisingly high 54% who believed sexual attraction to a client was unethical always. Another 13% believed it to be ethical only under rare circumstances. The difference is less striking among CAPS members, only 32% of whom believe sexual attraction to clients is always unethical (another 17% reported it to be ethical only under rare circumstances).

This can be viewed as encouraging or discouraging, depending on one’s perspective. Looking at these differences positively, Christian counselors have differ-

<table>
<thead>
<tr>
<th>Scale</th>
<th>CAPS Members</th>
<th>Scale Ratings</th>
<th>Non-CAPS Members</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Other Membership</td>
<td></td>
<td>Other Membership</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>N=41</td>
<td>N=18</td>
<td>N=114</td>
<td>N=116</td>
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<td>BEHAVIORS</td>
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<td>Sexual Counter-transference</td>
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<td>Immoral Violations</td>
<td>3.22</td>
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Note. a=main effect for other membership vs. no other membership ($p<.05$)
b=main effect for CAPS member vs. non-CAPS member ($p<.05$)
c=interaction effect ($p<.05$)

Table 4
Average Scale Ratings by CAPS Membership and Organizational Membership in APA, ACA, NASW, or AAMFT

1987), professional counselors (Gibson & Pope, 1993), and AACC members (McMinn & Meek, 1996).
ent values about sexual behavior than their secular counterparts. Though both groups avoid sexual contact with clients, Christians generally believe that sexual contact is only appropriate within heterosexual marriage. One way of adhering to this high standard of sexuality may be to closely monitor thoughts and feelings at every level. Jesus taught, “everyone who looks at a woman with lust has already committed adultery with her in his heart” (Matthew 5:28). From a more skeptical perspective, the different response patterns may reflect Christian counselors’ tendency to deny inevitable feelings of sexual attraction toward their clients. Learning to manage sexual feelings is important, and denial of the feelings may inhibit their management (Pope & Bouhoutsos, 1986; Pope, Sonne, & Holroyd, 1993). Interestingly, CAPS members and those with doctoral training are more likely to accept sexual feelings as ethical, but no more likely to engage in sexual contact with clients. These differences deserve careful consideration and should be the topic of subsequent research.

Organizational Membership

We were also interested in knowing if membership in an organization with a published code of ethics affected Christian counselors’ views on certain beliefs and behaviors. The factor analyses allowed us to simplify the 88 items into several scales which helped us address this research question. CAPS membership did not have a striking effect on any of the belief or behavior scales. However, those having a professional license (psychologist, social worker, or national certified counselor) or belonging to another professional counseling organization (APA, ACA, NASW, or AAMFT) differed from other respondents in two ways. First, licensed respondents and those with professional membership were more cautious about multiple-role relationships. This may reflect more training in the potential pitfalls of multiple-role relationships, or it may reflect the more permeable boundaries that face non-professional church-based therapists. It should be noted that these differences were more striking among the general sample of Christian counselors than among CAPS members, perhaps because most CAPS members are professionally trained in counseling. Second, licensed respondents and those with professional membership were more inclined than other respondents to admit sexual countertransference (i.e., being sexually attracted to a client and sexually fantasizing about a client). This could be interpreted as either a tendency for licensed counselors to have more sexually-conflicted feelings about clients, or as an indication that professional training prepares counselors to understand their conflicted feelings more than non-licensed counselors.

Conclusions and Recommendations

The results of this survey suggest that Christian counselors are generally aware of important ethical guidelines and report behaving ethically under most circumstances. The Christian counselors in this survey were at least as sensitive to relevant ethical standards as previously surveyed groups of psychologists and counselors. Despite this good news about Christian counseling in general, two of the response patterns deserve further investigation.

First, an issue for subsequent study has to do with maintaining adequate boundaries in counseling relationships. Christian counselors are often in situations which defy the traditional counselor-client roles, such as a pastor counseling a parishioner, a lay counselor meeting a friend at a restaurant for support, or a church staff member providing group counseling services to those attending the same church.
Rigid interpreters of professional standards might label these interventions useless or even harmful because they involve multiple-role relationships, ignoring the reality that this type of church-related helping has been happening for centuries. In the absence of practical, realistic standards regarding multiple-role relationships, Christian counselors are often left to define their own standards. Those who do not have professional licenses or do not belong to professional organizations appear to be defining their roles with clients more leniently than licensed professional counselors. The effects of these differences on counseling outcome are presently unknown. Unlike most professional counselors, many clergy counselors and lay counselors do not assume there is a “slippery slope” that predisposes those with more tolerant role boundaries to eventually exploit counseling clients. This assumption deserves careful consideration in future writing and research (see Geyer, 1994).

Second, it is surprising, and perhaps alarming, that such a high percentage of respondents believe sexual attraction to a client to be unethical. Although this may be an effective coping strategy for some, it may also cause some counselors to be unprepared for effectively managing attractions to clients when they occur. This may be less of a concern among CAPS members than among Christian counselors in general, because CAPS members were more inclined to acknowledge sexual attractions to clients. Fortunately, sexually exploitative relationships appear to be very rare among Christian counselors, and we have no evidence from this survey that Christian counselors are prone to act out sexually with their clients.

Note

1. Due to space limitations, the factor analyses could not be included. These analyses are available from the authors.

References


**Authors**

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*Katheryn Rhoads Meek, M.A., is a student in the Wheaton College Doctoral Program in Clinical Psychology.*

*Barrett W. Ray, M.A., is a student in the Wheaton College Doctoral Program in Clinical Psychology.*
### Percentage of Christian Counselors Responding in Each Category

<table>
<thead>
<tr>
<th>Item</th>
<th>Occurrence in your practice</th>
<th>Ethical?</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>1</td>
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<tr>
<td>1. Becoming social friends with a former client</td>
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<td>2. Charging a client no fee for therapy</td>
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<td>3. Providing therapy to one of your friends</td>
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<td>4. Advertising in newspapers or similar media</td>
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<td>5. Limiting treatment notes to name, date, and fee</td>
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(Appendix continues next page)
## Appendix (cont.)
### Percentage of Christian Counselors Responding in Each Category

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<th>Item</th>
<th>Occurrence in your practice</th>
<th>Ethical?</th>
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<td><strong>13.</strong> Having clients take tests (e.g., MMPI) at home</td>
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<td>26 38 14 16 7</td>
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<td><strong>14.</strong> Altering a diagnosis to meet insurance criteria</td>
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<td><strong>17.</strong> Using a collection agency to collect late fees</td>
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<td>8 24 15 22 31</td>
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<td><strong>18.</strong> Breaking confidentiality if client is homicidal</td>
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<td><strong>19.</strong> Performing forensic work for a contingency fee</td>
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<td>0 16 8 42 33</td>
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<td><strong>21.</strong> Inviting clients to an office open house</td>
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<td>29 21 22 10 18</td>
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<td><strong>22.</strong> Accepting a client's gift worth at least $50</td>
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<td>48 34 5 11 1</td>
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<td><strong>23.</strong> Working when too distressed to be effective</td>
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(Appendix continues next page)
### Appendix (cont.)
Percentage of Christian Counselors Responding in Each Category

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<tr>
<th>Item</th>
<th>Occurrence in your practice</th>
<th>Ethical?</th>
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<tr>
<td>24. Accepting only male or only female clients</td>
<td>78 8 8 3 3 19 19 19 21 23</td>
<td>87 3 4 3 3 10 16 21 19 34</td>
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<td>25. Not allowing client access to testing report</td>
<td>53 21 15 6 5 25 32 13 18 12</td>
<td>43 25 16 7 7 19 32 10 24 15</td>
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<td>26. Raising the fee during the course of therapy</td>
<td>67 23 9 1 0 40 28 9 14 9</td>
<td>41 37 20 1 0 23 28 7 30 12</td>
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<td>27. Breaking confidentiality if client is suicidal</td>
<td>12 19 23 13 33 3 8 4 12 74</td>
<td>13 26 21 13 28 1 4 3 11 81</td>
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<tr>
<td>28. Not allowing client access to raw test data</td>
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<td>45 15 6 10 24 10 14 17 19 40</td>
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<td>29. Allowing a client to run up a large unpaid bill</td>
<td>36 39 21 3 2 22 40 19 12 7</td>
<td>21 61 17 1 0 14 58 11 10 8</td>
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<tr>
<td>30. Accepting goods (rather than money) as payment</td>
<td>67 24 8 1 1 26 36 15 13 9</td>
<td>64 33 3 0 0 23 46 9 12 9</td>
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<tr>
<td>31. Using sexual surrogates with clients</td>
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<td>99 1 0 0 0 85 5 4 1 4</td>
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<td>32. Breaking confidentiality to report child abuse</td>
<td>14 17 29 31 4 7 1 12 76</td>
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<td>33. Inviting clients to a party or social event</td>
<td>68 19 9 3 1 46 29 8 9 7</td>
<td>75 19 6 0 0 51 36 4 5 4</td>
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<tr>
<td>34. Addressing your client by his or her first name</td>
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<td>0 3 3 18 77 4 1 1 27 66</td>
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(Appendix continues next page)
## Appendix (cont.)
Percentage of Christian Counselors Responding in Each Category

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<tr>
<td></td>
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<td>35. Crying in the presence of a client</td>
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<td>Earning a salary which is a % of client fees</td>
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<td>CAPS MEMBERS:</td>
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<td>34</td>
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<tr>
<td>37. Asking favors (e.g., a ride home) from clients</td>
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<td>38. Making custody evaluations without seeing the child</td>
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<td>39. Accepting a client's decision to commit suicide</td>
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<td>TOTAL SAMPLE:</td>
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<td>40. Refusing to disclose a diagnosis to a client</td>
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<td>41. Leading nude group therapy or “growth groups”</td>
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<td>49</td>
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<td>CAPS MEMBERS:</td>
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<td>23</td>
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<tr>
<td>42. Telling clients of your disappointment in them</td>
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(Appendix continues next page)
### Appendix (cont.)
Percentage of Christian Counselors Responding in Each Category

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<td>48. Avoiding certain clients for fear of being sued</td>
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<td>29</td>
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<td>TOTAL SAMPLE:</td>
<td>49</td>
<td>36</td>
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<td>49. Doing custody evaluations without seeing both parents</td>
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<td>50. Lending money to a client</td>
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<tr>
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<td>52. Having a client address you by your first name</td>
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<td>3</td>
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<td>53. Sending holiday greeting cards to your clients</td>
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<td>54. Kissing a client</td>
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<td>55. Engaging in erotic activity with a client</td>
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<td>56. Giving a gift worth at least $50 to a client</td>
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(Appendix continues next page)
## Appendix (cont.)

Percentage of Christian Counselors Responding in Each Category

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<th>Ethical?</th>
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<td>57. Accepting a client's invitation to a party</td>
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</tr>
<tr>
<td>58. Engaging in sex with a clinical supervisee</td>
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<td>59. Going to client's special event (e.g., wedding)</td>
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<tr>
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</tr>
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<td>60. Getting paid to refer clients to someone</td>
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<tr>
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<td>CAPS MEMBERS:</td>
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<td>61. Going into business with a client</td>
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<td>62. Engaging in sexual contact with a client</td>
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<td>63. Utilizing involuntary hospitalization</td>
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<tr>
<td>TOTAL SAMPLE:</td>
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<td>CAPS MEMBERS:</td>
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<td>53</td>
</tr>
<tr>
<td>64. Selling goods to clients</td>
<td>39</td>
<td>61</td>
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(Appendix continues next page)
## Appendix (cont.)
### Percentage of Christian Counselors Responding in Each Category

<table>
<thead>
<tr>
<th>Item</th>
<th>Occurrence in your practice</th>
<th>Ethical?</th>
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<tbody>
<tr>
<td></td>
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<td>68. Allowing a client to disrobe</td>
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<td></td>
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<td>69. Borrowing money from a client</td>
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<td>1</td>
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<td></td>
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<td>70. Discussing a client (by name) with friends</td>
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<td>71. Providing services outside areas of competence</td>
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<td></td>
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<td>72. Signing for hours a supervisee has not earned</td>
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<td></td>
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<td>73. Treating homosexuality per se as pathological</td>
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<td>13</td>
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<tr>
<td></td>
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<td>74. Doing therapy while under the influence of alcohol</td>
<td>99</td>
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<tr>
<td></td>
<td>99</td>
<td>1</td>
</tr>
<tr>
<td>75. Engaging in sexual fantasy about a client</td>
<td>72</td>
<td>24</td>
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<tr>
<td></td>
<td>66</td>
<td>31</td>
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<tr>
<td>76. Accepting a gift worth less than $5 from a client</td>
<td>28</td>
<td>35</td>
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<tr>
<td></td>
<td>8</td>
<td>38</td>
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<tr>
<td>77. Offering or accepting a handshake from a client</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>78. Disrobing in the presence of a client</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>100</td>
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</table>
### Percentage of Christian Counselors Responding in Each Category

<table>
<thead>
<tr>
<th>Item</th>
<th>Occurrence in your practice</th>
<th>Ethical?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
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<tr>
<td>79. Charging for missed appointments</td>
<td>35</td>
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<td>TOTAL SAMPLE:</td>
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<td>80. Going into business with a former client</td>
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<td>TOTAL SAMPLE:</td>
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<td>CAPS MEMBERS:</td>
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<td>81. Directly soliciting a person to be a client</td>
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<td>TOTAL SAMPLE:</td>
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<td>53</td>
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<td>CAPS MEMBERS:</td>
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<td>82. Being sexually attracted to a client</td>
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<td>83. Helping a client file a complaint re: a colleague</td>
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<td>CAPS MEMBERS:</td>
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<td>84. Not disclosing your fee structure to a client</td>
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<tr>
<td>TOTAL SAMPLE:</td>
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<td>CAPS MEMBERS:</td>
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<td>17</td>
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<td>85. Not telling a client of the limits of confidentiality</td>
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<tr>
<td>TOTAL SAMPLE:</td>
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<tr>
<td>CAPS MEMBERS:</td>
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<td>86. Disclosing a name of a client to a class you are teaching</td>
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<td>0</td>
</tr>
<tr>
<td>TOTAL SAMPLE:</td>
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<td>15</td>
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<td>CAPS MEMBERS:</td>
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<td>10</td>
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<tr>
<td>87. Using an agency affiliation to recruit private clients</td>
<td>45</td>
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<tr>
<td>TOTAL SAMPLE:</td>
<td>44</td>
<td>7</td>
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<tr>
<td>CAPS MEMBERS:</td>
<td>79</td>
<td>10</td>
</tr>
<tr>
<td>88. Joining a partnership that makes clear your specialty</td>
<td>44</td>
<td>7</td>
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</tbody>
</table>

**Notes.** Rows may not sum to 100% because of rounding. Percentages were computed after removing missing data. For occurrence in your practice?: 1=never, 2=rarely, 3=sometimes, 4=fairly often, and 5=very often. For ethical?: 1=unquestionably no, 2=under rare circumstances, 3=don’t know / not sure, 4=under many circumstances, and 5=unquestionably yes.
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<td>Exploratory Factor Structure for Ethical Beliefs Using Items with Factor Loadings of .45 or Greater</td>
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<table>
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<tr>
<th>Item</th>
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<td>Item 4</td>
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37
Counseling Conservatively Religious Fathers: Salient Treatment Issues

W. Brad Johnson  
George Fox University

William L. Johnson  
Whitworth College

Abstract

This article explores both theoretical and pragmatic issues relative to counseling with conservatively religious fathers (CRFs). Given the paucity of literature in this area, concern is expressed that CRFs may be an inadequately served clinical population. The article addresses common presenting problems, salient treatment issues and prevalent obstacles to effective counseling with CRFs. We conclude with a discussion of the value of conceptualizing this client group from a multicultural perspective.

Male gender role socialization in Western culture has been linked to increasing rates of physical and psychological illness, reduced life expectancy (Harrison, 1978; Pleck, 1987), and the underutilization of psychological services (Chodorow, 1978; Levant, 1990). Membership in the male community may require fathers to adopt traits such as relational separation and defensive ego boundaries, thus taxing their ability to function effectively as fathers and as clients.

In considering the traditionally limited role of fathers in family life, Margaret Mead once described fathers as a biological necessity and a social accident. Indeed, fathers have been sparsely represented in family research paradigms (Russell & Radojevic, 1992) and in discussions of child and family interventions. Nonetheless, evidence regarding the critical importance of fathers to the health of the family system is growing rapidly (Biller, 1993; Garbarino, 1993). For instance, level of father involvement is positively correlated with level of cognitive and emotional functioning and negatively correlated with the frequency of behavior problems and gender-identity disturbance in children (Buri, 1989; Johnson, 1993; Lamb, Pleck, Charnov, & Levine, 1987; Sagi, 1982).

