CHRISTIAN COUNSELLING:
Does It Differ From Secular Counselling.

A thesis
submitted in partial fulfilment
of the requirements for the Degree
of
Master of Arts in Education
in the
University of Canterbury
by
A.G.A. van den Bos

University of Canterbury
1996
## CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>1</td>
</tr>
<tr>
<td>I. INTRODUCTION</td>
<td>3</td>
</tr>
<tr>
<td>1. Christian and secular counselling</td>
<td>3</td>
</tr>
<tr>
<td>2. Previous research</td>
<td>3</td>
</tr>
<tr>
<td>3. A reason for concern</td>
<td>5</td>
</tr>
<tr>
<td>4. Definitions</td>
<td>6</td>
</tr>
<tr>
<td>5. Christian orientations</td>
<td>8</td>
</tr>
<tr>
<td>6. World views</td>
<td>10</td>
</tr>
<tr>
<td>7. Styles of practice</td>
<td>11</td>
</tr>
<tr>
<td>8. Therapeutic implications</td>
<td>12</td>
</tr>
<tr>
<td>9. Therapist values</td>
<td>13</td>
</tr>
<tr>
<td>10. Values and theory in practice</td>
<td>15</td>
</tr>
<tr>
<td>11. Therapeutic education</td>
<td>16</td>
</tr>
<tr>
<td>12. Client perceptions</td>
<td>17</td>
</tr>
<tr>
<td>13. Relations between psychotherapy and religion</td>
<td>18</td>
</tr>
<tr>
<td>14. Purpose of research</td>
<td>20</td>
</tr>
<tr>
<td>II. METHOD</td>
<td>23</td>
</tr>
<tr>
<td>1. Ethical approval</td>
<td>23</td>
</tr>
<tr>
<td>2. Subjects</td>
<td>23</td>
</tr>
<tr>
<td>3. Design</td>
<td>26</td>
</tr>
<tr>
<td>4. Materials</td>
<td>27</td>
</tr>
<tr>
<td>5. Procedure</td>
<td>28</td>
</tr>
</tbody>
</table>
III. RESULTS

1. Demographic data 31
2. Therapist data 31
3. Beliefs 39
4. Ethics 52
5. Counselling practice 57
6. Supervision 73
7. Professional development 76
8. Training 77
9. Support 79
10. Therapist interviews 81
11. Client data 83

IV. DISCUSSION

1. Demographic data 99
2. Theoretical approaches 101
3. Beliefs 109
4. Ethics 124
5. Counselling practice 132
6. Supervision 148
7. Professional development 151
8. Training 152
9. Support 154
10. Therapist interviews 156
11. Client feedback 158

V. CONCLUSION 167

ACKNOWLEDGEMENTS 171

BIBLIOGRAPHY 172

APPENDICES 179
LIST OF FIGURES

<table>
<thead>
<tr>
<th>FIGURE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sample population orientations.</td>
<td>25</td>
</tr>
<tr>
<td>2. Combined group styles.</td>
<td>32</td>
</tr>
<tr>
<td>3. Committed Christian therapists.</td>
<td>33</td>
</tr>
<tr>
<td>4. Non-committed therapists.</td>
<td>33</td>
</tr>
<tr>
<td>5. Therapy used by committed Christian therapists.</td>
<td>34</td>
</tr>
<tr>
<td>6. Therapy used by non-committed Christian therapists.</td>
<td>35</td>
</tr>
<tr>
<td>7. Therapy that would not be used.</td>
<td>36</td>
</tr>
<tr>
<td>8. Recall.</td>
<td>38</td>
</tr>
<tr>
<td>9. Perceived client problem causes.</td>
<td>49</td>
</tr>
<tr>
<td>10. Problem of humanity.</td>
<td>40</td>
</tr>
<tr>
<td>11. Shedding of self ignorance.</td>
<td>41</td>
</tr>
<tr>
<td>12. Is Christian counselling better?</td>
<td>42</td>
</tr>
<tr>
<td>13. Counselling as a spiritual experience.</td>
<td>43</td>
</tr>
<tr>
<td>14. A vindictive God?</td>
<td>44</td>
</tr>
<tr>
<td>15. Definition of sin.</td>
<td>45</td>
</tr>
<tr>
<td>16. Therapists who believe in:</td>
<td>45</td>
</tr>
<tr>
<td>17. Length of Christian beliefs.</td>
<td>46</td>
</tr>
<tr>
<td>18. Bible as guide for counselling.</td>
<td>47</td>
</tr>
<tr>
<td>20. Guided by the Holy Spirit.</td>
<td>48</td>
</tr>
<tr>
<td>21. Would counsel others.</td>
<td>54</td>
</tr>
<tr>
<td>22. Social contact with clients.</td>
<td>55</td>
</tr>
<tr>
<td>23. Client issues.</td>
<td>56</td>
</tr>
<tr>
<td>24. Self disclosure indices.</td>
<td>57</td>
</tr>
<tr>
<td>25. After hours home call service.</td>
<td>58</td>
</tr>
<tr>
<td>26. Home contact.</td>
<td>69</td>
</tr>
<tr>
<td>27. Cannot pay response.</td>
<td>60</td>
</tr>
<tr>
<td>28. Would speak to others about client.</td>
<td>62</td>
</tr>
<tr>
<td>29. If a clash of beliefs occurs.</td>
<td>63</td>
</tr>
<tr>
<td>30. Response to a clash of beliefs.</td>
<td>64</td>
</tr>
<tr>
<td>31. How much of beliefs are shared.</td>
<td>64</td>
</tr>
<tr>
<td>32. Bible quoting and prayer for clients.</td>
<td>65</td>
</tr>
<tr>
<td>33. Introduction of new procedures.</td>
<td>68</td>
</tr>
<tr>
<td>34. Supervisors.</td>
<td>73</td>
</tr>
<tr>
<td>35. Assistance sought.</td>
<td>75</td>
</tr>
<tr>
<td>36. Relevance of Christian training.</td>
<td>78</td>
</tr>
<tr>
<td>37. Desired association membership.</td>
<td>80</td>
</tr>
<tr>
<td>38. Viewpoint regarded.</td>
<td>91</td>
</tr>
<tr>
<td>39. Client perceptions.</td>
<td>96</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

## TABLE

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Summary of responses following a first request.</td>
<td>24</td>
</tr>
<tr>
<td>2</td>
<td>Return results from organisations following two appeals.</td>
<td>25</td>
</tr>
<tr>
<td>3</td>
<td>Demographic data of research participants.</td>
<td>31</td>
</tr>
<tr>
<td>4</td>
<td>Therapist theoretical orientation.</td>
<td>31</td>
</tr>
<tr>
<td>5</td>
<td>Importance of spirituality.</td>
<td>53</td>
</tr>
<tr>
<td>6</td>
<td>Methods employed in approaching the subject of spirituality and by whom.</td>
<td>53</td>
</tr>
<tr>
<td>7</td>
<td>Safeguards employed and how much by whom.</td>
<td>69</td>
</tr>
<tr>
<td>8</td>
<td>Styles of employment.</td>
<td>60</td>
</tr>
<tr>
<td>9</td>
<td>Type of information forwarded onto another therapist.</td>
<td>61</td>
</tr>
<tr>
<td>10</td>
<td>Constraints governing information &quot;shared&quot;.</td>
<td>61</td>
</tr>
<tr>
<td>11</td>
<td>Use of Bible quotations.</td>
<td>65</td>
</tr>
<tr>
<td>12</td>
<td>Occasions for use of prayer.</td>
<td>66</td>
</tr>
<tr>
<td>13</td>
<td>Responses to clients involvement in the occult.</td>
<td>66</td>
</tr>
<tr>
<td>14</td>
<td>Therapist actions when therapeutic progress stalls.</td>
<td>69</td>
</tr>
<tr>
<td>15</td>
<td>Therapist self-gauging techniques.</td>
<td>69</td>
</tr>
<tr>
<td>16</td>
<td>Respondent's supervisors.</td>
<td>73</td>
</tr>
<tr>
<td>17</td>
<td>Book topics and read by whom.</td>
<td>77</td>
</tr>
<tr>
<td>18</td>
<td>Reasons for receiving counselling and how many.</td>
<td>79</td>
</tr>
<tr>
<td>19</td>
<td>Demographic data of responding clients.</td>
<td>84</td>
</tr>
<tr>
<td>20</td>
<td>Client beliefs.</td>
<td>88</td>
</tr>
<tr>
<td>21</td>
<td>Reasons why Christian counselling does or does not offer better counselling.</td>
<td>90</td>
</tr>
</tbody>
</table>
ABSTRACT.

Psychotherapy has traditionally described religious counselling in a negative manner since it was felt such practices perpetuated rather than dealt with mental health problems. This research set out to examine if differences existed between the practices of Christian and non-Christian therapists and the consequences if they did.

A uniquely constructed questionnaire was sent to a number of therapists, but a very low return rate was received from non-Christian therapists possibly reinforcing the underlying anti-religious hostility expressed by this group. From the total of twenty seven returns received, liberal and nominal Christians were combined with the non-Christians making a (renamed) non-committed group of fifteen therapists. Twelve remained in the (renamed) committed Christian group.