In spite of the recognized significance of religiousness in the lives of clients (Lovinger, 1984; Propst, 1982; Spero, 1985), a review of the literature revealed no specific research or discussion of treatment issues relevant to religious fathers. Even comprehensive counseling handbooks for men and fathers fail to note the significance of religiousness in the father role and family system (Cath, Gurwitt, & Gunsberg, 1989; Meth & Pasick, 1990; Robinson & Barret, 1986; Scher, Stevens, Good, & Eichenfield, 1987). Additionally, the most current and comprehensive discussion of fathers in the context of family (Biller, 1993) offers no discussion of the role of religious belief in paternal behavior. It has been our experience that conser-
ervative religious fathers (CRFs) represent one of the most treatment resistant of all father groups requiring special training and sensitivity on the part of the counselor. In light of the paucity of information relative to the treatment of CRFs and the resulting lack of preparation at the graduate level for provision of services to this population, it is likely that conservative religious fathers constitute an underserved clinical population.

This article will explore common presenting problems for conservative religious fathers as well as difficulties inherent in commencing treatment. It will then consider salient treatment issues and common obstacles to effective counseling with these men. The article will conclude with a discussion of the need to incorporate religiousness as an important diversity variable in training clinicians for effective service delivery to men and fathers. For the purpose of this article, we define conservative as holding to traditional views regarding the male role in the family system. We recognize that a number of variables (education, family of origin, personality functioning, etc.) may serve to moderate the manner in which a male’s conservative religious beliefs and values will impact his paternal behavior (Hunt, 1993); however, we believe CRF’s often share a number of attitudinal and behavioral characteristics which directly influence their function in the family system as well as their response to professional mental health treatment. This is particularly true of those who are not only conservative but additionally somewhat rigid and dogmatic in their expression of religious faith. Given the limitations of space and our own clinical experience, the following discussion will focus primarily on conservatively Christian fathers. In applying current understanding of gender role socialization and therapeutic interventions designed for men in general to Christian fathers, we hope to contribute to a psychology for Christian living (Sappington, 1994).

**Presenting Problems**

**The Legacy of Male Socialization**

Traditional models of child and family psychotherapy have largely ignored the father, focusing primarily on the mother-child relationship (Rubenstein & Levitt, 1957). Part of the reason for the absence of fathers from this literature may be attributed to ongoing perpetuation of a rigid socially sanctioned gender role. A strong identification with this role is problematic in the treatment of fathers for two primary reasons.

First, fathers who hold very conservative and traditional masculine attitudes are considerably less likely than other men to seek professional psychological assistance (Carlson, 1987; Good, Dell, & Mintz, 1989; Heppner, 1981; Heppner & Gonzales, 1987; Levant, 1990; Robertson & Fitzgerald, 1992). Indeed, help-seeking in any sense may be considered the antithesis of maleness and may be as noxious to a man as acknowledging the very existence of a psychological problem. Shame and embarrassment are common experiences in men faced with the need for emotional assistance yet who own a legacy of father uninvolved or emotional withholding.

When fathers are either totally absent and/or irrationally strict or abusive, a defensive masculinity can develop on the part of the son. Boys then may internalize a strong but menacing anti-feminine image of malehood that further invites feelings of shame around desires for intimacy and caretaking from both men and women. (Spielberg, 1993, p. 179)
Fathers’ avoidance of professional assistance is particularly disconcerting in light of some recent research demonstrating increased frequency of physical symptoms and decreased self-esteem among men who are most active in their father roles (Barnett & Marshall, 1993; Hawkins & Belsky, 1989). Avoidance of outside assistance may be perpetuated by religious milieus which reinforce fear regarding the dangers of secular treatment.

Second, among fathers willing to participate in treatment, those who strongly endorse the traditional masculine role are likely to possess personal traits which predict negative treatment outcomes. These include: restrictive emotionality, relational isolation, disparagement of everything feminine (homophobia), success striving and relative silence regarding the self (Good et al., 1989; Graham, 1992; Levant, 1990; Thompson, Grisanti, & Pleck, 1985). These clients often become especially skilled at utilizing cognitive strategies (i.e., rationalization, intellectualization) to insulate themselves from personal and social discomfort (Meth, 1990). In fact, the traditional masculine socialization process, emphasizing rationality, power, self-control and competition, is quite likely to be at odds with the therapeutic values of traditional counseling approaches (i.e., self-disclosure, self-awareness, and admission of difficulties) (Robertson & Fitzgerald, 1992).

**Threat of Abandonment**

It has been our experience that many CRFs will only enter treatment when threatened by their spouses with separation or divorce, or when the focus of treatment is another “identified patient” within the family system. Coercion by an external source or circumstance is recognized as a primary reason for referral among men in general. Allen and Gordon (1990) noted the most common causes for referral included a pending separation, a depressed or acting out child, a court official (due to domestic violence) and/or the strong urging of a traditional male authority figure (pastor or physician). When threatened by loss of his marriage, the CRF may be authentically fearful and reluctantly become involved in treatment (Carlson, 1987). Part of the initial counseling session must include an assessment of the client’s level of motivation for treatment. Here the counselor must determine whether there is evidence of genuine brokenness and sincere willingness to participate in therapy or only surface compliance accompanied by high levels of resistance and guardedness.

Presenting problems voiced by family members (at times, only in the absence of the father) may include marital dissatisfaction, disagreement with the CRF’s parenting style (“spare the rod, spoil the child”), autocratic family leadership, and excessive devotion to work. Spouses are most likely to complain about the CRF’s restricted affect and lack of intimacy (Meth, 1990), autocratic decision-making styles (Thompson et al., 1985), and emotional or physical abuse (Thoreson, Shaughnessy, Cook, & Moore, 1993). Often, the “law and order” approach men find so productive at work is quite incompatible at home (Meth, 1990). While supported at times by decontextualized Old Testament Scripture, this style may lead the CRF to ignore sensitivity to and communication with spouse and children. The spouse of the CRF may also complain that the husband is too legalistic, controlling, and restrictive of her activities. In such cases, Scriptures are often used to back up exclusive male authority and control (e.g., Ephesians, Ch. 5).

When a CRF has labeled one of his children as the identified patient early in treatment, two dysfunctional father-child relationship styles are frequently detected (Pasick, 1990). First, disengagement may occur when the child experiences the
father as inherently critical and rejecting. Here the father may convey disappointment or disapproval regarding not only the child's behavior, but his or her very person. In response, the child experiences impaired development of self-esteem and withdraws from relationship with the father. Second, the Conflict relationship style is evident when the father assumes the exclusive role of disciplinarian relative to his children. In this case he may unwittingly reinforce acting out behavior as this becomes the sole venue for father-child interaction. Both dysfunctional relationship styles are likely to be promoted by fathers who are rigid, dogmatic and preoccupied with the hierarchical and authority components of their father role.

**Over-Control and Toxic Faith**

In their review of over 200 relevant studies, Gartner, Larson, and Allen (1991) found that among religious persons with psychological disorders, higher levels of self-reported religiosity were associated with disorders of “over-control” (characterized by dogmatism and authoritarianism). Additionally, Ferraro and Albrecht-Jensen (1991), in a survey of 2,939 adults, found that among respondents of all ages, those with the most conservative religious affiliations manifested the poorest health. Rather than assume that religious affiliations or beliefs are themselves correlated with over-control and diminished health, it is crucial to note the contribution of religious orientation as a mediating variable. Allport and Ross (1967) investigated the contribution of religious orientation to dichotomous and rigid thinking. Of note was their finding that indiscriminately proreligious persons (those who endorsed high levels of both intrinsic and extrinsic religiousness) were most inflexible and dogmatic in their expressions of and adherence to religion. It is likely that therapists offering services to religious families will be most challenged by indiscriminately proreligious fathers who wield considerable control within the family system and are most resistant to alternative interpretations of religious Scripture and tradition.

Hunt (1993) noted that among conservative Christian men, several qualities of faith expression could be “toxic” to the health of the family system. These include rigid and legalistic values, severe punishment or violence, autocratic leadership, simplistic (categorical) thinking, and demands for absolute submission by family members to his own authority and that of the Church or pastor. When dealing with these men in treatment, therapists must be particularly sensitive at the outset to consider the client's fear of having his faith discounted or ignored. While most religious clients may express some concern that their faith will be undermined by therapy (Rayburn, 1985; Worthington, 1986), CRFs may be additionally fearful that participation in treatment is indicative of their inadequacy in faith, leadership and spiritual modeling.

**Salient Treatment Issues**

When a CRF presents for treatment, the counselor must first reduce his fears regarding the counseling process and establish a working alliance. This can be accomplished by attending to several therapeutic issues unique to men, fathers, and conservatively religious persons. Below, we will discuss several of the most salient of these treatment issues.

**Demonstrating Respect for Religious Faith and the Father Role**

In light of concerns that their faith will be discounted by mental health professionals (Rayburn, 1985; Worthington, 1986), CRFs will be most responsive to the coun-
seler who skillfully demonstrates genuine interest in and respect for their religious convictions and related lifestyle choices (Gass, 1984; Lovinger, 1984; Stern, 1985). Gass (1984) noted that orthodox Christian values relative to counseling and therapy center on the therapeutic importance of religious belief, prayer and meditation, biblical teaching and counseling from within an explicitly Christian framework. In short, the counselor enhances the probability of a positive therapeutic alliance when he or she conveys to the CRF an authentic valuing of his religious commitment, including biblical doctrines supporting his role as spiritual head of the family. The CRF's specific biblical convictions and interpretations will provide important information to the counselor regarding the meaning and structure of family relationships.

Positive participation in the counseling process can be further enhanced by tailoring interventions specifically for men (Johnson, 1993; Levant, 1990; Russell & Radojevic, 1992). CRFs will respond more positively to counseling which overtly recognizes and values the strains and demands of the father role. Willingness to participate in counseling will increase significantly when these interventions have the explicit and public support of important institutions such as the church (Robinson & Barret, 1986). When designing individual, group or psychoeducational counseling programs for men and fathers, professionals are encouraged to not only consult with the client's pastor(s), but to seek opportunities for creating programs and services with support from and/or within local churches or religious organizations.

**Collaboration, Contracts, and Credibility**

It is important that the counselor conceptualize counseling with CRFs as a cross-cultural process (Levant, 1990). In establishing rapport with these clients, particularly those coerced into counseling and/or who maintain rigid and fear driven concerns regarding psychological treatment, it is imperative to create a therapeutic context which matches the language and behavior categories of the client. For instance, CRFs respond well to framing of the counseling relationship as a “contract,” “working relationship,” or “team effort.” Additionally, the process of counseling may be best described as a “task,” “mission,” “job,” or “challenge.”

CRFS will often need to be strongly reinforced for simply entering treatment (Allen & Gordon, 1990; Hill, 1995), and will respond most positively to a model of communication and intervention structured around active strategies such as goal-setting, use of lists and diagrams, homework and delineation of session tasks (Allen & Gordon, 1990). The avoidance of any violation of the father’s sense of propriety or masculine role comfort must be an ongoing therapeutic concern. For example, the counselor should not demand expression of affect early in counseling (Allen & Gordon, 1990), or require participation in family roles or activities to which the father is strongly averse or for which he is currently ill-prepared (Robinson & Barret, 1986). In addition, the counselor can demonstrate sensitivity, to the male client who fears affective expression and lacks requisite counselee skills by modeling affective sensitivity and disclosure (Heppner & Gonzales, 1987). Lastly, development of “camaraderie” and a sense of commonality through the sharing of personal anecdotes, and laughter appears to be important early on in groups designed for men as they adjust to the foreign demands of the counseling situation (Aries, 1976).

In addition to careful adoption of traditionally masculine communication styles and activities, we are convinced that effective service delivery to CRFS will require a collaborative approach in which the counselor establishes credibility by remaining flexible and respectful of various client religious ideologies and dogmatic biblical
interpretations. McMinn and Lebold (1989) noted that confrontation of a client's religious beliefs as pathological or absolutistic is clinically inappropriate and bound to produce resistance. This will certainly be the case among CRFs whose beliefs will, in their experience, be based upon God's Word and strengthened by expert authority in the person of the pastor and other Church leaders. A collaborative approach to the religious father will require accommodation (Johnson & Ridley, 1992) or functional utilization (McLemore & Court, 1977) of the client's language and belief system in counseling. Propst (1982) wrote that: “Therapeutic expectations are made more powerful if the active ingredients of a psychotherapy are translated into the language and belief structures of the patient” (p. 85).

In establishing credibility with the CRF, frequent and judicious use of Scriptures by the counselor will often facilitate building rapport and facilitate client commitment to exploration and change. Facility with Scriptures regarding biblical authority, roles of husbands and wives, discipline of children and the value of wise counsel are particularly salient. Hill (1995) recognized that conservative Christian fathers may selectively quote Scriptures which affirm their authority (“Wives, be subject to your husbands, as to the Lord” Ephesians 5:22) while omitting those which temper or modify their meaning (“Be subject to one another out of reverence for Christ” Ephesians 5:21; “Husbands, love your wives, as Christ loved the church and gave himself up for her…” Ephesians 5:25). After establishing credibility via shared faith and familiarity with Scriptures, the counselor may create what we call therapeutic dissonance among CRFs, for example, by noting the incongruity between pharisaic legalism and Christ-like grace. Facility with Scripture alone, however, is insufficient without a respectful accommodation of established techniques to the father's ideological worldview.

**Telling Stories and Finding One's Father**

One of the critical tasks of masculine development is the identification of the boy with men in the service of forming a healthy and secure male identity (Osherson, 1986). When the father figure is absent or otherwise fails to provide a positive model of manhood, the boy is left in a vulnerable position. Having suffered separation from the mother, he lacks a father to compensate for this loss and provide an inner male image. Outcomes of inadequate or disturbed father-son relationships include shame and insecurity among boys as they become men. Shame is devastating to healthy male identity and leads to increased rigidity and defensiveness (Spielberg, 1993). Such men are also more prone to dependency (decreased confidence and increased neediness) and subsequent violence in intimate relationships (Murphy, Meyer, & O'Leary, 1994).

Robinson and Barret (1986) noted that men with insecure identities are likely to have considerable difficulty functioning as effective fathers: “Major factors in a man's readiness for fatherhood are the extent to which he has separated himself from his own parents and his willingness to nurture his partner” (p. 66). It appears that some men who report significant dissatisfaction with their own fathers may engage in compensatory fatherhood (Barnett & Baruch, 1987), spending increased time with their own children (though we have no data regarding the quality of these relationships).

In counseling, it is important to assess the CRF's relationship with his own father as well as other significant male relationships and rites of passage. This may be accomplished by encouraging the CRF to tell his own story, either individually (Hill,
1995) or in the context of a group for men (Bernardez & Stein, 1979; Washington, 1979). In the latter case, the CRF is likely to benefit from the experience of cohesion with other men, structured self-disclosure and the relief which accompanies recognition of commonality of dysfunctional father/son relationships within the group. While CRFs report strong identification with their own fathers (Tobacyk, 1983), the quality of these father-son relationships has not been explored.

We have found that CRFs are most comfortable in processing this material with a male therapist. Others have recognized that a same-sex therapist can both model alternative attitudes and behaviors and provide permission for change as an authority figure (Bernardez & Stein, 1979). This is particularly critical in altering rigid sex-role behaviors and attitudes exacerbated by religious dogma. Finally, Bowman (1993) described a “Father-Son Project” in which a three-generational men’s retreat incorporated grandfathers, fathers and sons in an “enriching” and healing experience. Such a format may be ideally suited to a church or denominational setting. Goals for such an experience might include enhanced understanding of and amelioration of dysfunctional father-son relationship patterns, especially those rooted in dogmatic Scripture interpretations or church traditions.

Redefining Masculinity and Fatherhood

Effective counseling with CRFs will inevitably involve a redefinition of maleness and paternity in the context of a complete biblical perspective regarding one’s created image, gender, marriage roles and familial responsibilities. This will require a collaborative (McMinn & Lebold, 1989) process characterized by assessment and modification of foundational beliefs. Not only should the counselor identify central beliefs regarding fatherhood and relationships, but the source of those beliefs (Allen & Gordon, 1990; Hill, 1995). Beliefs about the male role and paternal style may be differentially influenced by culture, experience with one’s own father and mentors, formal religious education, and specific Scripture passages. It ultimately will be critical to identify the harmful beliefs and subsequently correct the beliefs (or their more rigid expressions) to the father’s presenting problem (Allen & Gordon, 1990).

Rigid codes of conduct resulting from gender-role socialization and/or religious teaching, represent significant obstacles to successful counseling with CRFs. The most problematic of these for rewarding and functional relationships are learned injunctions against valuing their own needs, feelings, and failures (Spielberg, 1993), and dogmatic demands for strength and self-sufficiency (Feldman, 1990). Recent research suggests that paternal rigidity is as damaging as any other single paternal quality (Robinson & Barret, 1986). For this reason, counselors should facilitate flexibility by emphasizing the father’s right and ability to choose among behavioral alternatives as a parent and husband. Decreasing rigidity and enhancing the constructive qualities of fatherhood relevant religious beliefs has been addressed by Hunt (1993) who described several counseling techniques to help CRFs work through the “toxic” qualities of their faith. They include: (a) flexibility within a solid foundation of commitment and moral-religious values, (b) child discipline which clearly relates to shared values, goals and consequences, (c) decision making which is more democratic than autocratic, (d) interpersonal warmth which compliments clear familial structure, and (e) willingness to critically evaluate one’s own beliefs as well as institutional church teaching.