Data obtained from the questionnaire indicated a number of differences between the two groups. Differences were found in styles of therapy, religious beliefs, and ethical practices.

Following the questionnaire, two therapists from each group were interviewed to gain further insight into the results and responses obtained.

Both Christian and one non-Christian therapist were supportive of the research, but for different reasons. Christian therapists felt it was needed to educate others whereas the non-Christian therapist used it to educate herself. The remaining non-Christian therapist expressed marked hostility toward the research perhaps reflecting the opinions of the majority of therapists who did not participate in this research.

Six clients also returned a questionnaire, enabling some insight from a client's perspective to be gained. This indicated that what therapists stated they would do and what either actually happened or was believed to be happening, did not always match.
This study may be greatly flawed, however, due to the small number of therapists being studied and its being conducted in a small geographical area.

This research serves to raise more questions for future research rather than give statements of general fact.
CHAPTER I

INTRODUCTION

I. CHRISTIAN AND SECULAR COUNSELLING.

If one reads current counselling textbooks, one becomes aware that religion in counselling rarely, if ever, is addressed as a topic of serious discussion or as the topic of scientific research. Perhaps this is because many researchers are afraid to address this issue either for fear of reprisals or because religious counselling has been previously considered the domain of religious educators. It may also be that counsellors refuse to address this dimension because they do not know what to do or how to approach the subject.

There has been as much literature within Christian circles about counselling Christians from a Christian perspective as there has about general counselling of clients without mention of religion in traditional circles. What is not certain is whether the methods employed by Christian therapists are extensions of traditional psychotherapeutic methods, traditional methods practiced by self-identified Christian therapists or unique. If Christian therapists are simply extending traditional therapies, how is this being done? If they are using traditional methods under a Christian banner, what are the implications of this, and if they are practicing unique methods of therapy, does this have some use for traditional therapists?

II. PREVIOUS RESEARCH.

Some research would suggest that psychology and Christian forms of ministry cannot be integrated (Adams, 1970; Lovinger, 1984) yet no research appears to have been carried out as to whether this has occurred anyway. Some papers suggest how Christians can use a specific style of
psychotherapy and remain true to their beliefs (e.g., Jones, 1989) but give no understanding as to whether this has actually occurred or whether it is even practically possible.

Research has shown that Christians as a group have experienced some misgivings about counselling (Worthington & Scott, 1983; Worthington, 1986). Considering the Freudian origins of modern psychotherapy with subsequent theories showing an anti-religious bias, these misgivings certainly have had some basis (Adam, 1993). The main fears have been that religious beliefs would be seen as pathological, that spiritual concerns would be ignored, there would be a failure to understand the language and concepts of faith, and that counsellors would recommend immoral remedies or practices (Worthington & Scott, 1983; Worthington, 1986).

Secular therapists have often had a negative attitude to religion and religious people, and fail to see religion as possibly having a positive and adaptive function in the lives of many people (Lovinger, 1984; Genia, 1990; Lowenthal, 1995). They are often reputed to be ignorant of Christian practices and values (Pupura, 1985; Fenchel, 1986), intertwined with prejudice (Lowenthal, 1995).

Other traditional secular therapists say that the negative reactions they have and the clinical judgements they reach are the result of inadequate information about the causes of the clients' behaviour and not the result of negative attitudes to religion, just a lack of information about the rules governing other people's behaviour (Lowenthal, 1995). Bergin and Jensen (1990), surveying the religious beliefs of 425 mental health professionals in the U.S.A., found that a religious preference was expressed by 80%, but only 41% regularly attended religious services. This was not markedly below the reported average for the general public and therefore the mistrust of psychotherapy by the religious may not be the result of the irreligiosity of the psychotherapists as people but more to do with either the therapists'
lack of knowledge of particular religious customs, beliefs and values, and/or the failure of some psychotherapeutic systems to integrate religious values, practices and needs into their framework.

Lowenthal (1995) found that many secular therapists admitted to having difficulties in sorting out which behaviours and feelings were pathological and which were related to healthy religiosity. Lowenthal found these therapists to be sensitive to religious issues but lacking in information which would enable them to make more informed judgements. For example, Littlewood and Lipsedge (1989) found that psychotherapists experienced difficulties in judging when a client's behaviour was disturbed, or when it was socially sanctioned and encouraged within a Christian beliefs framework.

Ludwig (1985) and Rogers (1980) found that an emphasis on outside forces and greater powers may be attributed to the recognition that a sense of spirituality is one of the factors that correlates with positive treatment outcomes. Agee and Everts (1993), found in a survey of New Zealand counsellor trainees that "some kind of spiritual meaning in life" had either "everything" (29%) or "a lot" (42%) to do with becoming a counsellor

III. A REASON FOR CONCERN.

Worthington (1989) identified five compelling reasons to give attention to the implications of religious faith in understanding both normal development and its remedial effects: (a) a high percentage of the population identifies itself as religious; (b) many people who are undergoing emotional crises consider religion as they manage their dilemmas, even if they have not been active in formal religion; (c) many clients are reluctant to bring up religious considerations as part of secular therapy; (d) in general, therapists are not as religiously oriented as their clients; and (e) as a result of being
less religiously-oriented than their clients, many therapists might not be adequately informed about religion to be of much help to their clients.

IV. DEFINITIONS.

1. Secular Therapist.

Secular therapists are defined as those therapists who either have a stated disbelief in a Judeo-Christian God and are not actively involved in Christian forms of worship, feeling that such practices have little or no relevance to their therapeutic methods.

2. Christian Therapist.

A Christian, for the purposes of this study, is defined as one who has made a conscious commitment to a way of life whose central theme is the person, the teachings and commandments of Jesus Christ.

A Christian therapist is defined as a deeply committed, spirit-guided (and spirit-filled) servant of Jesus Christ, who applies God-given abilities, skills, training, knowledge, and insights to the task of helping others move to personal wholeness, interpersonal competence, mental stability and spiritual maturity. They counsel clients utilising both Scripture and psychology, but "the biblical revelation has a higher priority" (Collins, 1977, p130).

3. Christianity.

There are about one billion people worldwide identified as Christians, mostly in Europe, the Americas, and Australasia. Their fundamental belief is in a Judeo-Christian God, the doctrine of the trinity (Father, Son and Holy Spirit), and the idea that the death of Jesus atoned for the sins of humanity.
Christians not only believe in God, but this belief is manifested in their everyday life, in their relationships with other people and is different from that demonstrated by non-Christians. Indeed Christians are expected "to be different" from the rest of the world in which they live (Adam, 1993, p5).


Bergin (1980) argues that pragmatic and humanistic values which are evident in western, and therefore New Zealand society, manifest an indifference to God and one's relationship to God thus ignoring the effect the spiritual can have in influencing many people's lives. Although there is a specific Christian sub-culture with a central belief in Jesus Christ, there are sufficient intra-group differences among Christians for an ignorance of them to disadvantage a counsellor-client relationship, especially since there has been considerable tension between supporters of different points of view.

5. Christian Beliefs.

Lowenthal (1995), stated that an important part of the Christian's world view is the dogma regarding sin. There is said to be a legalistic flavour to Christian doctrine and dogma on sin, which is seen by Christians as the result of the misuse of human freedom. Human wilfulness is to have and to enjoy, to turn to self and to the things of this world and away from God. Mental suffering is often believed to be the result of sin. Salvation involves justification, the removal of sin and its effects by becoming involved in one or more of the following: penance, indulgence, confession, absolution, and forgiveness (Dodge, Armitage, and Kasch, 1964; Solomon, 1965; Eliade, 1978-85; Gwinn, Norton, and Gretz, 1989).

Although suffering is not seen as a desirable end in itself, it is seen as a gateway to renewal and rebirth. Religious faith involves a trust that
everything that happens is ultimately for the good, plus the apparently paradoxical belief that it is up to the individual to do the right things. Eaton and Weil (1955) have suggested that this emphasis on viewing the self as sinful and guilty may account for a great prevalence of depressive disorders among the general population.

Not only do Christian counsellors assume, however, that the conflicts and struggles of their clients often come from the natural consequences of living in a sinful world where mental illness and physical disease are common, they also assume that demonic influences account for some problems seen in their counselling (Collins, 1993).

Another activity fundamental to religion is prayer. This is essentially a verbal activity, in which the person addresses God, often along with other techniques such as fasting, music, sacrifice or adopting special postures to focus the mind and to induce special states of awareness. Research (Finney and Maloney, 1985) has shown that prayer used as an adjunct to psychotherapy had helpful effects.

A further area of more apparent ambiguity in the Christian community than in a general sample of secular psychotherapists is monetary compensation. Oordt (1990), has suggested that Christian therapists were less inclined than secular therapists to pursue financial remuneration when payment from clients became less reliable.