The effective counselor will also seek opportunities to broaden the father’s understanding of the domain of maleness including the range of affective and rela-
tional experiences which define male identity. In this regard, Stanley Graham (1992) writes:

The term *a good man* was once a welded unity, a thoughtful caring person who touched the lives of all around him. To quote Mark Antony (Shakespeare, 1599/1919, Julius Caesar, Act 5, sc. 5, line 73), “His life was gentle, and the qualities so mixed in him that nature might stand up and say to all the world—this was a man.” (p. 841)

Collaborative expansion of the range of emotional and behavioral involvements with spouse and children will be enhanced by an educational climate in which the counselor works to heighten the CRFs’s awareness of opportunities for knowing himself and his family. Croteau and Burda (1983) reported on a structured group for men designed to educate men regarding the many social/emotional benefits of involved fathering. The focus of the group was “liberation” from rigid and traditional male role expectations. Group members were explicitly encouraged to critique detrimental role demands and experiment with male to male disclosure and help seeking/giving. Educating fathers regarding the numerous social/emotional benefits of involved fathering is central. Among more cognitively rigid and emotionally detached CRFs, it may be important to carefully introduce research findings indicating that active and nurturant fathers are more influential in their children’s development (Russell, 1978), as well as more prone to maturity, continuing personal development and emotional connectedness (Palm, 1993). Additional research indicates fathers who communicate with and emotionally support their children are more likely to have children adopt the fathers’ religious values and practices (Herzbrun, 1993).

**Training for Effective Fathering**

Crafting effective interventions for CRFs will necessarily require consideration of the inherent preferences for types of services among this client population. Roberton and Fitzgerald (1992) found that men who expressed highly masculine attitudes reacted most positively to descriptions of interventions such as classes, seminars and workshops as opposed to personal counseling. This psychoeducational preference appears to match the relative emphasis on the cognitive (versus affective) elements of relationships among men (Allen & Gordon, 1990). Programs designed for CRFs must go beyond classical models of counselor-client intervention to psychoeducational skill-based approaches (Johnson, 1993; Russell & Radojevic, 1992). Here the focus is on building male community, raising consciousness regarding the significance of fatherhood, ameliorating concerns relative to competence and explicit skill training.

Structured courses or psychoeducational groups designed for fathers are quite amenable for use with CRFs and could be effectively integrated into church programs. Such services must be promoted not as counseling, but as training (Levant, 1990), systematic skills education (Levant & Doyle, 1983), or classes (Resnick, Resnick, Packer, & Wilson, 1978). In general, these approaches share techniques such as workbooks, homework, communication skills, rituals, ceremonies and dyadic self-disclosure exercises. Heppner (1983) described a Coat of Arms technique used as an icebreaker in which men were encouraged to develop a personal coat of arms which symbolized aspects of their experience. Such an exercise could easily be accommodated to Christian men in considering symbols of their faith and/or biblical mentors.
Evidence from research on paternal involvement provides a strong rationale for offering training-based services to CRFS. This research disconfirms the notion of a "maternal instinct" and suggests that men can be as competent as women in parenting children when they are equally involved (Heath, 1976; Lamb & Oppenheim, 1989). Correlates of paternal involvement include motivation, requisite skills, self-confidence, and support from institutions (i.e., the Church). In addressing concerns regarding skills and competence among CRFS, it may be beneficial to offer a pre- and post-assessment of fathering skills with the Personal Fathering Profile (National Center for Fathering, 1990). This measure is psychometrically sound and allows an assessment of functioning on seven fathering dimensions: commitment, knowing your child, consistency, protecting/providing, loving their mother, active listening, and spiritual equipping (Roid & Canfield, 1994).

Primary Obstacles to Effective Counseling

Client Resistance
There are likely to be two primary sources of resistance among CRFS. First, there are a number of roadblocks to effective treatment emanating from the client's socialized gender role identity. As previously mentioned, many CRFS will come to counseling only after they have been threatened with, or have already been subject to a separation or petition for divorce (Washington, 1979). Not only have these men been socialized to avoid help-seeking, they may harbor a profound fear that their inadequacies will be exposed by the counselor. Counselors working with this population, both individually and in groups, may find them resistant to change and to expressing affect, often resorting to defenses such as intellectualizing and logical problem solving (Allen & Gordon, 1990; Heppner, 1981; Washington, 1979). While such masculine preferences for cognitive solutions are not inherently disruptive to effective treatment, they must be scrutinized and targeted for collaborative modification when they clearly promote lack of empathy and/or projection of blame on to family members.

A second source of resistance in this client population is the client's religious faith. In working with CRFS, unique manifestations of resistance to treatment may become evident (Greenberg & Witztum, 1991; Rayburn, 1985). These men may experience group pressure to avoid psychological treatment and may endorse faith-specific doctrines regarding the danger posed by psychotherapy and the therapist. Meehl (1959) suggested that clients may introduce religious material as a form of resistance, as an intellectualized defense style, or as an effort to seduce the therapist into cognitive combat. We have found it common for these men to engage in dogmatic, out of context verse quoting in the face of pressure to change. These clients may also discount the counselor's expertise because of perceived religious incompatibilities, or may attempt to gain control of the process of therapy via demands that prayer be the only (or primary) intervention. Finally, certain of these men may attempt to diminish the value of therapeutic interventions by seeking perspectives from peers or pastors which support their behavior and refute the counselor.

Counselor Experience/Training Deficits
Where there are deficits in the counselor's training and experience with CRFS, the probability of successful treatment is reduced. For example, counselors must be aware of the manner in which these clients may respond to a female counselor.
is not uncommon for CRFs to refuse counseling with a female counselor. If they do engage in treatment, they may attempt to take control of the process or may become aggressive and defensive if confronted by the counselor (Carlson, 1987). CRFs can be expected to have more difficulty relinquishing control to a female counselor than to a male when they hold firm beliefs regarding the headship and authority of the male.

In order to be effective with CRFs, counselors must also understand the barriers to effective and involved fathering and have realistic expectations regarding the speed with which CRFs can be expected to assume greater responsibility for household duties. Several of these fathering barriers are described elsewhere (Johnson, 1993; Palm, 1993) and include: employer demands, lack of parenting skills, poor systemic support for fathering, low cultural value (including religious) placed on fathering, and maternal gatekeeping.

Counselors who lack familiarity with or understanding of a father’s religiousness may inadvertently convey their own discomfort to the client (Greenberg & Witztum, 1991; Larson, Pattison, Blazer, Omran, & Kaplan, 1986; Lovinger, 1984; McLemore & Court, 1977; Rayburn, 1985; Spero, 1985). Therapeutic conflict or ineffectiveness may result from the counselor’s failure to grasp the significance of the client’s organizing system (Spero, 1985) and his or her inability to recognize the significance of biblical teaching and tradition. Informational or experiential deficits relative to religious/spiritual issues will likely hamper the counselor in attempts to understand the CRF. By demonstrating both respect for and familiarity with biblical doctrines relative to the family, the counselor will be able to work collaboratively with the client to modify those beliefs and practices most detrimental to the client and his family.

Counselor Countertransference

A final obstacle to effective counseling with CRFs is the counselor’s negative response to the perceived father-figure/religious authority represented in the person of the client, either because of overt hostility toward the client’s religious faith, or unexamined or unresolved issues with one’s own father. Bergin (1980) observed that the two dominant classes of values in the mental health field (clinical pragmatism and humanistic idealism) both exclude religious values and both establish goals for change that frequently clash with theistic belief systems. Counselors overtly hostile toward the client’s religious faith, or who overidentify with the client’s religiousness are less likely to be effective (McLemore & Court, 1977; Spero, 1985). With CRFs, such counselor countertransference will likely lead to early termination of the counseling relationship or perhaps inadvertent perpetuation of paternal practices which diminish the health of the family system.

The danger of unexamined or unresolved issues with one’s own father and/or rigid perspectives (liberal or conservative) regarding what constitutes competent fatherhood is substantial. For example, a defensive, hostile response to the client’s resistance to treatment (as may be the case if the counselor’s own father was uncommunicative or discounting) is a considerable therapist-generated error in counseling. On this issue, Pasick (1990) has written: “If the therapist is able to accept the resistance as a defense against anxiety and finds a way to validate the father’s importance to the family therapy, the likelihood of his continuing participation is high” (p. 102). Additionally, unexamined assumptions regarding appropriate masculine behavior may lead the counselor to communicate a lack of respect for
traditional father role functions or conversely may reinforce rigid and maladaptive fathering behavior (Heppner & Gonzales, 1987).

**Implications for Training**

The foregoing discussion of the unique treatment issues and obstacles in counseling CRFs suggests several implications for the training of mental health professionals. This client population is probably underserved by counselors with adequate training to effectively handle treatment concerns related to both male socialization and conservative religiosity. Both variables will be briefly considered as significant in multicultural efforts to enhance therapist comfort and confidence with diverse client groups.

Since 1978, the American Psychological Association (APA) has adopted specific guidelines for the treatment of female clients as a distinct population (APA, 1978). Nonetheless, no equivalent guidelines are available for male clients. In the absence of such, it is critical that counselors who work with this population understand and appreciate the marked differences between traditional masculine expectations of the counseling process and those of traditionally trained counselors (Levant, 1990; Robertson & Fitzgerald, 1992; Sherrod, 1987). Levant (1990) has noted the need to conceptualize services to men from a cross-cultural perspective.

The task of designing psychological services for men can be conceptualized as a form of a cross-cultural process in which it is recognized that the culture of traditional psychological services requires behaviors which conflict with aspects of the male role. (p. 311)

Specifically, counselors must be sensitive to the manner in which context and socialization impact the male client's definitions of paternal competence (Heath, 1976), involved fathering (Resnick et al., 1978) and acceptable expressions of emotion and intimacy (Sherrod, 1987). Adequate counselor training must include a familiarity with male personality development, socialization, and common world views (i.e., male culture). Each of these topics should be presented from a perspective which honors cultural and individual differences.

In addition to promoting sensitivity to issues unique to men and fathers, effective counselor training will increase competence in the provision of services to members of diverse religious faiths. Professional ethical standards for psychologists (APA, 1992) as well as guidelines for providers working with diverse populations (APA, 1993) support development of appropriate sensitivities in treating clients from varied religious traditions. In particular, aspirational guidelines relative to diverse populations (APA, 1993) recognize religiousness as significant to the therapy process and require providers to remain cognizant of the relative research and practice issues related to the population being served. Several of the specific guidelines have particular relevance for therapists offering services to CRFs:

Psychologists respect the roles of family members and community structures, hierarchies, values, and beliefs within the client's culture ... Psychologists interact in the language requested by the client and, if this is not feasible, make an appropriate referral ... Psychologists respect client's religious and/or spiritual beliefs
and values, including attributes and taboos, since they affect world view, psychosocial functioning, and expressions of distress. (p. 46-47)

Sensitivity to the manner in which religious faith combines with masculine identification to form the belief and behavior spectrum of CRFs will assist in averting misinterpretation of religious dynamics (Greenberg & Witztum, 1991; Larson et al., 1986). Such sensitivities will also allow the counselor to utilize religious beliefs and experiences to enhance treatment outcomes (Beit-Hallahmi, 1975; Lovinger, 1984; Stern, 1985). Finally, specific expertise in counseling CRFs will include explicit training in avoiding ethical liabilities unique to the situations in which therapeutic and pastoral roles are unavoidably blended (Younggren, 1993).

Contemporary models of multicultural training (Ridley, Mendoza, & Kanitz, 1994) might be easily tailored to training in religious diversity and specifically, provision of services to CRFs. Such training should be a specialty in religiously oriented doctoral training programs. We anticipate that training professionals to competently and sensitively address the needs of CRFs will positively impact family relationships and church communities.

References


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Forgiveness: More than a Therapeutic Technique

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Abstract

Although the concept of forgiveness is accepted by many as profitable in promoting personal and relational healing, some have abandoned its historical connection with religious faith. This uncoupling of religion and forgiveness overlooks a progression of healing that both includes and transcends personal healing for the forgiver, and may rob forgiveness of its therapeutic power. A brief discussion of the historical roots of forgiveness is followed by a proposed model of forgiveness that exemplifies the progression of healing proffered by religious faith. Current trends in the forgiveness literature are considered along with their therapeutic implications.

Forgiveness is historically coupled with religion, most notably the Christian religion in which it is the most crucial concept. The Christian Scriptures present a story of salvation where God continuously attempts to redeem a wayward people, to offer them a relationship that is only possible through forgiveness. It is exclusively through God's forgiveness that humanity heals, making it a paramount topic in Christian psychology (Roberts, 1993). Without God's forgiveness people remain in a broken and isolated state. With God's forgiveness they receive a new life (Jn 1:4, 3:36, 5:24; 2 Cor. 3:6), peace (Jn. 14:27; 16:33; Rom. 5:1), joy (Jn. 16:20; Rom. 14:17), and assurance of their salvation (Rom. 8:1; 5:9).

Over the past several years authors have begun to speculate about the potential benefits of employing forgiveness in therapy. It is viewed by some to be an essential component in healing. Forgiveness has been connected with release from anger and bitterness (Fitzgibbons, 1986), restoring broken relationships (Worthington & DiBlasio, 1990), and instilling hope in depressed people (Beck, 1976).

Unfortunately, both Christian and secular authors have generally abandoned its historical connection with religious faith, which is precisely where we find its most profound example of healing in emotional and relational pain. This is hardly surprising as modern psychological theorists, especially Christian psychologists, have been concerned with establishing credibility and have focused on that which is acceptable to the wider psychological community. Incorporating religious ritual into therapy has generally not been acceptable. Yet, forgiveness in the Christian Scriptures is much more than religious ritual. It is a progression of healing where people are confronted with the grace and mercy of God, despite their continual failure to deserve it. They learn to proffer the same grace and mercy to others in full awareness of their own fallibility. If we reduce forgiveness to a clinical technique devoid of this necessary progression, we may be diminishing it to a shallow or ineffective therapeutic procedure that is not likely to produce lasting effects.

The purpose of this article is to evaluate the current trends in the psychological
literature on forgiveness in light of Christian theology, and to discuss the resulting therapeutic implications.

Forgiveness in Christian Theology

The Bible is filled with directives and examples concerning our obligation to forgive. In the Old Testament, God continually forgave and restored a wayward chosen nation. Throughout the periods of slavery, wilderness wandering, judges, kings, and prophets, God's people opted for idolatry and rebellion. In each case, God allowed the consequences of their sin, then graciously forgave and restored broken people and a broken nation.

Humans, created in God's image, also demonstrated the capacity to forgive in Old Testament accounts. In the book of Genesis, for example, Joseph's forgiveness of his brothers who sold him into slavery served to end the tragic alienation of a family attributable to petty jealousy and selfish motivations for power and esteem. Instead of focusing on this deplorable abuse, Joseph reassured his brothers of God's sovereignty and grace in all that occurred. This example demonstrates the social context and effects of forgiveness. Forgiveness can extend far beyond emotional healing for the person who chooses to forgive and "benefit the one wronged, the wrongdoer, the relationship, and perhaps even the community" (The Educational Psychology Study Group, 1990, p. 18).

The New Testament places an even greater emphasis on the importance of forgiveness. It takes a central place in God's instructions regarding righteous behavior (Mk. 11:25; Lk. 17:3; 2 Cor. 2:7). The ultimate act of forgiveness is found in the sacrificial death of Jesus. He was abused, ridiculed, and finally His blood was "poured out for many for the forgiveness of sins" (Matt. 26:28). His death made relationship with God and each other possible. As with Joseph and his brothers in the Old Testament, God's forgiveness of humankind through the sacrificial death of Jesus introduced the possibility of restored relationships and interpersonal healing.

The New Testament also teaches us to forgive one another. In one of several similar passages, the Apostle Paul instructs, "be kind to one another, tenderhearted, forgiving one another, as God in Christ has forgiven you" (Eph. 4:32). Instructions such as these place Christians in a unique position with regard to forgiveness. We can know our own predilection toward wrongdoing, how we are undeservedly and regularly forgiven, and can use this information to respond in the same forgiving manner toward others. Forgiveness is humble submission to the one who continuously forgives us.

Thus, a Christian understanding of forgiveness begins with a recognition of the depravity inherent in humanity. We agree with Erickson (1985) that "our approach to the problems of society will ... be governed by our view of sin" (p. 563). Christians view sin as an inseparable part of the current human condition (Zackrison, 1992). It is ubiquitous, affecting every person (e.g., Romans 3), and breaking relationship with God and others. All humans are capable and guilty of either purposefully or unintentionally offending others. Sin cannot be captured in a list of acceptable and unacceptable behaviors, but reflects the general condition of humankind (Foster, 1988; Willard, 1988). As a result of our sinful state, humans experience guilt, punishment, and death, become enslaved to further sin, deny and distort reality, and experience broken relationships with God and one another.
Sinful actions never occur in a vacuum; they are the result of a depraved human condition and routinely affect interpersonal relationships.