V. CHRISTIAN ORIENTATIONS.

Theories and methods of therapy are as diverse as the spectrum of Christian beliefs. Adam (1993), however, usefully categorised all therapists as generally belonging in one of two groups, Reductionist and Non-Reductionist.
Reductionists were further subdivided into two groups representing the extreme ends of a continuum of spiritual and psychological methods and theories.

*Material reductionists* used only psychological theories and practices ignoring the spiritual dimension altogether. Examples would be Ellis's RET theory and Freud's Theory of Psychoanalysis.

*Spiritual reductionists* believe that once spiritual needs are addressed, all other problems are also automatically addressed. An example of this is the Nouthetic Counselling proposed by J Adams (1970, 1972, 1973). In this theory, clients are authoritatively confronted with the sin which is presumed to be causing their problems, expected to confess, and behave according to Bible-based principles.

Non-reductionists are those who have attempted to integrate both a spiritual and psychological dimension into their theories. In so doing many of the secular methods of counselling have been found acceptable to Christians and effective in Christian counselling. The degree to which non-reductionists achieve this further divides them into two sub-groups: integrationists and dualists.

*Integrationists* use only those psychological theories and practices which do not conflict with biblical teaching. Their techniques are distinctively Christian with the use of prayer, reading the Scriptures, fasting and fellowship with some inclusion and acknowledgment of psychological theory, such as Cognitive Behavioural Theory. Spiritual growth is deemed to be more important than the psychological growth which automatically follows when a person is healed spiritually.

*Dualists* work from a psychological background, including the spiritual as it is deemed necessary and/or therapeutic. Pastoral counselling is an example of this approach.
Both Integrationists and Dualists acknowledge the need for and wisdom of remembering that humans have a spiritual dimension which needs to be considered when emotional problems arise. The difference lies in where the emphasis is placed and to what extent the Christian world view is incorporated into the methods and techniques being used.

VI. WORLD VIEWS.

People who identify themselves as religious are often interested in showing that religion makes people happy, and people who identify themselves as non religious are often interested in showing that religion makes people miserable and ill. Both might be right. Spilka, Hood and Gorsuch (1985) suggest four general effects religion has on people. These are:

* Religion allows or fosters mental illness, for example by encouraging guilt.
* Religion controls or suppresses mental illness, for example by encouraging happiness.
* Religion may protect people from stress or its effects, for example by raising self esteem.
* Religion may be therapeutically useful, for example by providing sympathetic counsellors.

Each of us has a set of lenses, through which we view the world. Philosophers call these lenses world views, a world view being a set of presuppositions (or assumptions) which we hold (consciously or sub-consciously) about the basic makeup of the world. This is what we really believe, whether we have thought much about it or not. These are views of life and the world that we rarely question.

Our world view influences how we think about people, evaluate their problems, and make interventions to help them change. In counselling, our
world views determine how we think about human nature, evaluate the
causes of emotional problems, decide on treatment strategies, and evaluate
counselling progress. If we have a world view that is limited or inaccurate,
we can make mistakes in counselling and cause harm instead of healing.
Most counsellors realise this but may rarely think about their own world
views and how these are affecting themselves, their work and the lives of
their clients.

Collins (1993) implies in his book that if therapists are unaware of their
world views and come to the counselling room with no coherent life
perspective, then there is a much greater potential for confusion and
misunderstanding.

VII. STYLES OF PRACTICE.

Bergin & Jensen (1990) found that psychotherapists generally viewed
an individual's religious functioning as a negative influence to be
eliminated, ignored as unimportant or assumed to develop naturally after
development in other areas. Moreover, compared with the public at large,
secular psychotherapists were less likely to affiliate with or participate in
organised religion and were more likely to express their spiritual interests in
non traditional ways (Bergin & Jensen, 1990; Goud, 1990; Shafranske &

A fundamental goal of pastoral and spiritual counselling is to inspire
deep commitment to Judeo-Christian ideals. Techniques to accomplish this
goal include preaching, pastoral counselling, spiritual growth groups, and
religious education (Clinebell, 1984). To focus exclusively on spiritual
development or general psychological and emotional functioning, however,
is to ignore the dynamic interaction between these two important
dimensions in the religiously-committed individual. Ministers of religion
will cope with large numbers of self referrals for problems similar to those
seen by mental health professionals (Lowe, 1986), and mental health professionals will cope with large numbers of problems similar to those seen by ministers of religion. The sequelae of bereavement and other losses, family conflicts, and the "common colds" of psychiatry - depression and anxiety are all equally likely to be referred to a medical practitioner, minister of religion or a mental health professional. But there is very little cross-referral between psychotherapists and ministers of religion.

Some professionals may wear both hats at once. People may train both as ministers of religion and as psychotherapists. The advantage of this is that religious clients may trust the therapist not to misunderstand their religious beliefs and practices. However, Cunin, Cunin, and Cunin (1993) felt that a number of problems could arise as a result of doing so:

* Religious clients may over-idealise the religious therapist.
* Clients may expect a "magical" cure.
* The therapist may be placed in the role of a priest, rabbi or religious mentor and be expected to dispense advice and counsel not appropriate to psychotherapy.
* The therapist may have his or her own difficulties with religion ("unresolved conflicts") which could add to the difficulties of distinguishing between "healthy" and "unhealthy" religiosity.

Although some of these fears may have abated in more recent times, there still remains in many psychotherapeutic practices some values and assumptions which remain antithetical to Christian beliefs.

VIII. THERAPEUTIC IMPLICATIONS.

Traditionally, therapists see a problem, attempt to observe it carefully with the intent of discovering contributing and/or causal factors, and develop solutions. Christians are additionally concerned with producing an "ordered summary or synopsis of the themes of teaching in Holy Scripture."
(Beck, 1992, p102). The understanding of a client's belief system is therefore important for both Christian and secular therapists because they may well hold a world view that is different from their clients and if unaware of this, may impute negative traits to them (Sue & Sue, 1990). Gaining information about specific religious values then should be an important part of preparing counsellors to work with such issues in counselling (Bishop, 1992).

Psychology has often been criticised by Christians because of its reliance on scientific methodology, yet psychology's reliance on scientific methodology, has been an integral part of its growth and it shows no signs of abandoning it. This criticism has largely either been raised by those who are opposed to all aspects of psychology (such as the Christian fundamentalists), or those who focus on specific aspects rather than the wider perspective. For example, Christians may criticise psychology because it contains antithetical humanistic statements, but Existential-Humanistic theories are only a part of the greater discipline of psychology. Christian psychotherapists are increasingly now, however, more able to find ways to integrate many aspects of psychological theory into their practice.

Psychotherapy cannot avoid fluid frontiers with psychology, religion or other relevant disciplines. A recognition of this interaction is reflected in the fourth edition of the Diagnostic and Statistical Manual for Mental Disorders (American Psychiatric Association, 1994) which has added religious and spiritual difficulties as a distinct mental disorder.

IX. THERAPIST VALUES.

Therapists' cultural sensitivity toward their clients is a crucial aspect of their practice. Barring destructive, unhealthy practices all client expressions have some validity. Polanyi and Prosch (1975) stated that we can never be
so sure of the truth in matters of religion or spirituality that we can impose our views on others.

Religious values are part of the global elements of culture, and an important aspect of a person's psychological development and functioning, yet they are often not assessed or considered important from a psychological perspective (Russo, 1984; Sperry, 1988; Spilka, 1987; Theodore, 1984). Many therapists, however, explain that they separate and exclude religious values from counselling and discuss them only when the client is the initiator. Counsellors who fail to initiate discussion of the clients' religious values run the risk of overlooking potentially important aspects of the client's cultural background and current cultural experience. Even counsellors who are sensitive to other aspects of cultural differences are hesitant to explore clients' religious values. In order for counsellors to place clients' values in cultural context, they must know some specific information about their clients' culture (Pedersen, 1987; Sue, 1981). To be able to establish goals for counselling, counsellors need to understand the clients' views on what they consider healthy functioning and how they feel this is promoted or achieved.

In an increasingly multicultural world, counsellors can expect to be confronted by clients' religious beliefs and values more frequently than in the past. Many clients are highly religious; others are less so. If the client is highly religious, how is the counsellor to act? Numerous religious beliefs may be brought up by clients. Should counsellors be conversant with major religious beliefs, as has been suggested by Lovinger (1990)? Should counsellors respect clients' religious values even if counsellors disagree with clients' religious beliefs, as has been suggested by Worthington (1988)?

Counsellors who are unfamiliar with, or who are unwilling to accept the client's religious values, risk disrupting the client's value system and risk
working towards unreasonable therapeutic goals. Such an approach will inevitably lead to conflict in the therapeutic relationship, and according to Bishop (1992), borders on ethical malpractice.

X. VALUES AND THEORY IN PRACTICE.

While it has been generally accepted that therapists should remain neutral in the use of their personal values in therapy, it is still not known the extent to which (a) therapists' personal values are inadvertently communicated to the client and (b) how clients respond to such communication. It is generally well established that in successful counselling, clients often change their values to more closely approximate those of their counsellors. Bentler (1981) suggests that religious values are particularly susceptible to influence.