An essential part of the salvation process is learning to recognize oneself as an active part of the human problem: humans acknowledge sinfulness and God offers forgiveness and redemption through Jesus Christ. As we comprehend human weakness and propensity toward evil, both in its wider historical context and in our own individual lives, we recognize our need to both give and receive forgiveness. With a mature understanding of our own sin and God’s mercy, we are increasingly able to see ourselves as we view the wrongdoing of others. This is not to suggest that forgiveness is easy, but that forgiveness is facilitated by empathy and humility. Lewis Smedes (1984) describes this phenomenon in *Forgive and Forget*:

> With a little time, and little more insight, we begin to see both ourselves and our enemies in humbler profiles. We are not really as innocent as we felt when we were first hurt. And we do not usually have a gigantic monster to forgive; we have a weak, needy, and somewhat stupid human being. When you see your enemy and yourself in the weakness and silliness of the humanity you share, you will make the miracle of forgiving a little easier (p. 104).


Forgiveness, in this sense, is an act of compassion that comes from one person identifying with the other. It suggests that two people are equally fallible, one responding to the offense of the other in loving identification. St. Francis of Assisi, a 13th century monk, wrote of the personal lesson in humility to be gleaned from another person’s offense.

> Whom are we to count as our “friends”? All those whose unjust actions and words cause us all manner of grief and trial … How can I suggest that you should greatly love such people? For this reason: Their evil actions draw out and display to us our own evil responses—anger, gossip, slander, hatred and the like. Then we see our sin for what it is. And only then can we repent and forsake it…. (Hazard, 1992, p. 86)

Healing comes as we see ourselves in those who hurt us. We come face to face with our own sin and can turn to God for cleansing. This kind of humility enables us to truly forgive “from the heart” (Matt. 18:21-35). Francis of Assisi also believed that forgiveness must become a way of life for those who profess to love God:

> Very simply, you must learn not to be upset over an injury because it is an offense to you. Rather, out of your love for God, train your thoughts on the harm that your enemy is doing to his [or her] own soul with each sin or offense he [or she] commits. (Hazard, 1992, p. 53)

It appears that Francis is proposing unquestioned forgiveness, no matter what the offense. Perhaps he believed that in focusing on love for God and the damage that the offender is doing to his or her own soul, people are able to respond in love and
compassion rather than in bitterness and anger. A person with a heart full of forgiveness is in the unique position of being able to offer a hand of hope rather than one of condemnation, which parallels precisely what God did for humanity. In this paradigm, an act of forgiveness becomes a statement of empathy. One person is essentially saying to the other, “I may not have done exactly what you did, but I am also capable of doing evil.”

Forgiveness in Psychology

In Christian theology the process of forgiveness is linked causally to the healing of relationships, emotional healing, obedience toward God, and empathy and identity with the humanness of another. All of these consequences of forgiveness are restorative ones. They are outcomes that bring healing and wholeness to persons both personally and relationally, making forgiveness a topic of profound importance to the psychological community. Over the past several years agents of healing, both Christian and secular, have begun to investigate the potential therapeutic value of forgiveness. The primary thrust of the work done in this area centers around three main perspectives. The first perspective is one in which there is an adamant opposition to any employment of forgiveness in therapy, including its religious connotations (e.g., Bass & Davis, 1992; Miller, 1990). The second perspective is one in which the single goal is to alleviate inner discomfort and relational conflicts. Here, forgiveness is essentially reduced to a clinical technique aimed at providing the client with relief from the often destructive consequences of these types of relational struggles (e.g., Davenport, 1991; Hebl & Enright, 1993; Hope, 1987; Human Development Study Group, 1991; Worthington & DiBlasio, 1990). The third perspective is one in which the authors consider forgiveness to be an extension of theological understanding, or at least mention its theological roots and implications (e.g., DiBlasio & Benda, 1991; The Educational Psychology Study Group, 1990; Enright & Zell, 1989; Pingleton, 1989). A look at specific examples will shed some light on these models.

Opposition to Forgiveness in Therapy

While the gist of forgiveness literature tends to focus on its power as a therapeutic technique, there are several authors who either completely reject it or put severe boundaries on its use. Psychodynamic theorist Alice Miller globally writes against the pursuit of any form of either forgiveness or reconciliation. In her book Banished Knowledge (1990), she rebukes her colleagues who advocate forgiveness, and she makes every attempt to distance herself from them. She provides support for this position in a case example in which a man forgave his abusive father and two years later killed an innocent man (Miller, 1990, p. 153). Miller believes that forgiveness is actually detrimental to the patient and is almost always done out of moral obligation. Although Miller’s words point out that subtly coercing clients into adopting therapists’ values is problematic, we must equally resist the temptation to oppose what could potentially be beneficial to clients. In other words, rejecting an intervention solely because of contrasting personal values can also be a failure to act in the best interest of the client.

Other authors also address forgiveness in discussing sexual abuse. Bass and Davis (1992) in their book The Courage to Heal devote a section to the topic of forgiveness. They maintain that it is only necessary for the sexual abuse victim to for-
give her/himself, never the guilty party. For those readers with religious convictions regarding forgiveness, they have this to say:

If you have strong religious ties, particularly Christian ones, you may feel it is your sacred duty to forgive. This just isn’t true. If there is such a thing as divine forgiveness, it’s God’s job, not yours. (p. 150)

They further suggest that it is both “insulting” and “minimizing” to encourage an abuse victim to forgive her or his abuser (p. 150). What these authors categorically dismiss may be what their clients need the most.

While these positions appear to be somewhat rigid and harsh, pursuits of justice for abuse victims by avoiding any form of forgiveness is not without some strengths. Perhaps there is a justifiable fear on the part of some that encouraging forgiveness will cause guilt in clients who are unable or unwilling to forgive, but feel pressured to do so by their therapists. Others may view forgiveness to be utterly ridiculous or infeasible in light of the harm suffered by the client. To forgive would be in some way condoning the harmful action. There may be instances where the specific emotional or situational condition of the client makes it inappropriate to encourage forgiveness, or to even discourage him or her from actively pursuing it. Encouragement to forgive prematurely will likely yield false forms of forgiveness.

Forgiveness as a Clinical Technique

Several authors maintain that forgiveness is advantageous to clients because it helps them release painful and debilitating negative affect. Although these authors make a good beginning in addressing some of the basic elements needed to sustain long-term forgiveness, the required knowledge about forgiveness that the authors call for does not include the historical and theological foundations that promote self-awareness and lead to loving identification.

For example, Hope (1987) offers forgiveness as an effective tool with abuse victims. He portrays the healing benefits of forgiveness through a real case example. The scenario is one where a man, upon becoming involved in an evangelical church group, forgave his alcoholic father for years of heartache, trauma, and abuse. Upon forgiving his father under the direction of a minister, a “dramatic change” took place in him (i.e., his current relationships improved, he became a more active and loving parent, and engaged in less self-deprecating thought patterns) (p. 245). Hope connects this moving transformation to the one act of forgiveness, failing to consider the possible life changing effects of this man’s new religious faith. Perhaps what prompted his act of forgiveness was a deep awareness of his own failings and need for forgiveness and mercy. His experience of grace might naturally lead him to adopt the same attitude toward himself and others. In other words, perhaps the whole Christian belief system caused this one act of forgiveness to produce the emotionally beneficial consequences.

Some have noted the connection between clinical applications of forgiveness and theological perspectives, but have suggested that some separation between clinical application and theology is appropriate. Worthington and DiBlasio (1990) promote the facilitation of “mutual forgiveness” in couple therapy, which they believe requires some form of “repentance, atonement, and sacrifice” on the part of each person (p. 220). Implicitly imbedded in these concepts is religious meaning.
and a history of religious ritual that epitomize the process of forgiveness. The authors acknowledge this historical link, but go on to explain how therapists have effectively separated forgiveness from its religious ties and successfully incorporated it into their own theoretical paradigms.

Others have advocated forgiveness as a clinical strategy while warning that an understanding of the moral philosophical and historical underpinnings of forgiveness is essential. The Human Development Study Group (1991) recognizes the importance of therapists possessing a sufficient amount of knowledge regarding the definition and process of forgiveness before utilizing it in therapy. They even guard against focusing solely on the reduction of negative affect as an adequate outcome:

A definition that exclusively emphasizes forgiveness as the reduction of negative emotions may lead clients away from resentment or hatred, but into a cold neutrality that is not forgiveness. (p. 494)

In other words, people may think of forgiveness just as they think of “letting go” of an offense. Often this is nothing more than passive acceptance of an injury (Hope, 1987), or a choice to relinquish any plans for revenge. True forgiveness is an active process where a person chooses to absolve the guilty party. Instead of living in a state of “cold neutrality” the person often lives in a loving relationship with her or his offender. The Human Development Study Group expounds on this theme by extending the idea of compassionate forgiveness or forgiving out of “moral love” (p. 493). They also include as an essential component in the forgiveness process an awareness of the need for forgiveness from others. In doing so they boldly address what others might consider to be overtly value laden and thus inappropriate for therapy.

Those most aware of the theological and historical roots of Christian forgiveness find it difficult to simply employ forgiveness as a therapeutic technique. Although some therapists may advocate forgiveness to clients because “it will make you feel better,” many Christian therapists advocate a more insightful motive. Human forgiveness first requires us to see our own depravity, then to forgive in loving identification with another fallen human. This type of forgiveness does not always make people feel better, but instead requires them to see themselves and their faults more clearly.

Forgiveness as an Extension of Theological Understanding

Given the rich historical tradition of forgiveness revealed in Scripture, it seems important for Christian psychologists to understand forgiveness as an extension of theological understanding. Several authors have made important contributions in this direction, but it seems clear that our current understanding of integrating theological views of forgiveness with specific clinical strategies is quite primitive.

McCullough and Worthington (1994) conducted a review of the forgiveness literature and concluded that “theological, philosophical, and psychological understandings of forgiveness have not been well integrated” (p. 3). They go on to hypothesize that utilizing forgiveness in a therapeutic context has the capacity for tremendous spiritual implications for clients, which potentially leads to beneficial psychological consequences as well.

Pingleton (1989) begins with a thorough theological perspective on forgiveness
and then attempts to integrate it with a psychological perspective. His resulting process is one in which the therapist recognizes and “strives to cultivate” in his or her clients an understanding of what he proposes to be three essential elements embedded in the forgiveness process: “(a) forgiveness can only be received from God if given to others, (b) forgiveness can only be given to others if received from self, and (c) forgiveness can only be given to self if received from God” (p. 33).

Although this model is circular and somewhat difficult to follow, it does recognize that the ability to bestow forgiveness on self and others is inextricably linked to the ability to receive it from God. Finally, Enright and Zell (1989) attempt to answer some of the difficult questions related to our attempts to forgive others from a biblical perspective.

**Toward an Integrated View of Forgiveness**

While none of these perspectives are currently sufficient to understand forgiveness from a Christian perspective, each of them can play a valuable role in constructing a clinically responsible Christian perspective on forgiveness. Those who object to using forgiveness in counseling have offered legitimate cautions about ways forgiveness can be misused. Those who describe forgiveness as a clinical technique have provided useful perspectives on the ways forgiveness can be applied in counseling situations. Those who describe forgiveness as an extension of theological understanding have provided important perspectives, reminding us that a proper understanding of forgiveness cannot be accomplished without considering its philosophical and theological context.

Thus, a responsible Christian model of forgiveness in psychotherapy requires understanding all three perspectives: cautions about misapplying forgiveness in therapy, sensitive clinical applications, and a theological basis for forgiveness. When clinicians use forgiveness in therapy without understanding these three perspectives, they risk incompetence. Several examples are offered here to illustrate the need for all three perspectives.

First, some clinicians might employ clinical techniques of forgiveness without understanding the potential damage that can be caused by introducing forgiveness as a therapeutic goal. Clients who believe they must forgive in order to please a therapist or to fulfill a spiritual obligation have difficulty gaining the necessary insight for true forgiveness. This can lead to words and behaviors that reflect denial more than true forgiveness, with the client choosing conflict-avoidance over direct and honest communication.

Forgiveness happens as past resentments are owned, not dis-owned; are recognized, not repressed; are released, not retained; and are woven into new bonding relationships with others. (Augsburger, 1981, p. 95)

Second, some clinicians may apply a superficial theological understanding of forgiveness without considering the clinical implications and emotional difficulties of forgiveness work. This introduces an unhealthy urgency to forgiveness. The pressure to immediately grant forgiveness is exacerbated by passages of Scripture such as “don’t let the sun go down on your wrath” (Eph. 4:26). Christians find themselves “caught in self-tortuous logic” when they insist to themselves that they must forgive others before they have even dealt with the truth of the injury (Rose-
nak & Harnden, 1992, p. 191). Forgiveness should never excuse wrongful behavior, and does not substitute for legitimate consequences of sin (Rosenak & Harnden, 1992). Forgiveness which denies anger, or serves to keep emotions in check, is usually a false form of forgiveness. A typical response in this form of false forgiveness is, “I am not angry, only concerned.” The past may be dismissed, but it will not disappear. The anger will stew and grow, or might be displaced onto other relationships. To work through the anger of an offense means confronting feelings and broken relationships directly and honestly.

Third, if a clinician employs forgiveness techniques without understanding the Christian theological and historical foundations for forgiveness, the client may lose significant opportunities for insight and self-awareness. This theologically-deprived type of forgiving can create a mindset of superiority in the forgiven, as if the client believes, “I will forgive you because I live on a higher plane than you, and I refuse to let you drag me down to your level.”

**Therapeutic Implications**

For clinicians who believe that forgiveness is an effective healing tool and wish to employ it with their clients, several strategies can be recommended. First, Christian clinicians need to learn about the history of forgiveness, including its use in the pastoral care tradition. With a thorough understanding of the process of forgiveness in mind, they can teach their clients the process of forgiveness, in part by modeling it in the therapeutic relationship. Clebsch and Jaekle (1975) outline four historical functions of the pastoral care tradition: healing, sustaining, guiding, and reconciling. Interestingly, these relationship factors apply equally as well to the therapist interested in modeling and employing forgiveness. This is not surprising considering that “long before psychology was a distinct discipline or profession, Christian pastors and spiritual advisors were engaged daily in activities that required what today is viewed as psychological wisdom” (Oden, 1992, p. 137). Although forgiveness may be more readily applied when working with Christian clients, Clebsch and Jaekle’s four functions can also be applied in work with non-Christian clients. Therapists can model and affirm the humility and self-awareness they gain from a Christian understanding of forgiveness, and in the process provide clients from diverse religious backgrounds insight into the healing power of forgiveness.

Second, it is important to structure the therapeutic relationship in a way that gives value to the humility and self-awareness required for true forgiveness. Hope (1987) maintains that clinicians are already using forgiveness, consciously or not, when they unconditionally accept their clients despite any shocking information they might reveal in therapy:

> Perhaps it is this experience of being valued in the present despite obvious shortcomings and failures in the past that provokes clients into forgiving their pasts, developing a more forgiving attitude in the present, releasing judgments and grievances, and thus creating more options for the future. (p. 241)

Clients are often able to release the grip of shame in their lives as they experience this forgiving attitude. What seemed to be reprehensible and unforgivable thoughts and behavior in their own minds turn into failings that can be rectified in the presence of the effective therapist. It is usually only through the cleansing of personal
forgiveness that people can be promoted to extend it to others. The focus for the therapist is to become an accepting therapist from which client forgiveness is a natural byproduct of the relationship. This is not to say that acceptance and forgiveness are identical; rather a capacity to forgive is fostered by a humble, insightful, accepting therapist.

The therapeutic relationship is the most essential component in effecting positive outcome in psychotherapy. Whiston and Sexton (1993) conducted a review of the numerous studies that attempt to determine what produces the best outcome in therapy. They concluded that it is not the techniques alone that produce positive outcome, but rather the relationship that is vital for therapeutic growth. Techniques are seen to be secondary in that they “occur within the interpersonal context of a counseling relationship” (p. 470). If the client feels a positive regard and connection to his or her therapist, the clinical interventions employed are likely to be much more effective. Thus, the therapist who models empathy, forgiveness, loving identification, and functions as a co-worker in the healing process will likely have far greater benefits than the therapist who is viewing the technique alone as the solution to each malady. Specific techniques can be helpful in psychotherapy, including forgiveness techniques, but they must be viewed in the broader context of the therapeutic relationship.