Numerous authors have advised therapists to be acutely aware of and satisfied with their own religious orientation and to observe how it influences their therapeutic relationships. For example, Bergin (1980), has recommended that therapists reveal their religious values because "until the theistic belief systems of a large percentage of the population are sincerely considered and conceptually integrated into our work, we are unlikely to be fully effective professionals" (p95).

Many other therapists are empathic toward a religious perspective, but do not feel competent to address religious issues with clients (Holden, Watts, & Brookshire, 1991; Shafranske & Malony, 1990a, 1990b). This lack of confidence is due partly to the fact that secular psychotherapists receive limited, if any, formal religious training, education in the psychology of religion, or preparation for dealing with religious issues in clinical practice. Thus, the reluctance of some psychotherapists to tackle religious issues may reflect their limited education and training in this area of psychotherapy.
XI. THERAPEUTIC EDUCATION.

The academic study of religion is rarely an aspect of the therapist's training. When it is, Lovinger (1984) found that the overall effect of a psychology-oriented education was generally to foster a negative attitude towards religions. Two personal examples may help to illustrate this. The university where this researcher did his study, whilst offering postgraduate training in counselling, does not have as part of its syllabus any content relating to either the clients' or therapists' spiritual issues. Similarly, this same university offers only one lecture in a postgraduate human development psychology paper on the relation between human development and religion. When I attended that particular lecture, it began with the statement that "a psychologist could not have any religious beliefs."

A recent book on counselling admonished counsellors not to use "religious values to solve clients' problems" (Meier, 1989, p.35). Such general statements may reinforce secular counsellors' impressions that a client's religious ideation is therapeutically "off limits", even when such ideation conflicts with the theology of the church to which the client belongs and seems to be an exacerbating factor in the client's distress.

With a recent resurgence of interest in religion (see articles in the International Round Table for the Advancement of Counselling/NZAC Conference Proceedings, 1993; NZAC Newsletter, 1995), secular psychotherapists are challenged to become more attuned to and responsive to their clients' religious values (Bergin, 1980; Worthington, 1988).

Increasing efforts to incorporate a religious dimension into psychotherapeutic work, however, raise many issues for the individual therapist and the counselling profession as a whole.
XII. CLIENT PERCEPTIONS.

In spite of well-meaning noises about psychotherapy and religion learning from one another, Christian and secular counselling are often perceived as being quite different by prospective clients (Worthington, 1988). This is further endorsed by some religiously-oriented psychological professionals such as Amsel (1976) and Pupura (1985) who see very little evidence of accommodation by psychotherapy or psychotherapists to the religious needs of clients.

Keating and Fretz (1990) asked potential clients how they would perceive a Christian or secular counsellor. Those potential clients who were themselves highly committed Christians were no different in their anticipations about the counsellor than those who professed no Christian beliefs at all. Those potential clients who were not, however, highly committed Christians had more positive anticipations about a Christian counsellor.

Lowenthal (1995) found that many religiously-committed people in emotional distress turned to religious counsellors because they saw secular therapists as "irreligious" and "inclined to categorise religious behaviour as a delusion, an obsession or a compulsion" (p. 172). The therapists were often perceived to be antagonistic to the client's life style, condescending, lacking in understanding and likely to insist on courses of action that were in conflict with the client's values and beliefs (Grossberg, 1978; Wikler, 1979; Lowenthal, 1995). Many others do not, therefore, go for treatment because of the mistrust by potential clients who fear that their religious behaviour and feelings would be misjudged (Quackenbos, Privette and Klentz, 1985, 1986; Worthington, 1986; Lowenthal, 1995).

Chalfant and Heller, (1990) found that 40% of their sample seeking help for psychological distress indicated a preference for a cleric rather than a mental health professional. Yet some who have religious concerns may also
be reluctant to seek religious-oriented counselling for fear that they might not receive the psychological care they need (Genia, 1994).

Normally there was less stigma involved in seeking Christian counselling or therapy from a member of one's own religious group (Wikler, 1986) than in going to a secular psychotherapist. Going to a secular professional was seen as a last resort. Those seeking help may, therefore, feel forced to choose between a religious counsellor who is competent to provide spiritual guidance but unprepared to handle psychopathology or a clinically sophisticated secular psychotherapist who is uncomfortable with religious material. In either case, the therapeutic encounter excludes or inadequately addresses a significant part of the client's experience. These issues pose a challenge and should:

"prompt the profession to discern its responsibility to understand further the impact religious and spiritual variables have on the mental health of individuals and to provide educational training, and research opportunities in psychotherapy and religious orientation." (Shafranske and Malony, 1990b, p.230).

XIII. RELATIONS BETWEEN PSYCHOTHERAPY AND RELIGION.

Psychotherapeutic professions have traditionally had very strong - but ambivalent - relationships with religion (Lowenthal, 1995). Prototypically, the secular psychotherapist has had a strong disinclination to religion, and psychotherapy has had quite a bad press in religious circles. Some writers suggest that psychologically-orientated therapists in particular tend to believe that some religious or spiritual convictions are "illusive and neurotic" (e.g. Genia, 1995, p.2). Strongly influenced by Freud's thinking about religion, many psychoanalysts believe that reliance on God is an outmoded continuation of childhood dependency (Genia, 1995). Despite
the fact that much of Freudian theory is anathema to behavioural psychologists, many share Freud's negative opinion of the religious life.

An aversion to religion and spirituality has been particularly evident among cognitive-behavioural psychologists who link psychological dysfunction to childhood trauma and emotional problems to distorted thinking patterns (Genia, 1995).

Bobgan and Bobgan (1979, p11) took one extreme by totally rejecting psychotherapeutic practices because they were "based on ideologies which contradict Scripture". The worrisome aspect of the Bobgan position is that every person who comes to them for counselling is pre-diagnosed either as having a chemical imbalance which should be medically treated or as suffering a sin which needs to be confessed and absolved. There is never any type of "mental/emotional" problem.

Collins (1977, p 131) represented a milder form of the same approach when he suggested that "Christianity and science are harmonised by testing science against the Bible". Narramore (1973, p16) took a similar stance in arguing that "when our human views (contaminated by our limited perceptions) come into conflict with the Bible we must place our allegiance in the Scripture".

Farnsworth (1982) argued that psychology should not be rejected automatically but, rather, when the two sets of interpretations conflict, then we need to re-examine both data bases for the source of the conflict.

The Christian psychologist believes that the "author of nature and of the Biblical revelation are one" (Beck, 1992, p102). Hence, the objects of study in psychology (the human) and in theology (God) are connected in the acts of creation. Therapists thus have an obligation to study each of these subjects in the context of the other. Christian psychologists filter psychological truth through biblical truth and accept only that which is not contradictory to God's special revelation.
While traditional therapists may tend to regard all religious thinking as illusive, religious professionals also often fail to appreciate the psychological significance of disordered religiousness. Counsellors often encourage people to believe in themselves, in the future, in the possibility of change, in the power of positive thinking - but rarely are there references to God in the counselling room. In most counselling rooms, God does not exist - at least in the words and thoughts of the therapists and their clients. Is it possible that God is also left out of counselling by many who call themselves Christians?

XIV. PURPOSE OF RESEARCH.

In summary, there are four basic approaches therapists could take:
(a) reject psychology, (b) reject theology, (c) examine both psychology and theology for sources of conflict, or (d) look for means of reconciliation between psychology and theology. A purpose of this research is to examine the psychotherapeutic practices of those therapists who profess a belief in God and those who hold no such beliefs. In so doing, sources of potential conflict are also sought.

The literature available indicates that much of the research previously done in this area appeared to focus on a single issue in isolation from a general arena of activity and was written from a single theoretical orientation. The purpose of this research is to gain information about a specific area (Christian/Secular counselling) from as broad a perspective as possible. The information gathered is intended to act primarily as a catalyst for further research. A major focus of this research is fact finding since very little is known about what is actually occurring within therapists' practice. We know they counsel and are likely to be using a variety of means in doing so. What we do not know is how they are doing what they are doing and whether there are any differences between two broad groups
otherwise identified as committed Christian or non-committed therapists. Therapists' styles of practice and the boundaries surrounding their practice will be examined within the context of this report under the two headings "theoretical approaches" and "ethics".

A large part of this research focuses upon the actual practices engaged in by the therapists. Since information of this type appears to be absent from previous research data, it may be that it has been taken for granted that all therapists operate in much the same way. A student will readily tell you that one teacher can easily differ from another yet we appear to simply accept that they teach. A number of typical scenarios are therefore put to the therapists in a section headed "counselling practice" in an attempt to discover how therapists actually practice.

Accountability has always been recognised as a means by which we can gain some reassurance that what we have has been measured against some standard. Within counselling, this is achieved through appropriate supervision. Christians are also accountable to God (Romans 14:12). Do Christian therapists therefore forfeit their accountability to another (supervisor) or maintain a dialogue with both? An answer to this and associated questions is sought in a section headed "supervision".

It could probably be safely assumed that Christians read the Bible, but do they read any other professional material, and, if so, what? Does what they read differ substantially from what is read by secular therapists or are both interested in learning the same material? After all, they do deal with the same type of clients. Some answers are sought in a section headed "professional development".

What of the training received? How much of what they have been formally taught is still used and how much of what is currently known can be credited to practical experience? There are many courses, conferences, workshops offered every year. How many of these are attended and is one
group more apt to seek ongoing training than the other? A section titled "training" seeks to gain some understanding in this area.

A last section (titled "support") was born out of personal interest resulting from a personal realisation that firstly many therapists were actively seeking (by their own admission) to pursue a counselling career in order to "better understand themselves". This raises a number of questions regarding transference and counter-transference as well as co-dependent behaviours. Previously, my raising concerns over this issue has largely fallen upon deaf ears or at least disbelieving ones.

This research does not examine the issues involved with therapists undergoing therapy or seeking to "understand themselves" better. It is designed only to find out whether this should be an area of concern and if so, hopefully some further research may follow.

Another personal quest, also the result of many comments being passed to myself, was to find out whether there was as strong a desire for a National Christian Counselling Association.
CHAPTER II

METHOD.

I. ETHICAL APPROVAL.

An initial requirement prior to commencement of this study was to provide the Human Ethics Committee (University of Canterbury) with full details of the proposed research. In addition, the research proposal was presented to the Ethics Committee of the Education Department along with copies of the questionaries to be used for data collection. The research was subsequently approved by both committees (see Appendix A & B).

Since its approval, the research has had to undergo several modifications. All the modifications are acknowledged in this report. However, nothing of substance in the original proposal, as approved, was altered in the modification process.

To preserve anonymity, all subjects were given two code numbers identifying them only to the researcher. One code number was used to identify the participants' work place and another to identify the individual.

II. SUBJECTS.

Only therapists working in Christchurch, New Zealand, were contacted. No attempt was made to control for gender, ethnicity, or education: the result was a totally Caucasian subject population, all of whom had graduated from tertiary institutions.

All therapists and counselling organisations advertised in the "yellow pages" telephone directory who offered general counselling rather than counselling of a specific type (eg, AIDS or Adoption counselling) were contacted by phone and asked if they would be willing to participate in research exploring the differences between secular and Christian therapy and therapists.
Whenever an organisation was contacted, an effort was made to speak
to the director of that organisation. When this was not possible, the
receptionist was used for liaison purposes.

A final return-by-date of six weeks from date of posting was indicated
on the information sheet. Also, a code number identifying the individual or
organisation was placed on the return envelope to identify to the researcher
who had returned their questionnaires and, in the case of organisations, how
many were returned.

Seventy-two counsellor questionnaires were sent out to the nineteen
organisations and nine private practitioners who had indicated they would
be willing to participate in this study. Table 1 summarises the response rate.

<table>
<thead>
<tr>
<th></th>
<th>Number of practices</th>
<th>Number of subjects</th>
<th>Completed returns (%)</th>
<th>Blank returns (%)</th>
<th>Nil returns (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisations:</td>
<td>19</td>
<td>63</td>
<td>14 (22.23)</td>
<td>17 (26.98)</td>
<td>32 (50.79)</td>
</tr>
<tr>
<td>Private Practice:</td>
<td>9</td>
<td>9</td>
<td>8 (88.89)</td>
<td>0</td>
<td>1 (11.11)</td>
</tr>
</tbody>
</table>

Regrettably, there was a much lower rate of response than the
organisations initially indicated. Due to the low response rate, in particular
by the organisations, a follow-up letter urging those who initially showed a
willingness to participate to now do so was sent along with another
"therapist package" twelve weeks after the initial posting.

This resulted in five more questionnaires being returned.

Table 2 demonstrates that the large non-response rate was particularly
influenced by the larger organisations approached.
Eight weeks after the second posting, a final appeal by telephone was made to the two largest organisations without further success. It was therefore decided to proceed using the data from the twenty-seven therapists.

Figure 1 illustrates the subjects' belief orientations in accordance with question seventeen of the "Counsellor Questionnaire".

![Sample Population Orientations](chart.png)

Of the forty-five therapists who did not respond, eleven were employed by institutions whose director had advised the staff to decline participation because the research was "irrelevant" or "too time consuming" and made a personal decision not to allow distribution of the questionnaires to their staff. This information was gained through personal contact with the receptionist/secretary of the two largest organisations and in one of these organisations, confirmed by a staff member known to the researcher. When two attempts by phone to dissuade the directors from their decisions were unsuccessful, it was considered unethical to approach the staff employed
by these institutions in person (with the exception of the one staff member
who contacted the researcher of his own free will).

A further five therapists declined to participate upon receipt of the
questionnaire, claiming it was culturally biased/insensitive. They felt that
the questionnaire was structured in such a manner as to exclude answers
from a Maori or female perspective.

One respondent declined to continue because she was soon departing
overseas and felt, therefore, that she would not be fully available for the
study. One other counsellor returned the questionnaire unanswered without
stating any reasons.

Of the other twenty-seven who did not respond, twenty-six came from
three organisations which employed more than five staff. Despite
assurances from the director of one of these organisations that they would
courage their staff to respond, the return rate remained nil (in the case of
two) or low. The one remaining non-response was a therapist in private
practice.

III. DESIGN.

Each therapist or organisation initially indicating an interest in
participating in the research was sent an appropriate number of therapist's
packages. Each package contained a Consent Form, Information Sheet (see
Appendix C), "Counsellor Questionnaire" (see Appendix D), Answer Sheet
(Appendix E), "Christian Spectrum" (see Appendix F), and a stamped
addressed return envelope.

Two therapists who completed the "Counsellor Questionnaire" from
each of the two researched therapist groups were interviewed. All four
interviewees were given two "Client Questionaries" (Appendix G), Answer
Sheets (Appendix H), and stamped addressed return envelopes to be
distributed to two clients of their choice.
No further contact with any of the other therapists was made following the receipt of their questionnaires.

IV. MATERIALS.

1. Counsellor Questionnaire.

The task of gathering information was felt best achieved through the use of an initial questionnaire followed by interviews with a sample of respondents. Because there was no existing questionnaire available to the researcher, one was constructed based on the relevant literature and the researcher's own experiences as a Christian therapist in private practice.

In order to construct a questionnaire which suited the purposes of this research, the contents of general counselling texts, relevant questions raised within these texts, and questions raised by both myself and colleagues were used. A second source for further questions was previous research in the areas under investigation.

Questions sampled eight areas of practice: theoretical orientation of the therapist; religious beliefs (since this research was focusing on possible differences between committed Christian and non-committed therapists); ethics (a fundamental concern for any appropriate therapeutic practice); counselling practice (since this was a major focus of the current research); supervision (an extension of good ethical practice); professional development and training (which continued beyond the therapist's initial training), and therapist support networks (as a brief insight into the therapists' personal background to look at issues which might affect their ability to practice).

The original questionnaire, once constructed, was submitted to the researcher's supervisors (both non-Christians) for comment. This resulted in a further five drafts before being distributed to two Christian therapists.
for their evaluation and comment. This brief pilot testing resulted in two further drafts.

Yvonne Adam (1993), in a paper she presented at the International Round Table for the Advancement of Counselling/New Zealand Association of Counsellors conference (1993), suggested that those who had a belief in a Judeo-Christian God could be sub-divided into a five category continuum depending on their strength of belief and practice. Adam called this continuum the "Christian Spectrum". This same spectrum was used in this research to categorise those therapists stating a belief in God.

2. **Client Questionnaire.**

Because it was intended to measure the degree of congruency between the beliefs of clients and their therapists, the client questionnaire was constructed asking the same questions as those used in the therapists' questionnaire.

V. **PROCEDURE.**

At least twenty therapists who professed some form of Christian belief (one of the five categories within the "Christian Spectrum") and twenty therapists who indicated no Christian orientation were sought. Regrettably, only twenty-two therapists with some professed Christian belief and five who indicated "no belief" returned completed questionnaires.

Because a comparison between self professed Christian and non-Christian therapists was central to this research, the answers to questions in the "Beliefs" section were examined. When the twenty questions of the "Belief" section were analysed, it became clear that ten therapists indicating a Liberal or Nominal Christian belief were more closely aligned with non-Christians on eleven of the questions (see Appendix I). The remaining nine
questions did not differentiate any of the Christians and/or non-Christians. As a consequence, it was decided to group the ten Liberal and Nominal Christians with the five non-Christians. This led to a more even balance of subjects in the two therapist groups. One group (committed Christian therapists, n = 12), consisted of those therapists who had identified themselves, according to the Christian Spectrum, as being "Conservative" or "Moderate". The second group (non-committed therapists, n = 15), consisted of those therapists who had identified themselves as being "Liberal", "Nominal", or having no belief in God.

Initially it was intended to interview a sample of respondents in both groups to explore their beliefs and practices in more depth. Since the return rate was so low, it also provided an unexpected opportunity to explore why this occurred and what the therapists thought about the questionnaire in general.