Third, when forgiveness techniques are used in therapy with Christian clients, they should be considered in the context of self-awareness, empathy, humility, and insight, and not just as a way for a client to experience emotional relief. Our capacity to forgive one another depends, at least to some extent, on our capacity to understand both our need for forgiveness and God's gracious gift of forgiveness. This type of healing brings a person into a deeper relationship with God and others. Consider the case of the man who upon forgiving his alcoholic father experienced life transforming consequences (Hope, 1987). Before this act he had poor relationships and low self-esteem. He was not only harming himself, but he was also causing his family to suffer. In order for him to receive complete emotional healing, he will not only need to forgive his alcoholic father, but perhaps even more importantly, he will need to seek forgiveness from his own family for failing them. When the forgiveness process is complete, he will not only have experienced emotional healing, he will also have grown spiritually. His act will presumably bring him into a deeper relationship with God and with his family.

Fourth, it is important to recognize risks in encouraging clients to forgive too quickly or without a proper understanding of the emotional and relational affects of sin. The therapist helps the client recognize the offense, making sure that he or she does not excuse, condone, or dismiss it. In fact, he or she is supportive of the anger process and even encourages it by actively acknowledging the pain and injury. The therapist sees the undeserved consequences in the client’s life, and eventually helps him or her to move beyond anger to forgiveness (Davenport, 1991). This type of presentation by the therapist helps to rebuild trust in the client. The client learns to trust again first by trusting the therapist to legitimize the undeserved anguish, but more importantly trusting that the therapist will not leave him or her in an unresolved state of bitterness and anger. Forgiveness includes risking in relationships again, often with the person who caused the injury. The therapist becomes a model who provides safety in the initial steps toward this end. This is not to suggest that reconciliation is the appropriate goal for all forms of forgiveness. In some situations, especially where an offender is likely to offend again, full recon-
ciliation is not possible. In these cases, the wisdom and spiritual discernment of the therapist and client are essential tools for making healthy choices.

Conclusion

Forgiveness is a powerful therapeutic tool that has a capacity to affect emotional well-being in people’s lives when utilized in its proper context. But forgiveness is more than a technique. It has a theological and historical context which endows it with healing power. Forgiveness represents the end of isolation, anxiety, depravity, and brokenness, uniting humans with God and one another.

The current trend in the psychological literature is to abandon the religious significance of forgiveness so that it might be more acceptable to non-religious clients and therapists. Yet the therapist who is educated about the theological and historical bases of forgiveness can use it effectively with his or her religious and non-religious clients by becoming a therapist who models forgiveness, recognizes fallibility in the client without being condemning, presents choices and consequences around the option to forgive or to remain angry, and provides a safe and trusting environment.

References


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Social Skills Activities 
that Enhance Relationships of 
Children with Attention Deficit 
Hyperactivity Disorder

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Abstract

It is apparent that children with Attention Deficit Hyperactivity Disorder (ADHD) suffer from a loss of self-esteem which in turn interferes with their ability to make friends and interact in socially appropriate ways. Current research literature indicates that social skills education focusing on structured interventions of play, modeling and other group administered activities as outlined in this article could begin to assist ADHD children in correcting those inappropriate social behaviors.

Children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) may also suffer from a deficiency in proper social skills. One area in which their abilities are especially lacking involves social and peer relationships (Wheeler & Carlson, 1994). Improper social relationships will impede children's progress in other areas. Elliott and Gresham (1987) noted that social skills have been shown to be critical prerequisites to interpersonal success. Janos (1986) pointed out that social development is critically important for success in life, and perhaps even more for happiness. This may be especially true for children with ADHD, since research suggests that ADHD is often accompanied by unhappiness (Lahey, Schaughency, Strauss, & Frame, 1984).

The ability to get along with others contributes to a child's self-esteem. Such skills include the ability to interact effectively with others which, in turn, increases the child's feeling of well-being. Children with ADHD apparently are not well received among peers and are aware of their unpopularity, thus affecting their self-esteem (King & Young, 1982). The ability to interact socially is critical for participation within peer and school groups. Therefore, it is important that children with ADHD be able to develop social skills that will allow them to maintain interpersonal relationships. This article suggests methods of social skills education that may help alleviate the alienation caused by ADHD.

A Progressive Pattern

Many factors suggest that children with ADHD have difficulty maintaining friendships due to behaviors that alienate others. There is a relationship between poor personal interactions, misbehavior and friendships. Alienation from well socialized children occurs as one engages in misbehavior (Mitchell & Rosa, 1981). Patterson...
(1982) showed that without some type of positive intervention, misbehavior generally progresses from less to more severe forms of misbehavior as children with ADHD grow older. This suggests that misbehaviors may predict a continual course toward social dysfunction. Children affected by ADHD exhibit characteristics which may lead to greater social impairments even throughout adulthood. This may include greater risk of emotional instability, higher unemployment rates and less contact with friends, relatives and social organizations such as community agencies, schools and churches (Wadsworth, 1979). Loeber (1982) argued that problem behavior that occurs consistently throughout childhood and adolescence predicts a number of other significant problems throughout adulthood.

If this is the case, then some type of intervention strategy is necessary to avert misbehavior. Social skills education may assist children experiencing ADHD overcome the negative social effects of alienation and to increase the likelihood of satisfying friendships. Specific activities are employed to enhance the child's ability to make friends. It includes strategies like play, reinforcement, role play, coaching and modeling.

The Importance of Play

Krough (1994) told of how two boys dealt with socialization in a new situation and how the teacher acted as intermediary.

Pablo made friends easily, Charles was unable to choose the right attitudes and behaviors. Pablo's technique was to stand on the sidelines, quietly watching the children play. If someone dropped a block, he would pick it up, say simply, "Here," and hand it back. After a few days he began to offer tidbits of advice when there were building problems. Before long, Pablo was invited in. Charles' approach was heavy handed. He said in a loud voice, "Hey! Can I play with you?" It was more a statement than a request, and he followed it up by grabbing a few blocks and adding them to the current building project. "Hey! Not there," one of the boys said, and three children made faces of frustration and anger. Similar incidents followed over the succeeding days. Madeleine (the teacher) realized that the children were never going to accept Charles if she didn't intervene. First she helped Charles see that his tactics weren't working and asked him if he could think of any alternative behaviors. He couldn't. Madeleine suggested variations on Pablo's techniques and had Charles rehearse them, right down to the exact words he should say to the children. She then went to the children and told them what she had been doing with Charles. She asked that they respond appropriately to his new attempts at being a more skillful friend. She knew it would take some time for Charles to learn to interact with social skillfulness. She also knew that her continued efforts were an important element in her role as a teacher. (p. 109)

Play is related to everyday interactions. The teacher plays a significant role in these situations by modeling and directing attention to appropriate behavior (Sara-
son, 1976). The teacher is a very important part of this process. The teacher provides instruction and modeling (coaching) of correct behavior.

Currently, there is little in the way of an effective plan to train children with ADHD in reducing their disruptive behavior and improving their interpersonal relationships. Therefore, at present it remains difficult to improve poor social skills. One way to change this may be through play and role play activities within the classroom.

Free play is an ideal way to observe and then teach through role play and feedback by the teacher regarding what behavioral changes need to be made. Art materials, toys and games can all be used to create scenarios from which positive behaviors can be modeled and practiced. Children can express themselves and create fantasies, which will in turn lead to improved social interaction. These are strategies that can be used to help children verbalize feelings, emotions and work through conflict.

Reinforcement

During social interaction children can be rewarded for practicing positive behaviors. Reward strategies reinforce ideas of getting along. Behavior modification techniques, with their emphasis on reward and reinforcement, are a mainstay of any behavioral change program. Verbal praise and tangible reinforcers can be used for any observed positive behaviors. Peer group feedback also plays an important role. The peer group is the place where children have the opportunity to share and explore their feelings with those in class. It is in the group process that children give and receive praise and feedback. The children work along with the teacher within the context of the group to discuss and practice what they learn.

One of my favorite duties when I was a counselor in the public school system in Florida was to work with children in learning how to affirm one another (i.e., practicing being nice to each other). As one student realized, “You have to be a friend to make a friend.” We would practice finding ways to affirm something about one another. Verbal praise was far more effective than tangible rewards because it was taken into the soul. When one child learned to say simple things like, “I liked your choice of color in your picture” it meant much more in establishing friendships than giving out candy.

Social Skills Education

For children and adolescents engaging in various forms of misbehaviors, social skills education may prove to be effective. Amatea and Sherrard (1991) stated that social skills education is a central factor in shaping and reducing problem behavior. Deffenbacher, McNamara, Stark and Sabadell (1990) found that social skills education in a group context was an effective measure for reducing anger as a result of poor self-concept and low self-esteem.

Social skills education works exceptionally well with children because in general, children enjoy being together. Much of what a child does is within a group context, often supervised by an adult. Therefore, we should take advantage of this natural opportunity to assist children with ADHD learn within the group setting. Landreth (1987) reported that group play activities, as a form of instruction, built better relationships among children. Social skills education in the form of free play and role play help alleviate children’s distress which often manifests itself in disobedience,
poor achievement and social adjustment difficulties (Sigmon, 1986). Wheeler and Carlson (1994) suggested social skills education in the form of coaching can be an important intervention strategy for children with ADHD. Such coaching strategies, with an emphasis on highly structured instruction, modeling, and play, can assist ADHD children in overcoming the harmful effects of childhood alienation. Severely disruptive students’ misbehaviors decreased and their level of self-esteem increased as a result of social skills education (Nenortas, 1987).

I employed these strategies daily. Out of necessity I incorporated coaching strategies in my “after school clubs.” These clubs were designed to enhance children’s classroom experiences through self-esteem programs. We would re-enact scenarios from curricular guides that were intended to foster greater peer appreciation. In our “after school clubs” we practiced how to resolve conflict and develop friendships. We also addressed expressing our selves in appropriate ways through role play.

Just as a coach draws his team to the side to explain what caused poor execution, we need to draw children aside. The coach then diagrams how to meet with success; we too should diagram how children can meet with success. The coach explains and then models effective performance. We need to explain and then model effective performance for success and making friends.

One third-grade boy (who was supposed to be in fifth) would intimidate others and often leave school during the day. He would then get into trouble with his teacher. Therefore, his teacher and I set up an individualized Education Plan (IEP). The IEP consisted of participation in an “after school club” where role play and coaching mediums could be explored, exposure to new activities (one of which was free golf lessons from the local professional) and daily reading assignments from selected sports magazines could be accomplished. Using social skills strategies, I was able to elevate his classroom performance. These strategies along with daily monitoring made him feel like a leader in class instead of an agitator. He showed up for class more often, was more eager to participate, and got along better with other students.

**A Biblical Example**

From a biblical perspective, an analogy can be drawn regarding patience and love using the example of the Prodigal Son (Lk 15:11-32). In this story the father is loving and patient toward his wayward son. This is the attitude God has toward us. The father does not admonish his son saying, “you must straighten out or else,” but understandingly says, “I love you and will be patient, never giving up on you. I will help in any way I can.” Finally, the son realized he must return home. He went through many difficulties, but a feast awaited him at long last. The father’s patience paid off.

**Spiritual Connections**

We all experience difficulties paying attention, especially when it comes to our relationship with God. We all too often vacillate between holiness and carnality. God in these matters is patient, kind, tolerant and compassionate with us. God perseveres, allowing us to experience difficulties due to our lack of spiritual focus. We want our way instead of God’s way. We exhibit all the characteristics of a child with ADHD in our spiritual journey.
The point is that it does not pay to be harsh with children and it is often inappro-
priate to issue ultimatums like, “when are you going to start accepting responsibility
for yourself?” when indeed they may not be able. God looks at us and realizes how
incapable we often are at combating sin. God does not issue ultimatums, but rather
understands and looks beyond our shortcomings. We need to do the same when
working with children experiencing ADHD.

Help and assistance is needed through modeling and coaching. Jesus modeled
an example to follow. He coaches us as we live and learn through the Holy Spirit.
Spiritually, we need to learn to behave and live in accordance with God’s precepts.
In like manner, we need to view children with ADHD by those same principles.

Conclusion

Children with ADHD are aware of their difficulties. They understand they are
unpopular. They also know that their lack of appropriate social skills leads to alien-
ation. These deficiencies in making friends may contribute to misbehaviors which
may increase in severity without proper intervention.

Appropriate social skills contribute to personal confidence and are prerequisites
to success and happiness. Therefore, it is important to develop within ADHD chil-
dren social abilities which will allow them to maintain positive interpersonal rela-
tionships.

These strategies are presented as means in overcoming the social alienation
brought on by ADHD. Play is presented as the natural context through which
instruction may take place. Specific strategies include reinforcement (for
encouraging positive interactions), role playing (as a way of presenting appro-
priate social behavior), and coaching (to model in an ongoing manner positive
behavior).

References

Amatea, E. S., & Sherrard, A. D. (1991). When students cannot or will not change their
behavior: Using brief strategic intervention in the school. Journal of Counseling and Devel-
opment, 69, 341-344.
Deffenbacher, J. L., McNamara, K., Stark, R. S., & Sabadell, P. M. (1990). A comparison of
cognitive-behavioral and process-oriented group counseling for general anger reduction.
Journal of Counseling and Development 69, 167-172.
Elliott, S. N., & Gresham, F. M. (1987). Children’s social skills: Assessment and classifica-
Janos, P. M. (1986). The socialization of highly intelligent boys: Case materials from Ter-
deficit disorders with and without hyperactivity similar or dissimilar disorders? Journal of the
counseling. Elementary School Guidance and Counseling, 21, 253-261.
Child Development 53, 1431-1446.


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Clinicians’ Columns

PRACTICE AND PROFESSIONAL ISSUES

Advancing the Kingdom Together: Psychotherapists and Pastors
Kathleen M. Lattea, Christ United Methodist Church and Westview Psychological Services, Frederick, MD

As a Christian and psychotherapist, I seek to be used as an instrument for Christ’s advancement of His kingdom of light in a world of darkness. I have found in thirteen years of experience networking with pastors in my community that this shared perspective of kingdom work provides the basis for relationships of mutual respect and support. It doesn’t hurt that I’ve also had fifteen years experience being married to a pastor. I know the heart of a devoted shepherd of a local body, and I have learned how to communicate the power of psychotherapy to contribute to the goals of a pastor for the sanctification of his or her beloved flock members. I also know the concerns pastors share about the therapy process (I share many of them myself), and I have found honest discussion of problems leads to miles of ground taken for the kingdom and lost to the adversary’s agenda of disunity.

1. Focus on Shared Goals
   At a meeting of evangelical pastors in our community, my group of colleagues and I were given time to present ourselves and our work. I took the introduction section, outlining the shared concern of pastors and therapists for the congregants in our diverse churches. Many Christians are broken and wounded at deep levels from past or present injuries to the psyche, and their lives are consequently blighted by sinful attitudes and actions, destructive family and church behavior patterns, and unrealized potential for the kingdom. Pastors grieve over the resultant suffering caused to individual believers and to whole congregations; they desire to see families in their churches loving each other and God and serving God effectively through the local body. The therapist who can intelligently and sympathetically make the case for the helpfulness of psychotherapy in strengthening the bruised reed will find a receptive ear from the compassionate pastor. We need to show we can look beyond our narrow focus on the status of our practice to the larger, uniting vision of community ministry. While some in my profession may disagree with me, I told the pastors’ group what I believe: my work as a psychotherapist is really a specialized extension of the daily sanctification work going on in churches and individual lives.

2. Develop Mutual Respect
   It is therefore very important for me, as I network with pastors with the most obvious goal of courting referrals, to truly respect pastors’ gifts in and knowledge of the kingdom work of sanctification. They have usually developed spiritual discernment of their congregants’ (my potential clients’) character and motives; they have often observed how a given individual interacts in the body; and they have almost always formulated well-reasoned theological positions on issues that affect us both as we seek to help hurting people. Too many pastors find therapists poor listeners when it comes to learning from their expertise.
When a pastor tells me this member/client needs to work on Bible reading and prayer, s/he is not necessarily spiritualizing a problem. When I am told a client has been delivered from their issues, I respond that I would like to be used by God to help them learn to walk in this new deliverance. When I am warned of a spirit of ______ (fill in the blank), I remember that spiritual warfare is a part of all healing. When a pastor responds angrily to my request to collaborate with a difficult client/member, I consider the power of projective identification on unsuspecting helpers in this client's life.

An angry congregant may present an innocuous facade at church, yet be filled with unresolved turmoil from earlier life events. Church members and pastors can be caught up in this person's powerful projections of blame and bitterness without clear understanding of the sources of the anger. Showing a pastor I understand his or her concern for the welfare of the flock may open the door for giving an explanation of how congregational dynamics are influenced by one troubled parishioner.

Of course it is also important that pastors understand and respect some things of value to our field of psychology. It is here that therapists need to work on nondefensiveness. I admit that I too get riled (and even talk back to John MacArthur on the radio) when “uninformed” critics attack the place of Christian psychotherapy in kingdom work. Nevertheless, there are thoughtful criticisms of our field that need to be acknowledged and addressed. Christian psychotherapy does not advance the kingdom when it lowers biblical standards of conduct in the name of compassion, places healing above holiness, or undermines the role of the church in sanctification. The pastor who hears me say that therapy does not substitute for church, that wounds don’t excuse sin, that both personal responsibility and the miraculous healing work of God are validated in my office, is a pastor who is more likely to refer to me. He or she will also be more likely to hear me out as I seek to explain the intricate nature of my treatment of injured psyches.