It was decided to interview as many of the five therapists who professed no belief in God who were willing to be interviewed. Since only two were willing to be interviewed, only two Christian therapists were also interviewed. The two Christian therapists interviewed were chosen at random. Interviewing occurred only after all of the completed questionaries had been returned.

Each interview was relatively unstructured although all therapists interviewed were asked what they thought about the questionnaire and why they felt there had been a low return rate from non-Christian therapists. Interviewees were also asked if they had any specific difficulties with any of the questions in the questionnaire and were encouraged to elaborate further on their answers. For example, if the interviewee believed a question was Christian biased, they were asked why they felt this to be the case and how would they alter the questionnaire to lessen the bias. All the interviewee responses were recorded in writing during the interview.
attempt was made to defend the structure or content of the questionnaire. Each interview ranged in time between forty to ninety minutes.

Following each interview, the therapist was asked if he/she would be willing to give a "Client Questionnaire" to two of his/her clients. It was not the intention of this research to examine in detail a client's perception of the therapist. However, it was felt useful to investigate any degree of incongruence between the therapist's beliefs and practices and their clients' perceptions of therapy. For example, whilst a Secular therapist may state that they have no difficulty working with Christian client, previous research has indicated that Christian clients may feel differently (McCullough, and Worthington, 1995). This study focuses upon the therapists' self-stated beliefs and practices. How a client perceives their therapist is both a different perspective to that investigated by this research and a different project. It is fully recognised that the small number of client questionnaires involved (n = 6), does not even begin to explicate this perspective.

All four of the therapists interviewed agreed to do this although one (non-Christian) therapist predicted a nil return from his clients, which proved to be the case. A third non-Christian therapist who had previously declined to be interviewed was re-approached for assistance in distributing a further two client questionnaires. Whilst willing to co-operate in this request, neither questionnaire was returned. Thus, only six "Client Questionnaires" were returned. This resulted in three distinct groups of clients evolving, consisting of two Christian Clients seen by committed "Christian therapists", two non-committed clients seen by a committed Christian therapist, and two Christian clients seen by a non-Christian therapist. There were no non-committed clients seeing non-Christian therapists. An ideal fourth client group could not, therefore, be established.

As data was received, the researcher entered all information into a computer using a Microsoft Excel Version 4.0 program.
CHAPTER III

RESULTS.

The results section is presented in sequence of data collected.

I. DEMOGRAPHIC DATA.

Demographic data gained from responding therapists is summarised in Table 3.

Table 3.
Demographic data of research participants.

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Age (mean)</th>
<th>Range</th>
<th>Gender</th>
<th>Work Place</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>I. &quot;Committed Christian Therapists&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fundamentalists</td>
<td>0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Conservatives</td>
<td>3</td>
<td>40</td>
<td>36-46</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Moderate</td>
<td>9</td>
<td>44.5</td>
<td>21-63</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td></td>
<td></td>
<td>8</td>
<td>4</td>
</tr>
</tbody>
</table>

II. "Non-committed Therapists" |

|                          |       |            |         |        |     |         |              |
| Librals                  | 3     | 40.5       | 38-43   | 1      | 2   | 0       | 3             |
| Nominals                 | 7     | 43.3       | 39-48   | 5      | 2   | 4       | 3             |
| Non-Christians           | 5     | 40.6       | 33-47   | 4      | 1   | 0       | 5             |
| Totals                   | 15    |            |         | 10     | 5   | 4       | 11            |

II. THERAPIST DATA.

1. Theoretical Approaches.

Therapists were asked to state whether they classified themselves as eclectic (implying a multiple style approach), or theoretical (predominantly using one style of therapy). Table 4 records the therapists' orientations.

Table 4
Therapist Theoretical Orientation

<table>
<thead>
<tr>
<th>Therapists' Stated Orientation</th>
<th>Eclectic</th>
<th>Theoretical</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Committed Christians</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>II. Non-committed therapists</td>
<td>8</td>
<td>7</td>
</tr>
</tbody>
</table>

Using a chi-square analysis with a Yates correction for continuity given the small numbers involved, no significant difference \( \chi^2 = 3.040, p > .05 \)
was found between the two groups' orientations despite more non-committed therapists specifying a particular theoretical orientation than committed Christian therapists.

Whilst quoting of Biblical Scripture, Prayer, Healing meetings and Word of Knowledge are not seen in an academic or traditional sense as being part of psychotherapy, these practices are widely endorsed and maintained by Christians both in a traditional worship manner and in pastoral counselling. Figure 2 displays the styles of therapy most likely to be employed by therapists from each of the two groups.

![Figure 2](image)

As would be expected, Christian-orientated therapeutic styles (Biblical Scripture, Prayer, and Word of Knowledge) were dominated by those therapists with a Christian belief.

One non-committed therapist indicated using Bible quotations as part of therapy. However, this was possibly due to the inclusion of therapists who had a stated belief in God within this group. This therapist used this form of therapy only 5% of the time.
Figures 3 & 4 illustrate the number of respondents who were likely to employ a particular therapeutic style along with how much time on average they were likely to use it.

Figure 3.

![Committed Christian Therapists](image1)

Figure 4.

![Non-committed Therapists](image2)

It is interesting to note that whilst more therapists may indicate they use a particular style of therapy, they may not necessarily employ such a style as their predominant method of therapy. For example, although most committed Christian therapists say they use Cognitive-Behavioural therapy,
Psychodynamic forms of therapy, when used, are used for a greater percentage of therapy time. This means that one therapy may predominate in terms of "amount of time used" over other styles employed.

The five most practiced styles of therapy of committed Christian therapists and the percentage using these styles is illustrated as Figure 5.

![Therapy used by committed Christian therapists](image)

Similarly, the five most practiced styles of therapy used by non-committed therapists and the percentage of this group who are using these styles is illustrated as Figure 6.
In comparing the two groups, it becomes evident that non-committed therapists differ from their committed Christian counterparts by their use of Existential-Humanistic and Gestalt therapies. Likewise, Committed Christian therapists differ from their non-committed counterparts through the employment of Prayer and the Bible from which they quote.

Therapists were asked whether there were any particular styles of therapy they would not employ and why. Figure 7 illustrates the styles of therapy that would not be used by therapists from each of the two groups.
Predicably, several of the non-committed therapists would not employ Christian-oriented forms of therapy. What is surprising is the number of committed Christian therapists who answered in a similar way. Committed Christian therapists are noted, however, for their apparent hostility regards the use of Gestalt and Existential-Humanistic therapies, the two therapies earlier indicated by non-committed therapists as the ones most employed by them.

Reasons given for not using a particular therapy included: (a) Trait and Factor therapy - five stated that they had no knowledge of this style of therapy and two gave conflicting answers. One stated that it was not prescriptive enough whilst the other stated that it was too prescriptive; (b) Psychodynamic therapies - three reasons were given, "not trained" in its usage, "nonsense" form of therapy, and "not Biblically" appropriate; (c) Cognitive-Behavioural therapies - whilst some committed Christian therapists' had stated that they would use this type of therapy, others indicated that they would not; (d) likewise, there was also some resistance to Rational-Emotive therapies by the same group stating that neither form of therapy was "Biblical" and was likely to "impede a client's spiritual
growth". Committed Christian therapists also cited contradiction with Biblical teachings as their reason for not using (e) Gestalt and/or (f) Existential-Humanistic therapies.

Because Biblical quotations, prayer, healing meetings, and Word of Knowledge are considered predominantly Christian-orientated styles of therapy, the slightly greater negative response of non-committed therapists to these forms of therapy was not unexpected. Non-committed therapists were the most unlikely to employ these styles of therapy saying that they were either too value biased, not a legitimate form of therapy, or that they lacked training in these styles. Committed Christian therapists who indicated some reluctance to employ these styles of ministry felt that it would be "inappropriate" to do so.

On the issue of forgiveness, committed Christian therapists were more likely to encourage their clients to "forgive those who had offended them" than were non-committed therapists. Nine of the twelve committed Christian therapists affirmed that they would encourage their client to forgive those who had offended them as part of the therapeutic process whereas only five of the fifteen non-committed therapists believed similarly.

Regarding the legitimacy of encouraging clients to recall past incidents, committed Christian therapists appear to see this as being more desirable than non-committed therapists (see Figure 8). This becomes even more pronounced when the therapists are separated into their original "belief" groups (see Figure 8a).
All the respondents affirmed that recall should be done on both an emotional and cognitive basis.

2. Section Summary.

Committed Christian therapists tended to be more slightly more varied in their therapeutic orientation using predominantly psychodynamic,
developmental, cognitive-behavioural, Bible quotations and prayer as their choices of therapies. They were least likely to use Existential-Humanistic and Gestalt therapies.

Non-committed therapists tended to embrace gestalt, existential-humanistic, psychodynamic, cognitive-behavioural and developmental therapies as their preferred choices. The therapies least likely to be used by this group were Biblical quotations, prayer, healing meetings, and Word of Knowledge.

Forgiveness and Recall of past events were more endorsed as principles of practice by committed Christian than non-committed therapists.