My husband refers to the therapy office as a “black box” into which pastors hesitantly refer a troubled parishioner. As pastors become educated on the process of psychotherapy, light is shed inside that box and the pastor’s concerns for his or her church member’s experience are relieved. While I may have an open-door policy for my clients to bring family or pastor into their sessions if they choose, I explain to the pastor why this may not be acceptable for either pastor or client at certain points. When pastors ask questions about symptoms they see in a specific person in treatment, I can answer in generalities that explain why therapy is often a deeply disturbing and preoccupying process for any client. Pastors welcome clarification of areas such as confidentiality and why it is crucial, common problems encountered by clients in therapy and how to help, realistic estimates of the length of therapy, uses of adjunct groups and medications, and why forgiveness work often comes near the end rather than at the very start of therapy.

### 3. Tell Where You Stand

Another important way to reassure pastors is to create and disseminate clear mission and doctrine statements. Pastors wonder: What will this member hear in that office about life, church, and God? What kind of “advice” will be given regarding divorce, abortion, and sexual practice? Will my members be strengthened in their commitments to
family and church? Will this therapist share Christ with a seeker? Are there doctrinal differences between myself and this therapist, and how will they be handled? Will my congregant be referred back to me for spiritual counsel? If the answers to these questions are unknown by pastors, then the number of referrals lost (and missed opportunities to help people) will be unknown to me.

A mission statement that clarifies your identity as a tool for the kingdom, and a doctrinal statement that stresses adherence to orthodox basics versus millennial minutia can open the door for more dialogue. For our overall mission statement, our practice hammered out the following: “As a Christian multidisciplinary team of psychological service providers, we commit to love and obey God by participating in His work in the local church and the larger community.” The emphasis is on how our particular gifts and training are submitted to God and contribute to kingdom victories. Details can spell out the philosophy and practice of the group in regard to personal and corporate ethics, church involvement, continuing education, fees and sliding scales, relationships with other local providers and insurers, and commitment to highest levels of competence and caring.

4. Clarify the Working Relationship

Open discussions with pastors about client confidentiality should also include statements of desire for pastoral input when the client allows. The sharp pastor realizes that what s/he hears from the client (“my therapist said”) is not always a verbatim quote. I have had to clarify with more than one pastor that I do not make statements to clients recommending quick divorce. Over time, a relationship of trust develops. I also make sure pastors know I am always open to phone calls to shed light on situations where a client may be splitting myself and the pastor into conflicting positions.

I have also enjoyed conducting free phone consultations for pastors in tricky situations in their own counseling, premarital work, or in group dynamics problems. I find pastors appreciate having someone with them in a psychologically messy situation who sees that personality issues, not pastoral failings, are at the root of some parishioner complaints. Lastly, pastors know I am available to do teaching, seminars, or workshops in areas of congregational need. It’s fun to contribute through my teaching gifts when a pastor sees a need for a jump start among his or her people in the area of child-rearing, marriage, life transitions, or personal growth. Our group offers regular free seminars in an attempt to give psychology away and prevent some unnecessary heartache requiring therapy.

5. Offer A Service

When I first began networking with pastors for my solo practice, I took as my model my father’s approach to his vocation in sales. “You are not pressuring a sale but offering a service to meet the needs of your contact.” Our product as psychotherapists is not just therapy; I am my product. To be a good “product,” I have always handled my own sanctification in my typically dutiful style. I gain legitimacy when pastors hear that I read the Bible through each year, see that I lead community Bible studies, understand that I have done my own therapy work (twice!), and perceive over time that I strive for genuine integrity. This brings initial referrals. (Of course, this is not the first reason to be serious about my own spiritual growth; I trust that godliness with contentment is the greatest gain.) Over time the quality
of my treatment should increase referrals by word of mouth.

Talking with pastors need not be intimidating. I again think of my father's approach: we are two professionals discussing how both our goals can be reached by cooperation. I expect to like the pastor and to enjoy sharing our triumphs and trials as we each pursue God's call on our lives. If he or she is initially uncomfortable talking to a psychologist, I pour grace over the relationship, ignore any off-hand remarks, and concentrate on clarifying how we can help each other. First, I listen to the vision of the pastor for his or her body, the concerns for personal and corporate growth in Christ, and the programs in place already helping parishioners heal. Then I share how my ministry might advance the church's mission. I go in equipped with concrete examples of how hurting congregants can move toward wholeness in family and church life through competent therapy. I enthuse about the victories of marital and family interventions. I go into details about our group practice only if the pastor has time; specifics about our fee arrangements or insurance coverage can be covered in a follow-up letter. I make sure before leaving however that the pastor knows exactly the steps involved in making a referral. One point I've found beneficial to stress is that I welcome one-time evaluation appointments. Pastors can tell an uncertain member that I offer trained feedback in one session to help them look at their alternatives and choose a course of action to solve their current problem; no commitment to long-term therapy is expected. When I leave the pastor's office I hope we both feel encouraged to go about our calling.

Early in my practice I visited pastors' offices bearing my brochure and offering free consultations and seminars. I was diligent to contact every referring pastor, take every speaking offer, and hand out cards at every community event. Now, busier and less driven, my marketing is minimal and I wonder if I do enough. I notice my focus shifting to prevention and giving psychology away so more people can be served. Prevention comes through community education and leveraging by training church leaders, lay counselors, and gatekeepers. Getting self-help groups off the ground interests me. Helping other pastoral families bear the burdens of their calling is one of my burdens. All of these dreams will involve new forms of networking with pastors to share the excitement of advancing the kingdom.

**Final Note: Networking Up Close and Personal**

This shared thrill of ministry has sustained my husband and me through difficult pastorates and a demanding new church start. I have learned a great deal about how Christian psychotherapy joins the work of the church, and at times how it doesn't. I have learned humility in my relations with pastors by observing with profound respect the mind-renewing, life-transforming, psyche-healing daily shepherding my husband provides. The pastor is a part of my client's real world, exposed to the congregation's pain in less packaged doses than my clean 50-minute sessions. He takes their issues full force without the norm or format of immediate examination of the motives for their remarks. He sees psychologically dysfunctional people in less formal environments without a predetermined ending time; his role provides less protection from their daily pain and projections. Yet every Bible teaching, every sermon, all his meeting leadership, and the many discipling
phone calls and visits are seasoned with grace and truth, ministered in healing doses without the protective blank screen divider of the therapeutic relationship. A loving church family he has labored to shape provides a therapeutic community in which my clients can heal. It takes a tremendous level of pastoral dedication and effort to pull that off in this time and society. My husband and his colleagues are very grateful for the ways Christian therapists advance the kingdom in the lives of hurting congregants. We therapists can be thankful for the redemptive work of pastors and churches in the lives of clients God brings to us for our particular form of ministry.
Religiousness and Coping: Implications for Clinical Practice
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There is significant, substantial, and increasing empirical evidence that appraisal and coping play important roles in persons' adjustment to life stress (e.g., see Carpenter, 1992, for a review). One of the primary theoretical models (Lazarus & Folkman, 1984) upon which this research has been based defines coping as an ongoing transactional process between the person and the environment, influenced by both cognitive appraisal and coping behavior. Through cognitive appraisal, the individual assesses the person-environment relationship (primary appraisal) regarding its degree of relevance, threat, loss, challenge, or benefit. When situations are appraised as relevant stressors (i.e., involving threat, loss, and/or challenge), the individual then evaluates (secondary appraisal) the adequacy of coping resources. After appraisal, coping behaviors ensue as attempts to either manage, alter or master the situation (problem-focused coping), regulate emotional responses to it (emotion-focused coping), or perform some combination of these functions. Following coping responses, the person-environment relationship is reappraised, and this cycle repeats as the situation unfolds. According to this model, stress occurs when the individual appraises her/his relationship with the environment as draining or exceeding personal coping resources.

Until recently, religiousness has received little empirical attention in coping research. It has typically been viewed either as a defense (Pargament & Park, 1995) or ignored as tangential to psychological functioning. Over the past fifteen years, however, a growing body of research has challenged these assumptions, suggesting instead that the psychology of religious coping represents an important area of study in its own right. Pargament (in press) provides a comprehensive review of this literature, upon which much of the current article is based.

More recently, religiousness and/or spirituality have gained increasing acceptance as valid expressions of healthy individuals. Indeed, religious and/or spiritual problems are now given v-code status as potentially nonpathological stressors in the DSM-IV, (American Psychiatric Association, 1994). For example, the term “religiosity” is frequently used in the literature, even though this term often denotes “excessive or affected piety” (Soukanov & Ellis, 1988; p. 993) and can suggest pathology. (For this reason, the more neutral term “religiousness” is used in this article.) In addition, the majority of coping research does not regard religiousness as a unique avenue of coping in its own right, classifying it instead simply as one emotion-focused coping strategy (e.g., Folkman et al., 1991). This narrow view not only ignores the possibility of problem-focused religious coping, but also fails to consider that religious coping might entail a unique coping dimension. Thus, a broader view of religious coping is needed, particularly if it is to provide a resource for clinical practice.

Fortunately, recent research findings provide such a broad perspective, revealing the complexity of religiousness as it relates to coping. This article highlights some of these findings with particular relevance to clinical practice.
Given that 74% of clinicians in a recent survey (Shafranske & Malony, 1990) believed that religious or spiritual issues can be relevant to psychology—yet 67% of this same sample believed that psychologists are not competent to assist clients with spiritual issues—such information is clearly needed. Indeed, another recent survey suggested that even explicitly religious clinicians do not tend to recommend religious coping and/or make religiously pertinent interventions (Jones, Watson, & Wolfram, 1992). With this in mind, the following summary highlights some findings of particular relevance to clinical practice and provides some practical suggestions for maximizing religiousness as a coping resource and minimizing its detrimental effects.

1. Religious Coping is not simply an avoidant defense mechanism. Whereas the vast majority of Journal of Psychology and Christianity readership undoubtedly accept this statement as valid, there are at least two reasons to include it as foundational. First, it is a reminder that many mental health professionals still view religion basically as a means of avoidantly reducing tension. Second, it is noteworthy that growing empirical evidence contradicts this stereotypical view. In a recent review, Pargament and Park (1995) noted that whereas religious coping can serve simply to provide tension reduction, it has also been shown to be motivated by a search for significance, intimacy, self, and/or spirituality in its own right. In addition, religious coping can be adaptively problem-focused (Pargament et al., 1988), particularly when individuals view God as a benevolent observer or as a willing collaborator. Furthermore, religious coping can be expressed in a wide variety of ways. For example, Pargament et al. (1990) identified six different classes of religious coping, consisting of 29 specific strategies. They found that spiritually based coping activities (those emphasizing a personal relationship with God) were positively related to adaptive general outcomes, general health, and religious outcomes. Furthermore, religious coping strategies were found to predict outcome variance above and beyond that explained by nonreligious coping strategies.

Because negative stereotypes regarding religion still remain amongst some mental health professionals, clients might continue to assume that their religious beliefs will be assessed as pathological. Given the growing empirical support for the potentially adaptive qualities of religious coping, clinicians should be particularly sensitive to this issue. By creating a therapeutic environment in which clients feel safe to discuss their faith, clinicians will facilitate clients’ optimal reliance on religiousness as a coping resource.

2. Religious Coping is not always adaptive. In reviewing the empirical literature, Pargament (in press) concludes that religious coping is more typically a help than a hindrance. As with any class of coping behavior, however, it can also be ineffective at best and detrimental at worst. Pargament proposes that religious coping can involve maladaptive choices regarding ends and means, respectively. Regarding ends, extrinsically using religion purely as a means to the end of anxiety reduction (e.g., seeking pastoral support only in time of crisis, accumulating good deeds as attempts to atone for guilt of a secret offense) might exemplify a potentially maladaptive strategy. Indeed, the extent to which persons are generally extrinsically religious (Allport & Ross, 1967) has been shown to correlate positively with anxiety (Baker &
Gorsuch, 1982), perceived powerlessness (Donahue, 1985), and fear of death (Gorsuch, 1988). Regarding means, Pargament proposes various potentially problematic approaches, such as using religious explanations to the exclusion of others (e.g., attributing illness solely to sin), using only religious coping strategies (e.g., relying on prayer alone to resolve illness) and using religion to justify maladaptive behavior (e.g., physical abuse in the name of biblical discipline).

Clinicians should attend to their clients’ potentially deleterious religious coping behaviors, while respecting religious orientation. To this end, helping clients identify faulty coping appraisals underlying general coping problems can be useful (Meichenbaum, 1996). Similarly, empowering religious clients to abandon illogical premises, while maintaining their faith, may decrease resistance to constructive change. For example, a client who desires to obey Scripture, but insists that prayer is the only valid response to illness, might reexamine this premise in light of Paul’s instruction to Timothy to take some wine for his frequent stomach problems (1 Tim. 5:23).

3. Religiousness should be included in clinical assessment. Bergin and Jensen (1990) cite Gallup poll results showing that nearly 75% of Americans surveyed base their whole approach to life on their religious faith. Given that religiousness is thus not only relevant to coping but also common within the general population, including religious questions in assessments could well be considered an ethical requirement. (Those clinicians concerned that such questions might appear either too tangential or too personal should note that sexual history questions could also be viewed from either perspective.)

Kirkpatrick (1994) has argued that God beliefs can provide a projective assessment of a person’s attachment styles (e.g., with an avoidant attachment style corresponding to belief in a distant or nonexistent God). Assessing religiousness can be even more important when therapeutic efforts involve restructuring clients’ maladaptive internal models; and such models have clear relevance to coping styles (e.g., avoidant-passive vs. constructive-active). This assessment need not always be comprehensive. Including at least one general question (e.g., “Could you briefly describe any religious beliefs you hold and any impact they have on you?”), however, opens the door for more in depth analyses where applicable (e.g., Tan, 1996). For clients expressing interest in religion—and in light of Kirkpatrick’s reasoning—asking projective questions (e.g., “Who is God?” “How does God help you?” etc.) can be useful. Specifically, clients’ responses (e.g., “God is the man upstairs,” “God is my father and friend,” “God helps me as a constant comfort and guide,” “I try not to bother God unless it’s a crisis,” etc.) may inform clinicians regarding clients’ interpersonal attachment styles as well as their religious and nonreligious coping styles.

Stylistic assessment is only a starting point. Pargament (in press) notes the importance of assessing religiousness contextually, particularly regarding religious coping. For instance, a person who generally tends to use collaborative religious problem-solving (i.e., seeking God’s help in working actively to resolve stressors; Pargament et al., 1988) will likely experience increased distress if she/he insists on using this coping strategy exclusively. With truly uncontrollable stressors, for example, a deferring approach (e.g., turning the stressor over to God or accepting it as
God's will) will probably be more adaptive than a collaborative one, whereas persistent attempts to solve the problem might result in anger at God and general maladjustment.

As with assessment in general, both gender and ethnoculture must also be considered when assessing religiousness. Even among persons with comparable denominational affiliations (e.g., Protestant Christians), religiousness cannot be assumed to function uniformly for those from distinctive ethnocultural groups (Bjorck, Lee, & Cohen, 1996) or across gender (Bjorck & Cohen, 1993; Kirkpatrick, Shallito, & Kellas, 1996). Clearly, increased empirical attention to these assessment issues is also needed (Worthington, Kurusu, McCullough, & Sandage, 1996).

4. Religious Coping can shape intervention. Pargament (in press) proposes a clinical intervention model for religiously related problems, based on analysis of the client's religious means and ends, whereby assessing the adaptiveness of means and ends suggests four interventions:

(a) Preservation: Even when a person's religious goals and methods of attaining these goals are both good, she/he might still consult a clinician when facing a crisis. Pargament suggests that such a person may simply need supportive affirmation that she/he is actually coping well given the circumstances. Additionally, Pargament proposes that acute stressors may result in failure to utilize religious resources already in place. In such cases, intervention may involve empowering the client to resume regular religious coping behaviors within the novel situation.

(b) Re-construction: Pargament notes that some clients have adaptive religious goals, but due to new circumstances, their former methods to achieve these goals become inoperative or maladaptive. For example, religious beliefs (e.g., that God lovingly watches over God's children) can provide a sense of security which facilitates necessary risk-taking behaviors (e.g., driving, banking, shopping, etc.). This sense of security can be sought via maladaptive methods, however (e.g., basing one's risk-taking on the assumption that godly living guarantees safety), which can result in severe stress reactions (e.g., P.T.S.D.) if such methods fail (e.g., being robbed while leaving a Bible study). In such instances, clinicians will need to help clients re-evaluate their religious methods and consider others (e.g., basing risk-taking on the assumption that God is always present and prevents danger from exceeding God's loving will). When such clients are religiously committed, referring to appropriate sacred texts alluding to adaptive religious coping methods can be useful. For example, encouraging a Christian or Jewish client to compare Psalm 23:4 ("Yea, though I walk through the valley of the shadow of death, I will fear no evil, for Thou art with me ...") to her/his apparent misquote (e.g., “… I will fear no evil, for You will always keep me completely unharmed …") can facilitate reassessment of contradictory religious methods.