III. BELIEFS.

![Figure 9](image)

Figure 9 gives the impression that committed Christian and non-committed therapists are reasonably similar in their beliefs as to what they felt were the most predominant reasons as to why their clients had
difficulties. However, Committed Christian therapists answered "other" to indicate a combination of "bio-chemical", "socio-economic", and "sinful nature" factors whereas non-committed therapists answered "other" to indicate a combination of "bio-chemical" and "socio-economic" and "spiritual" factors.

Eighty percent of the non-committed therapists and forty percent of the committed Christian therapists agreed that human beings were innately good.

Therapists were given a choice of two options from which to choose indicating their belief as to why they felt there is a current problem of humanity. These choices were taken from Collins (1993) who believed that one choice ("a" in question 8) summarised the humanistic position and the other ("b") summarised the Christian position. Not surprisingly therefore, committed Christian therapists were significantly more likely to perceive problems of humanity as arising out of rebellion against a Holy God and His moral laws whereas non-committed therapists believed the problems of humanity arose from a lack of understanding about self potential (Figure 10 $X^2 = 13.210$, $p < .05$).

Figure 10.
Resolution of these "problems" was also, therefore, significantly different between the two groups. Committed Christian therapists saw resolution occurring through "repentance" and "a faith in Jesus Christ" whereas non-committed therapists endorsed self enlightenment.

In view of the previous responses given to problems of humanity, a concurring greater support for the statement that "Once we know more about ourselves and the universe, we will shed our ignorance and life will become better" (Q9 of the counsellors, questionnaire) would be expected from the non-committed therapist group. This was found to be the case (Figure 11).

Figure 11.

[Diagram showing shedding self ignorance between committed and non-committed therapists]

Question ten asked if respondents felt Christian-based counselling "offers a better solution for clients than secular counselling". As expected, committed Christian therapists were significantly more inclined to endorse this belief than were non-committed therapists $\chi^2 = 4.457, p < .05$; see Figure 12).
Reasons offered by committed Christians for this belief were that Christian-based counselling relied upon "God's wisdom and not man's" (41.67%), or that it recognised "our spiritual selves" (25%). The remaining 33.33% of the committed Christian group who did not feel that Christian based counselling offered a better alternative to secular counselling felt their own personal beliefs were not important in counselling others.

Non-committed therapists opposed to the notion that Christian-based counselling was better than secular counselling did so because they either also felt that their own personal beliefs had no effect on their effectiveness to counsel (46.67%), that Christian based counselling was too "narrow and prescriptive" (40%), or that it was too "destructive (6.67%). One non-committed therapist did believe Christian based counselling was better than secular counselling, but no reasons for this were given.

Agee and Everts (1993) asked a number of therapist trainees "how much does being a counsellor have to do with some kind of spiritual meaning in life for you?" In their study, they did not differentiate between those who held Christian beliefs and those who did not. This question was, therefore, also asked in this study so any differences between the two groups might be examined. Only a very small difference was found between committed Christian and non-committed therapists (Figure 13).
One reason for this may have been the respondents' ability to answer using a broad definition of spirituality. An examination of the reasoning given for their answers reflects this. Committed Christian therapists stated that counselling had spiritual significance for them because it was recognised as "God directed" (58.33%), a response to God's calling upon their lives (33.33%), or just "important" (8.34%). Non-committed therapists were more inclined to see counselling as a spiritual experience because in understanding themselves, they were able to help others (40%), they could reach a "state of communion between two souls" (20%), or one therapist just felt it to be "important" (6.67%). A third of the non-committed therapists gave no reasons for their answers.

A following question reinforced the differences between the two groups regarding their understanding of spirituality. Committed Christian therapists were significantly more likely to understand spirituality as a process of "looking outward to Christ" whereas non-committed therapists understood spirituality as "tapping into an unlimited power within themselves" $X^2 = 16.440$, $p < .001$).

The remaining questions in this section of the questionnaire were to gauge the extent of specific Christian beliefs and practices among therapists who stated that they held some belief in a Christian God. Despite this
portion of the questionnaire being legitimately able to be ignored by those therapists who held no such beliefs, almost all the questions were answered by them anyway. Those questions they did not answer are noted in the following text.

Respondents were asked to state whether or not they believed God to be "one who is vindictive, irrational, and inclined to pile on the guilt." There was an almost unanimous agreement amongst both groups that this was not the case (Figure 14).

Figure 14.

From three options given, respondents were asked to choose from three definitions of "sin". Figure 15 indicates a predictable and significant $\chi^2 = 14.375, p < .001$) difference between the two groups. Committed Christian therapists believed sin to be "a state of alienation from God", whilst their non-committed colleagues almost all believed sin to be "an act or thought that robs a person of their self esteem".
While all the committed Christians believed in the existence of God and Satan, some doubted the existence of demons, angels, heaven and hell which is contrary to some people's perception of evangelical Christians (Figure 16).

Non-committed therapists indicating beliefs in some Christian concepts possibly resulted because Liberal/Nominal Christians were included in this group.
Liberal/Nominal Christians, did not vary considerably from their committed Christian counterparts in the number of years they professed themselves to be Christian-orientated (Figure 17).

Figure 17.

All of the committed Christian therapists stated that they were currently involved in regular church activities, a finding which differed significantly from non-committed therapists $X^2 = 10.008, p < .01$.

Given committed Christian therapists had previously stated (in response to question 10) that their counselling was "God directed", it was predicted that committed Christians were significantly more likely than non-committed therapists to also believe that their skills were "God given". This proved to be the case $X^2 = 5.219, p < .001$.

Committed Christian therapists indicated a strong belief that the "Bible should be used as a guide for counselling" (Figure 18). Predictably, non-committed therapists were significantly less likely to agree with this $X^2 = 5.091, p < .05$.
Given the strong belief by committed Christian therapists that the Bible should be used as a guide for counselling, it was anticipated that they would also have confidence in their ability to interpret what the Bible says. There was a predictable positive correlation between a therapist's professed degree of faith and ability to interpret the Bible (Figure 19).

There was no apparent statistically significant difference ($t = 1.684, p > .05$) between the amount of time committed Christian therapists spent "studying Scripture" each week and that spent by Liberal/Nominal...
Christian therapists despite a large dissimilarity between the two groups. Committed Christian therapists spent an average of nine hours per week studying the Bible whereas Liberal/Nominal Christians therapists spent less than a total of five minutes a week.

Neither was there any statistically significant difference found between the two groups in how they used the Bible as part of their therapy $X^2 = 0.574, p > .05)$. All who made comment felt that the Bible was relevant because parallels could be drawn between their clients' current situation and those spoken of in the Bible, but according to the therapists they had no set method as to how this was applied.

All committed Christian therapists felt they were "guided by the Holy Spirit" (in a Christian manner), whereas significantly fewer $X^2 = 7.135, p < .01$ non-committed therapists were inclined to hold this view (Figure 20).

![Figure 20.](image)

Two non-committed therapists did not know whether they were guided by the Holy Spirit.

Committed Christian therapists were significantly more likely $X^2 = 6.237, p < .05$ to use "deliverance" (freeing a person of demons through specific forms of prayer) as part of their therapy (when applicable) than non-committed therapists. Given that this is a specific (but not
exclusive) form of Christian practice, this result was expected. A small percentage within the non-committed group did, however, also indicate the employment of "deliverance", again reflecting the influence of having Liberal/Nominal Christians within this group.

1. **Data Summary.**

<table>
<thead>
<tr>
<th>Question</th>
<th>Committed Christian therapists</th>
<th>Non-committed therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 7. Are human beings innately good?</td>
<td>40% agree we are.</td>
<td>80% agree we are.</td>
</tr>
<tr>
<td>Question 8. What is the problem of humanity?</td>
<td>25% say a lack of self knowledge.</td>
<td>6.67% say rebellion against God.</td>
</tr>
<tr>
<td>Question 9. To know ourselves is to shed ignorance.</td>
<td>Mean of 3 on a scale of 10 (1=disagree).</td>
<td>Mean of 7 on a scale of 10 (10= agree).</td>
</tr>
<tr>
<td>Question 10. Is Christian counselling better? agree.</td>
<td>66.67% agree.</td>
<td>6.66%</td>
</tr>
<tr>
<td>Question 11. Does counselling have spiritual meaning?</td>
<td>Mean of 8.1 on a scale of 10 (1=none).</td>
<td>Mean of 8.46 on a scale of 10 (10=a lot).</td>
</tr>
<tr>
<td>Question 12. What is your understanding spirituality?</td>
<td>91.67% say looking outward to Christ.</td>
<td>93.33% say looking inward to self.</td>
</tr>
<tr>
<td>Question 13. Is God vindictive, irrational and inclined to induce guilt?</td>
<td>All say no.</td>
<td>90.33% say no.</td>
</tr>
<tr>
<td>Question 14. What is your definition of sin?</td>
<td>83.34% say alienation from God. 8.33% say robbed of self-esteem.</td>
<td>93.33% say robbed of self-esteem. 6.67% say alienation from God.</td>
</tr>
</tbody>
</table>
Question 15.  
Do you believe in:  
Demons? 94.5% do.  
Angels? 94.45% do.  
Satan? 100% do.  
Heaven/Hell? 94.45% do.  
39.685% do.  
32.24% do.  
19.05% do.  
20.95% do.