(c) Re-evaluation: Pargament suggests that for some clients, the presenting problem is a loss of religious goals, even though there is nothing intrinsically maladaptive with their religious methods. For example, a Pastor nearing retirement might experience an increasing loss of direction regarding religious purpose, particularly if no new goals are readily apparent. Encouraging such a client to explore alternative goals (e.g., focusing on visitation, writing, mentoring of young pastors, etc.) may enable the
retiree to continue “pastoring” while renewing a sense of religious direction. Similarly, a couple who believed that their primary purpose was to raise godly children might experience a crisis upon learning that they are infertile. Encouraging them to consider alternative goals (e.g., adoption, being “spiritual” parents to neighborhood youth, etc.), while maintaining their religious method (raising godly children), could provide a renewed sense of purpose. Concomitantly, encouraging them to grieve the loss of their original desire and to accept it as beyond their control (i.e., deferring religious coping) would likely enhance their adjustment to this stressor.

(d) Re-creation: Distress is often greatest for those lacking both adaptive religious methods and viable religious goals. Pargament suggests that, in such cases, a new start through forgiveness can be a means of restoring both, particularly for victims of abuse. Indeed, religious forgiveness might serve not only as a coping method for freeing oneself from the offense of others, but also as a goal (i.e., becoming an increasingly forgiving person), particularly if forgiveness is viewed as a form of self-empowerment and release from bitterness. An empirical assessment of forgiveness, however, is still needed to assess these possibilities (McCullough & Worthington, 1994). Pargament also posits that religious conversion can be a form of re-creative coping, whereby maladaptive religious means and ends are replaced with adaptive counterparts. Clearly, clinicians need to carefully ensure that interventions suggesting such dramatic changes do not become coercive or imposing (Tan, 1996). In such cases, consulting with clergy and/or including them as treatment team members may represent the most ethical route to facilitating change.

5. Religious Coping can contribute to prevention efforts. Whereas mainstream preventionists have at times viewed religiousness and prevention to be unrelated (Pargament, in press) or even antithetical (Albee, 1991), the preventive role of religiousness is actually widespread (Björck, 1992; Maton & Wells, 1995). Furthermore, it is also becoming the object of increasing empirical scrutiny. Maton and Wells review relevant research and note that religion can be preventive through congregational systems in a variety of ways, including (a) strengthening of families, (b) enhancing parental support, (c) providing moral guidelines which facilitate development (e.g., stressing pre-marital sexual abstinence, discouraging substance abuse), and (d) instilling religious coping resources (e.g., belief in a compassionate God who never abandons believers, belief in the efficacy of prayer, etc.). They further propose that congregations can provide more tangible coping resources, such as support groups, rituals (e.g., being prayed over for healing), and crisis counseling (e.g., pastoral counseling, lay counseling, etc.). Indeed, lay counseling ministries are becoming increasingly widespread and serve as a valuable resource, particularly for those whose religious beliefs make them less likely to seek secular services or whose financial status make such services unaffordable (Tan, 1991).

Prevention efforts should promote the potential benefits of maximizing religious coping efforts within the context of general coping. A recent analogue study (Björck & Cohen, 1993) suggested that—even for intrinsically religious persons—religious coping resources are underutilized. Whereas highly intrinsic persons projected strong reliance on religious coping when facing extreme
stressors in general, classifying stressors as either threats, losses, or challenges revealed a differential coping pattern. Specifically, considerable religious coping was planned regarding threats and losses, but comparatively little religious coping was projected regarding challenges. Furthermore, this low reliance on religious coping with challenges was recently replicated (Bjorck & Klewicki, in press).

Thus, prevention efforts might encourage increased religious coping with challenges and propose that persons view challenges as lower-risk opportunities to develop and improve religious coping skills. Doing so could be compared to practicing driving skills in a vacant parking lot in order to enhance skills needed when driving in heavy traffic. Indeed, McIntosh (1995) has proposed that developing a more comprehensive religious schema might facilitate cognitive processing and result in improved coping and adjustment when stressors potentially related to religious issues arise. In support of this, McIntosh, Silver, and Wortman (1993) found that greater importance of religion was associated with more cognitive processing of—and more meaning found in—the death of one’s child. Thus, prevention efforts encouraging religious coping in nonstressful times may enhance religious coping efforts when crises occur.

Whereas empirical study of religious coping and its ramifications for clinical interventions has already made important contributions to the literature, much more is needed. The majority of religious coping research has assessed nonclinical populations, and generalizations to those seeking treatment need to remain cautious (Worthington et al., 1996). To this end, researchers will do well to remain informed of the general coping literature as it relates to clinical populations. For example, Folkman et al. (1991) have recently proposed ways in which general coping theory can be directly applied to intervention (e.g., coping effectiveness training). Translating such models for explicitly religious purposes, or expanding them to include religious coping, both represent potentially fertile areas for future research. Researchers will also do well to submit their findings to high-profile APA journals, so that the importance of religious coping can become common knowledge among mainstream psychology (Larsen & McCullough, 1997). Hopefully, such efforts will result in continued progress toward effective interventions for all clients, regardless of their religious orientation.

References


The Case of the Missing Diagnosis
James R. Beck

Ann and Ted pursued their pastoral ministry with the conviction that the Lord had richly blessed them with children. Nothing was very unusual about their family except perhaps the fact that their oldest and youngest were adopted and the middle two children were their own biological offspring. The first to join Ted and Ann's family was Chester. It was a private adoption facilitated by a physician in their home town who knew of their interest in adoption. The family took Chet home from the hospital two days after his birth; he was normal in weight and size. Within a year Ted and Ann gave birth to another boy. Their daughter was born two years later at about the same time as the adoption of their youngest son. Four children, two of whom were adopted, were 3 years apart in age. Others might think the family's configuration was unusual, but Ted and Ann didn't; they just saw it as evidence of God's blessing on their lives.

Ted enjoyed pastoring small Baptist churches in Alabama. Ann was a trained special education teacher, but she worked out of the home only after the children were well into their teenage years. The childhood years of these four pastor's kids were quite unremarkable. Nothing gave the parents a clue as to what was ahead of them when their oldest son reached his adolescence.

Hindsight always helps us locate signs and indicators of trouble that, at the time, passed by almost unnoticed. After Chet had entered his turbulent adolescent years, the parents did identify some events that were slightly out of the ordinary. When their second son was born prematurely, the baby and mother had to stay in the hospital for a few days while the doctors treated the baby's hyaline membrane condition and the mother's toxemia. At that very same time, Chet developed severe croup and had to be hospitalized. Ted recalls the chaos of those days when three of the four family members were medical inpatients. Chet's croup was severe and at times he had to be restrained while the staff administered medications. But soon the young, growing family was back home; no one thought that the experience was predictive of later hospitalizations for Chet.

Chet's infancy and childhood were unremarkable. Chet had some qualities of a "strong-willed child," but nothing that the family could not manage. Ted and Ann told Chet from the very beginning about his adoption. Chet had never shown much interest in the matter; in fact, on only one occasion when he was 16 has Chet ever asked for any information about his biological parents. After receiving the requested information, Chet dropped the issue.

Ann now looks back on a few of Chet's childhood idiosyncrasies and wonders if they were precursors of his adolescent struggles. Chet refused to wear high collars such as characterize turtleneck sweaters, hated Kleenex, and resisted medical interventions such as throat cultures. The parents thought his medical aversions were probably linked to his earlier hospitalization trauma.

Chet's strong-willed behavior did not interfere with his performance at school. He did well in academics. Teachers noticed nothing unusual about Chet. He displayed some perfectionist tendencies. Ted feels that one of Chet's major goals in life was to have everyone view him as inconspicuous; he wanted not to be noticed. He matured physically into a capable school athlete who at one time made the all-star team in football.
The first sign of abnormality came when Ted and Ann took a short-term foster child into their home. Chet was 12 years of age at the time. Almost immediately Chet began to object to the way in which the new foster child ate her food. He claimed she was biting her fork. He couldn’t stand any of the normal noises of eating and breathing that she and soon other members of the family exhibited. Chet’s objections to these normal noises of family meal times escalated sharply and continued even after the foster child left the home. Soon the family could not eat together. Chet’s struggles began to increase but only in the home environment. School continued to be hassle-free for Chet.

Soon the sounds of the dishwasher, knives and forks banging against stoneware plates, and other kitchen noises irritated Chet to such an extent that the family switched to the use of plastic tableware. Family meal times became less problematic although the family was baffled by Chet’s peculiar objection to normal noises. Ann says of this period in time, “Parishioners who came as guests to eat in our home must have been dumfounded. Surely they thought we were very poor.”

Chet’s aggravation with clanging silverware spread to restaurants and the homes of other people. The family soon did not eat at the homes of friends and they avoided restaurants. Fast food became their only food luxury to break up the monotony of eating off plasticware at home. His acute auditory sensitivity soon extended to sound equipment. He would shout out, “Turn that thing off!” Those around him could not hear the very faint hissing or popping noises from the speaker that would drive Chet to distraction.

Chet’s sensory sensitivity soon spread to smells. Perfumed hand lotions, after shave colognes, and other cosmetic smells would throw him into immediate rages. The family’s impressions of these outbursts was that Chet would go out of his mind. Chet was able to control his furious responses to noise and smell while at school, but the intensity of these fits of rage consequently increased when he was at home. The parents became alarmed when Chet began to be more physically aggressive, sometimes striking out at one or more of his three siblings. His violence coupled with deteriorating school performance prompted the parents to realize that they needed help.

Ted and Ann began asking professionals they knew about Chet’s odd condition. Most people whom they asked were uncertain as to what might be the problem, although most all of them recommended that they take Chet to someone qualified to do a complete evaluation. Chet refused to go to any evaluation session. His performance in the classroom and on the playing fields of public school soon crashed. He also refused to allow anyone at the school to test him. Thus the family was not able to get him qualified for any forms of alternative education. The family was in a survival mode. Because Chet was 15 years of age and as strong as or stronger than his father, his lack of cooperation with any kind of professional evaluation paralyzed the family.

Chet dropped out of school. The district provided a homebound teacher. The teacher had great success involving Chet in his ongoing school work, but the amount of time the district would allow for homebound instruction was quite limited. When the teacher’s allowable time with Chet had expired, Chet dropped out of school. He never graduated from high school although
he later passed the G.E.D. examination with no difficulty.

No one knew what was wrong with Chet. One child psychiatrist whom the parents visited made the off hand comment, “Sounds like autism,” but because Chet refused to be evaluated, no further authentication of his condition could be made. No one else ever mentioned autism as a possible explanation for Chet’s struggles.

Meanwhile the family was learning first hand how difficult it can be to deliver mental health services to an uncooperative person, even if he is only an adolescent. The options available to them were rapidly shrinking in number. As his violence increased and his condition deteriorated, they realized that their only hope was to arrange for treatment against his will. Such interventions are never easy and are fraught with high risk.

A private psychiatric hospital cooperated with the police to place him on an involuntary hold for psychiatric evaluation. The ambulance came to their home while Chet was asleep to take him to the locked unit. The trauma on the parents was nearly unbearable. “It was the hardest day of my life,” says the father. The admitting psychiatrist assured the family that they would be able to help the family and to identify Chet’s problem. After 30 hours had elapsed, the hospital called and asked the family to come get their son. There was nothing the hospital could do, they explained.

When Chet arrived at home, his problem and the accompanying outbursts of rage intensified a great deal. Chet was understandably upset and felt very betrayed. The family also felt betrayed by the emergency psychiatric team who had promised far more than they delivered. Now Chet was no longer constrained by the Christian standards of conduct that had characterized their home. His language took on a foul color and the family struggled even more to coexist in the same house.

Friends of the family tried to help. Some suggested that they were being too tough on their son; they needed to loosen up and give him more freedom. Others suggested that they were not being tough enough. The parents began attending Tough Love group meetings. Other group members were understanding and tried to be supportive. But the general content of the approach did not seem to fit their son Chet. He was not a rebellious teenager. When he was not in a rageful fit, he behaved and interacted in quite a normal manner. The Tough Love meetings did not really help the parents.

One day Chet’s next younger brother sprayed some deodorant in the living room of the house. Chet flew into a rage because of the noxious smell of the spray. He attacked his brother and in the ensuing struggle managed to break the brother’s thumb. The father rushed to intervene and was also injured by Chet who was clearly out of control. The parents had to summon the police who came and arrested Chet. He was placed on another involuntary hold at a different psychiatric hospital where they prescribed Haldol.

Chet’s reactions to the medication were severe, but the staff persisted in getting the Haldol to therapeutic levels. For the first time in years, Chet was calmer and more able to resist reacting to sounds and smells. Later Chet was transferred to a public, locked psychiatric facility. His total hospitalization this time was three months. The family reconstituted itself without the terrorizing presence of Chet. The other three
children were able to relax and resume their normal levels of functioning.

Chet made significant progress while hospitalized and while under the effects of Haldol and an anti-depressant medication. During one family session at the hospital, Chet was able to hug his father, receive and exchange affection, and tell his parents that he loved them. For the first time in many years the parents felt like their son had received help and that he had a future. On a pass with his family, Chet was able to eat in a restaurant for the first time in many years. Home visits, overnight passes, and eventual discharge soon followed.

The ending of this story is quite positive and hopeful. A family friend took Chet on as a project, taught him a trade, and helped him learn how to work. Living in a halfway house soon helped Chet learn how to be more independent. The family began to notice a growing level of maturity. As Chet's confidence grew, he moved to Mississippi, lived by himself in an apartment, and continued to learn handyman skills. He apparently outgrew his need for Haldol having learned how to exercise control over his reactions to noxious noises and smells. In the following years, Chet has been able to succeed in the workplace and has recently married. No one feels that all of his internal struggles have ended, but he is coping very well with life's demands and has successfully emancipated himself from his parents.

Professional mental health interventions with Chet indirectly succeeded in spite of the fact that, according to the parents, Chet was never diagnosed correctly. The Haldol helped Chet get through the toughest years of adolescence so that he could face adult life with more appropriate levels of maturity. The original prescription of Haldol was motivated by the need to find something that would help Chet with impulse control. One unexpected benefit of the medication and attending hospitalizations was that Chet was helped with his real problem.

Ann's professional work as a special education teacher eventually required her to attend a conference on autism. As the speakers began to explain the disorder and to distribute descriptive materials, she began to sense that her son had struggled all of these years with a mild, perhaps rare form of autism. Granted, Chet did not fit the standard description of many of the pervasive developmental disorders including autism. Even Asperger's Syndrome did not accurately describe Chet. Yet his struggles correlated closely enough with this family of disorders that Ann has become convinced that Chet's sensory sensitivities and over-reactions were very autistic in nature. Finally as her son turned 24 years of age, she understood him more fully.

What prevented those caring yet unaware professionals from understanding Chet more accurately? Hindsight seems to indicate that they sustained two handicaps in trying to deal with this difficult case. First, these mental health providers often seemed obsessed with their own etiological bias when they were interviewing Ted, Ann, or Chet. Some would insist that Chet's struggles were nothing but examples of the adoption syndrome. Either Chet had failed to bond to his parents or he was struggling with an internal inability to build an identity as an adopted child who had been given up by his birth parents. Other evaluators suggested homosexual panic, oppositional behavior, sexual abuse, or bad parenting.
Some secular counselors were convinced that it was the conservative religious climate in the home that was the source of Chet's outbursts. Christian counselors did no better, sometimes suggesting sin or demonic attack as their best guess as to what was wrong with Chet. In each case, the diagnosticians did not seem to have a broad enough spectrum of possibilities with which to assess Chet's odd and peculiar struggles.

The second major error that seems to have been committed by those who have tried to help the family over the last decade is that they all seemed to distrust the intuition of the parents. The temptation to write off parental skepticism as instances of denial or resistance is too hard to overcome for some therapists. This family was not dysfunctional in its interactions even though they had one very distressed child within that family circle. He had never been sexually abused, was developing sexually in a normal fashion, was greatly loved by his parents who, though not perfect, were neither pathologically too severe nor too lenient with him. Whenever the parents objected to some of these misguided suggestions, they were not believed.

Chet improved even though all efforts to help him were not based on accurate diagnosis. God's healing interventions are thankfully not contingent on human skill, and Chet prospers today in spite of it all.

Therapists of all persuasions who are interested in the integration enterprise are indebted to colleagues from the pastoral counseling discipline. Pastoral counseling authors have made sterling contributions to the task of integration by providing all of us with powerful examples of solid theological and psychological groundwork and illustrative case studies that flesh out the theory into practice. Hunsinger’s book is no exception. Her work presents to us an outstanding and premiere example of solid integration that attends faithfully and fully to both the psychological and the theological domains.

Deborah Hunsinger, an assistant professor of pastoral theology at Princeton, assembles material from Karl Barth and from various psychodynamic schools of thought as the building blocks of her new interdisciplinary approach. She describes in the Preface her personal journey of wrestling with the challenges of integration. She was puzzled with how the two fields could at the same time be existentially connected in the lives of people but also be logically diverse and systematically uncorrelated in subject matter. Her struggle faces anyone who wishes to work with these two disciplines together. They fit together, yet they do not fit together. Psychology and theology are closely related to one another, but they are also quite asymmetrical to one another. She kept this issue in a productive, tensive state until she began to see that the theological method of Karl Barth might shed some light on the issue.

From a Barthian perspective, as I eventually came to see, the alternative to systematic correlation involved the construction of ad hoc analogies. The turn to analogy seemed to bring a number of advantages. It respected the basic competence of each discipline within its own distinctive field and, therefore, allowed each to have its own realm of significance. It also seemed to make reciprocal influence possible without resulting in a loss of identity for either discipline (p. xii).

Hunsinger’s struggles pivot around the well documented distinctives between psychology and theology (different subject matter, methods of inquiry, aims, and data banks). Different theorists have handled these distinctives in different ways. Carter and Narramore describe them as challenges to be overcome; Paul Clement described them as proof of the orthogonal relationship between the two fields. Hunsinger treats this important matter in a theological manner by using the Chalcedonian formula, a method Barth frequently used during his long theological career.

The Chalcedonian formula, according to Hunsinger, is relevant here because fifth century Church fathers used it successfully to describe the close relationship between two other very asymmetrical entities: the human nature of Jesus and the divine nature of Jesus. The Chalcedonian formula dealt with issues of unity (the
two natures of Jesus are related without separation or division), integrity (the complete deity and the complete humanity of Jesus existed together in indissoluble differentiation), and asymmetry (their indestructible order consisted of the priority of his deity, the subsequence of his humanity, and their existence ordered in mutual freedom). This Chalcedonian formula has been successful in describing the incarnation, not because it consists of verbal gerrymandering but because it describes well the close connection between two very asymmetrical realities that can be described accurately in no other way.

Regarding the integration of psychology with theology, Hunsinger says that this formulaic approach to the problem affirms that both disciplines are united in our personhoods and experience, that they are each separate yet inseparable, and that the theological takes priority over the psychological subsequence even though the two are mutually ordered with each other in freedom. Hunsinger’s work here is well argued and meticulously organized. She provides for readers frequent previews and summaries of her logic. She includes an extensive case summary that is paradigmatic of her approach and two briefer case studies that are nonparadigmatic of her approach. She describes her work with clients as characterized by deft, bilingual competencies as she switches between the theological and the psychological.

Readers will find two unexpected bonuses in the book. The first is an extensive discussion of Ana-Maria Rizzuto’s important work on God representations as it bears on Hunsinger’s new model. Also, Hunsinger gives extensive treatment to an important dissertation that is not otherwise readily available to integrationists: Daniel Price’s 1990 Aberdeen work on Karl Barth and object relations theory, especially Fairbairn.

Hunsinger makes a fine contribution. Serious readers will find ample material of value in her well-written book.

* * *


Although the reader is not told this explicitly until almost the end of the book, the author is expounding a psychotherapeutic approach based on a new movement called “communicative” psychoanalysis, founded by Robert Langs, which has had its own journal for about nine years. However, the proselytizing style of the book and the fact that almost all of the sources that support the author’s position are either books by Dr. Langs or articles from the journal, make this fact hard to miss. The core tenet of this approach is that we all have a “deeper mind” that knows what is right and is trying to guide our conscious minds by indirect “communications,” such as seemingly unrelated stories in conversation.

Hodges refers to the deeper intelligence as the “right brain” and to the conscious mind as the “left brain.” For those familiar with hemisphericity and lateralization in brain research, it will be clear that he has re-defined the terms “left” and “right” to fit his theory. The deeper intelligence works in three ways: guidance mode (in life decisions), boundary mode (setting limits), and stabilizing mode (security, strength). Through these modes the deeper intelligence fulfills the three core human needs for commitment, autonomy and stability. The last major part of the book is comprised of six chapters, each dealing with an area in which the deeper intelligence may be used: marriage, parenting, codependency, therapy, spirituality and self-esteem.

The professional psychologist, or even the intermediate student of psychology, will
find nothing truly new in Hodges book. In order to maintain the sense that commu-
nicative psychology is a “breakthrough,” the author uses distorting generalizations
that downplay other psychological movements. While he notes that the deeper intel-
ligence is really the same thing that Freud called the “subconscious,” he claims that
Freud “missed the gold mine on which he was sitting” because he “was not open to
the ideas of the deeper mind.” But all of the case material in the book does not ever
really clarify what it is that Freud missed. The Jungians (all of them, apparently) are
no better. They talk more about the subconscious mind, “but when it comes to actu-
ally listening to the deeper intelligence, Jungians are in practice no different than
Freudians” (p. 27).

What makes the real difference in the “communicative” theory seems to be in the
way of interpreting the subconscious. Dr. Langs is alleged to have “broken the
code.” The book would in fact be helpful to the average layperson if it were not filled
with so much hyperbole and giddy praise for Dr. Langs. This tends to obscure help-
ful aspects of the book, which are located primarily in the final chapters on application.
But even here the message is contradictory. Ironically, Hodges’ advice to us is
not to take advice. Just listen to your deeper intelligence. This is really hard, so you
should go see a therapist. And the only ones who can break the code are “commu-
nicative” psychotherapists. It would be humorous, if it were not so painful, to note
that in the majority of the longer stories pertaining to therapy settings, the deeper
intelligence of the patient (as decoded by the therapist) tells the patient how impor-
tant it is to pay the therapist. He gives the example of one of his patients, who did
not want to pay for a session she missed. Hodges “decoded” some stories she told
as telling her that she should pay. Upon hearing this decoding, she disagreed with
her “left brain” (conscious mind), but later told a story about a sensitive coworker,
which Hodges then further decoded as “indicating that deep down she appreciated
what I had said” (p. 249).

One final problem with the book is theological: the entire enterprise is built on the
premise that we have within us everything we need in order to do what is right, and
that “deep down” we want to do what is right. This obviously contradicts a belief in
original sin and the biblical witness, rendering Dr. Hodges’ attempt to “Christianize”
communicative psychology a failure.

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PATHOLOGICAL SELF-CRITICISM: ASSESSMENT AND TREATMENT. Raymond
more (Chattanooga Bible Institute/Chattanooga, TN).

Here’s a book whose unique title grabbed my attention. I cannot recall seeing or
reading anything quite like this latest installment in the Plenum Series in Social/Clin-
ical Psychology. Raymond Bergner takes us beneath the worn out buzz word of
self-esteem and addresses pathological self-criticism, which he contends is a com-
mon root of depression and “low self-esteem.”

As the first step in healthy criticism is accurate observation, I shall make some
observations about the book. Bergner, who draws freely from the work of P. G.
Ossorio and others, encourages one to look at oneself as if he or she were two per-
sons, one being the self and the other its critic. He suggests therapists find appro-
riate metaphors for individual clients to represent this, such as parent-child,
boss-employee, coach-player. He explains how self-criticism is a normal task that is
misused by some to their detriment. Through processes he calls “self-degradation
ceremonies," comparable to court martials and the like, individuals pronounce critical judgments on themselves which lead to a perceived position of being ineligible to participate in good things in life, restrictions on behavior because of convictions of poor self-efficacy, and emotional distress. This destructive process of self-labeling produces the symptoms that lead to the consulting room.

Bergner outlines procedures for assessing such negative and ineffectual self-criticisms, along with their motives and possible origins from early in life. Most of his techniques are essentially cognitive-behavioral ones, though Bergner is eclectic and draws from humanistic, analytic, and Gestalt methods as well.

In essence, the self-critical function is intended, like good coaching or parenting, to enable one to receive affirmation when one does things well, and specific, corrective feedback when one errs or falls short. He notes how the good coach is one that praises successes, but offers specific corrective advice to mistakes. For example, the good basketball coach says, “Next time arch your shot more” and not “What a terrible shot, you’re hopeless.” The goal is to provide feedback to improve performance, not to discourage effort or damage the person. The self-critical function should serve the same purpose.

Bergner proceeds to detail therapeutic techniques and homework assignments that help the patient to see her or his self-destructive style and how to change it. He offers specific approaches to dealing with resistances and to promote healthy self-critical functioning, for he makes clear that he does not advocate complacency with oneself. The author draws from Carl Rogers to discuss vital factors in the therapeutic relationship which actually begin the process of change.

My hopefully healthy criticism of this work begins with assenting to the good work Bergner has done in concretely conceptualizing a common problem that is often vague in its presentation in the counseling office. I recommend this work because of its enlightening description of the self-critical process and its role in emotional and behavioral problems. The author is thorough and clear in covering the issues, and offers numerous case studies to illustrate them. His ideas come from a solid blend of research and clinical experience. Though he does not write from a religious perspective, his strategies should prove helpful with Christian clients who are often paralyzed by guilt or feelings of inadequacy.

I would offer corrective advice, however, especially from a Christian standpoint. The Gospel call is one that bids us acknowledge our inabilities and view ourselves as falling short. Bergner is right when he challenges perfectionism by comparing us to other people who are imperfect just as we. But scripturally we are called to live up to the standards of God’s law which we cannot do apart from Christ. Christians who choose to utilize Bergner’s models will need to adapt it to this perspective. Bergner encourages self-forgiveness but suggests one devalue the external critic when this critic judges him or her unfairly. However, external forgiveness would appear to have a place as well.

The only specific criticism I offer otherwise is that Bergner’s work suffers from its own value neutrality. He leaves each person to move toward their own “perfection,” which may or may not be adaptive. Challenging one’s direction, not just one’s method of pursuing it, is also a part of psychotherapy at times. Nonetheless, there is much of value in this book, and its fresh angle makes it a very worthwhile work for Christian counselors and researchers.

* * *


To get the greatest value from Helping Worriers (a pastor's resource) and Why Worry? (the client's companion workbook), the reader must understand the concept of Strategic Pastoral Counseling (SPC) formulated by David G. Benner, a clinical psychologist and faculty member at Redeemer College. His outstanding 1992 volume, Strategic Pastoral Counseling: An Overview (which I use as a text in my Pastoral Counseling course), presents a time-limited (five sessions) model of counseling “designed to fit the role, resources, and needs of the typical pastor who counsels” (Helping Worriers, p. 10). Formulated to address single, identifiable problems, Benner’s strategic approach is the basis for a ten-volume counselor’s library which will, when completed, include books on addictive behavior, anger, depression, forgiveness, grief trauma, guilt and shame, marital stress, parenting issues, sexual dysfunction, and worry. Assuming each volume follows the lead of Helping Worriers, the essence of SPC is presented in a lengthy preface by Benner. The rest of the book then describes the three basic components of SPC covered in five sessions, Encounter, Engagement, and Disengagement. A final chapter gives an example of the process from start to finish.

A conceptual question arises immediately for the counseling professional when reading of Benner’s approach in general or its particular application in Helping Worriers. Is a symptomatic approach to these spiritual/emotional/psychological struggles sufficient and appropriate? Can this very disciplined, five-session intervention really assist someone who is experiencing worrying to the extent described in the text? Recognizing the context in which the strategic pastoral counseling is accomplished, the pastorate and the church community, I believe that the answer is a very positive, “probably.”

First, if the worry is only a symptom of a deeper problem, then the pastor can help to ease the effects of the symptom so that the real struggle may be addressed. This is much like an infection which must be reduced or eliminated before surgery may be attempted. The authors then recommend and present an excellent process for referral, which, if necessary, is incorporated into the final session. If, however, the presenting problem is the primary focus, then, in the pastor’s limited time availability, the process and approach presented are extremely valuable.

After an Introduction on “Counseling Worriers” and the initial chapter on “The Psychology of Worry,” the next five chapters have a dual purpose. They link the process of counseling worriers to Scripture (without rejecting appropriate psychological understanding), and they provide the basis for the companion workbook, Why Worry?, which is to be assigned to the client. The chapters are edited and modified for use in the workbook. The use of the workbook is described and encouraged in Helping Worriers (and, I assume, in the other volumes of the series).

These five chapters are the foundation for the five sessions of the SPC: The Encounter Stage: Session One (The Bible and Worry), The Engagement Stage: Session Two (Scripture and the FEELINGS of Worry), The Engagement Stage: Session Three (Scripture and the THOUGHTS of Worry), The Engagement Stage: Ses-
sion Four (Scripture and the behavior of Worry), and The Disengagement Stage: Session Five (Final Thoughts from Scripture on Worry).

Each chapter, utilizing a scriptural foundation, discusses the conceptual as well as the practical, encouraging very useful and valuable homework exercises for the client.

I, as a counselor not limited by pastoral restraints, still gained greatly from these two volumes. First, the authors' and Benner's approach can easily be incorporated into a non-time-limited process. Second, the excellent biblical scholarship in this work (and, again I presume, in each of the series' volumes) is extremely helpful in applying Scripture to the area of concern. Third, the emphasis on the use of Scripture by the client and not just as a principle basis for my own counseling was a much-needed reminder, "Thy word have I hid in mine heart that I might not sin against thee" (Psalm 119:11). And, finally, it was good to see published confirmation of that which I have observed over the years, that chronic worry is the pain and disappointment of the past projected into the expected experiences of the future and brought then back into the present as the driving force governing thoughts, feeling and action. Essentially it is today's payment on tomorrow's assumed interest from yesterday's loan.

Particularly for pastors, I highly recommend Benner's approach of Strategic Pastoral Counseling and the series, SDC Resources, especially if the other volumes are all of the quality of Helping Worriers and Why Worry?


In sum, this book represents the basic position taught for years by Jay Adams and his follower, Wayne Mack, but with a new twist from John MacArthur. The book has historical value from the standpoint of following the Adams position and its development as now represented at The Master's Seminary (Santa Clarita, CA) with its move to the right of Biola University and Talbot Seminary. All the authors are closely associated with The Master's Seminary.

When the 1980 lawsuit against Grace Community Church occurred, Pastor MacArthur was, in his words, "startled and dismayed" to hear several psychologists testify in court that they didn't believe responsible counseling could be done "using only the Bible" (p. 5). He links this set of events and his reactions to the writing of this book. This explains the book's purpose, and the choice of authors who contributed chapters to it. Of the fourteen writers, only five of them are working in the field of counseling, while nine work in fields such as Bible, theology, or pastoral functions. In terms of major focus, this book is more about theology than it is about counseling methods, though the last two sections of the book are about process and practice of biblical counseling, and follow pretty closely to Jay Adams' orientation and approach. I saw nothing essentially new to the Adams' position in those last two sections.

The theological sections present an anti-integrationist polemic. Their argument runs: If we take Scripture seriously, we must assert that Jesus is all-sufficient to meet every need; psychology and study of general revelation are entirely suspect ("Christian psychology is an oxymoron," p. 10); any kind of integration between the-
ology and psychology is inadmissible. However, they make no clear demarcation between legitimate and illegitimate uses of general revelation. In addition, they frequently argue their case by using partial ideas from psychology to condemn the whole enterprise, much like David Hunt in *The Seduction of Christianity* or the Bobgans in *The Psychological Way / The Spiritual Way*.

Systematic theologian Douglas Bookman leads off the theology section by taking aim at the often-used affirmation by integrationists that some kind of harmonization of truth between special and general revelation should now be in process. He asserts that by definition revelation is nondiscernable by human investigation or cognition. It is simply a given to be passively received. He appears to ignore the rational effort involved in seeking to understand revelation with the help of divine grace and illumination. Note, however, that even such an obviously divinely given set of truths as the set of visions in Daniel was accompanied by a command “… to consider the word and understand the vision” (Dan. 9:23, emphasis mine).

People like Nicholas Woltersdorff distinguish control beliefs from data beliefs. A control belief accepted by evangelical integrationists would be that Scripture as a whole is the Word of God and has ultimate authority, especially in terms of the clear purpose of Scripture to lead us to salvation and obedience to God. A data belief would be that the truths or ideas we collect and interpret from Scripture or nature always need to be weighed carefully and compared with what we understand the clear central teachings of Scripture to be. Bookman often seems to confuse two levels of authority, that of *Sola Scriptura* with the authority of theology. Truth is not identical to our grasp of it. Much truth in the Bible is absolutely clear, but not all. A naive objectivism tends to be overly dogmatic. This also shows up in the somewhat simplistic treatment of sin in the applications sections of the book.

One interesting exercise with this book would be to trace back many of the authors’ counseling methods to secular psychology and counseling theory. Put another way, if we were able to put Wayne Mack back into the Middle Ages and ask him to take his Bible alone and come up with a counseling methodology, would it have looked anything like what we have in this book? If one compares the historic pastoral care documents in Clebsch and Jaekle’s collection from various periods since Jesus, Mack and his colleagues come off as very modern. Clearly, they have learned many ideas from the psychology of modern times, even though much of their counsel looks more like discipleship mentoring than counseling. Mack does more integration than he admits to.
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