Question 16.  
How long have you been a Christian?  
Conservatives: mean of 28 years.  
Moderates: mean of 27 years.  
Liberals: mean of 35.67 years.  
Nominals: mean of 25.5 years.

Question 18.  
Are you involved in Christian fellowship?  
All are.  
36.51%

Question 19.  
Are your skills God given?  
Mean of 8.89 on a scale of 10 (1= disagree)  
Mean of 4.92 on a scale of 10 (10 = agree).

Question 20.  
Should the Bible be used in counselling?  
83.34% say yes.  
4.76% say yes.

Question 21.  
How confident are you of understanding the Bible?  
Mean of 7.63 on a scale of 10 (1=not confident)  
Mean of 3.1 on a scale of 10 (10 = confident)

Question 22.  
How much time do you spend each week studying the Bible?  
9.22 hours per week.  
Less than one hour per week.

Question 23.  
Is there a particular method you use when using the Bible?  
25% say yes.  
6.67% say yes.

Question 24.  
Are you guided by the Holy Spirit?  
All say yes.  
33.33% say yes.

Question 25.  
Do you practice deliverance?  
58.33% say yes.  
10% say yes.

2. Section Summary.

Committed Christian therapists predominantly felt that problems arose due to Bio-Chemical, Socio-Economic factors and a sinful nature. They were almost equally divided in the belief that humans were innately good but generally agreed that the current problem of humanity was due to our
rebellion against a Holy God and His moral law. The task of the clients was therefore not to know more of themselves but rather to look outward to Christ.

Predicably, committed Christians felt that Christian counselling would offer a better means to such ends but saw counselling as less of a spiritual experience than their non-committed counterparts.

Committed Christian therapists did not see God as "vindictive, irrational" or "inclined to pile on the guilt" and defined sin mainly as "a state of alienation from God". Along with a belief in God, they generally accepted the existence of demons, angels, Satan, and an after life which included heaven and hell. All had been practicing Christians on average for more than twenty-five years and were still actively involved in a Christian fellowship at the time of responding to the research questionnaire. Much of their counselling skill they attributed to God, His Holy Spirit, and the ability to use Biblical Scripture which they felt confident in interpreting. Because of their beliefs they also believed that some of the problems presented by their clients were demonic in nature and required deliverance (or freeing from demons).

Non-committed therapists predominantly felt that client difficulties arose from Bio-Chemical, Socio-Economic, and Spiritual factors. They generally believed human beings were innately good and felt that the current problem with humanity was a result of a lack of understanding of the self. The task for clients is, therefore, to shed self ignorance and draw on an unlimited power within. Non-committed therapists did not agree that Christian counselling offered a better solution to the clients' difficulties since they felt such a therapeutic regime to be too narrow, prescriptive and irrelevant. They did, however, see counselling as a form of spiritual experience.

Like their committed Christian counterparts, non-committed therapists were not likely to see God as "vindictive, irrational, and inclined to pile on
the guilt", but defined sin as an act or thought that robbed people of their self-esteem. A small number of non-committed therapists believed in God, demons, angels, Satan and an after life including heaven and hell, but many, however, also doubted the existence of such things.

Because this group contained Liberal and Nominal Christians, a small percentage indicated current involvement in Christian fellowship. This did not include those who professed no belief in God at all.

For the same reasons, some non-committed therapists felt their skills were God-given but did not feel that the Bible should be used for their own guidance since they were not confident in its interpretation. Their study and use of Biblical Scripture was negligible and unlikely to be used in therapy, neither did they acknowledge being influenced by the Holy Spirit.

Their restricted beliefs in Christian concepts also possibly contributed to not feeling confident about the belief that some client difficulties arose due to demonic influences. Deliverance was, therefore, unlikely to be employed by this group as part of their therapy.

IV. ETHICS.

All of the non-committed therapists and almost all (91.67%) of the committed Christian therapists were members of a professional organisation and abided by its code of ethics. Therapists who did not belong to such an organisation felt they were able to monitor their own actions so as not to compromise their integrity.

Therapists were asked about the importance of including spirituality as a topic in their formal training. Both groups attached much the same significance to this possibility (Table 5).
Table 5. Importance of spirituality.

<table>
<thead>
<tr>
<th>Questionnaire number</th>
<th>Topic</th>
<th>Committed Christian therapists.</th>
<th>Non-committed therapists.</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.</td>
<td>Spirituality in education.</td>
<td>7.78 on a scale of ten. (1 = unimportant)</td>
<td>7.79 on a scale of ten. (10 = important)</td>
</tr>
<tr>
<td>28.</td>
<td>Spirituality in therapy.</td>
<td>7.4 on a scale of ten. (1 = unimportant)</td>
<td>7.2 on a scale of ten. (10 = important)</td>
</tr>
</tbody>
</table>

Likewise, both groups attached an almost identical degree of importance to dealing with the client's spiritual needs as part of the therapeutic program (Table 5). Respondents who felt that spirituality was an important part of the therapeutic program were asked how they approached this subject with their clients. Comments were made by all of the respondents. Table 6 details the tactics employed by the therapists to encourage their clients to speak about their spirituality and the percentage of each group using these methods.

Table 6. Methods employed in approaching the subject of spirituality and by whom.

<table>
<thead>
<tr>
<th>Response to client's enquires.</th>
<th>Conservatives</th>
<th>Moderates</th>
<th>Liberals</th>
<th>Nominals</th>
<th>Non-Christians</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>33.34%</td>
<td>33.33%</td>
<td>100%</td>
<td>71.43%</td>
<td>40%</td>
</tr>
<tr>
<td>Directly approaching subject (excluding during an assessment).</td>
<td>33.33%</td>
<td>44.45%</td>
<td>-</td>
<td>28.57%</td>
<td>60%</td>
</tr>
<tr>
<td>As a result of being raised in an assessment.</td>
<td>33.33%</td>
<td>22.22%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

A mixture of methods appears to be employed by the varying groups with Conservative Christian therapists having no strong inclination toward any one method of approach, Moderate and Non-Christian therapists were more likely to approach the subject directly (except during the initial assessment), and Liberal/Nominal Christian therapists preferred to wait till the client raised the subject.

Respondents were also asked whether they would counsel a "close family member", a "distant family member", a "close friend", a "distant
friend, and/or a member of their congregation". Figure 21 indicates that neither committed Christian nor non-committed therapists were likely to counsel a close family member. Some committed Christian therapists would, however, counsel the others mentioned. Non-committed therapists also indicated that they would counsel the same people as those indicated by the committed Christian therapists with the exception of close friends. The percentage of those non-committed therapists who would, however, remained smaller than indicated by the number of committed Christian therapists.

Figure 21.

Committed Christian therapists indicated a far greater likelihood to meet their clients in a social capacity than non-committed therapists (Figure 22).
Respondents were asked to comment on when this occurred. Committed Christian therapists met clients at church gatherings (37.5%), at social gatherings (25%), in accidental meetings (25%), and when invited to clients' homes (12.5%). Non-committed therapists were less inclined to meet their clients outside therapy but those who did gave the following reasons: accidental (75%) or at social gatherings (25%).

The final question in this section asked respondents how willing (using a 10 point scale where 1 = uncommitted and 10 = very committed) they felt they would be to working through issues of the client obtaining an abortion, establishing/maintaining a homosexual relationship, establishing/maintaining a de-facto relationship and/or having sexual relations outside marriage. It was expected that committed Christian therapists would be significantly less inclined to commit themselves to such issues with their clients due to their anti-religious nature. This proved to be the case for abortion ($t = -2.328, p < .05$), and establishing/maintaining a homosexual relationship ($t = -2.399, p < .05$) but, not for establishing/maintaining a de-facto relationship ($t = -1.970, p > .05$) or having sexual relations outside marriage ($t = -1.610, p > .05$). Committed Christian therapists remained, however, less willing to offer support on these issues than non-committed therapists (Figure 23).
1. Section Summary.

All of the non-committed and most of the committed Christian therapists were members of a professional national association whose code of ethics they abided by. Likewise, both groups attached the same importance on the inclusion of spirituality in a therapist's education program. This same consideration was also felt to be important when addressing a client's own personal spiritual beliefs.

No clear division occurred between the two groups in how they approached the subject of spiritual issues with their clients. Responding to the client's initiative and directly approaching it were the two most common means of approaching the subject of spirituality with their clients for both groups.

Committed Christian therapists were far more likely to counsel distant family members, friends and persons known to them socially than were non-committed therapists. Committed Christian therapists were also more likely to meet with clients socially.

56
There were some issues that committed Christian therapists were less likely to commit themselves to assisting their clients in than non-committed therapists were. These included obtaining an abortion, establishing/maintaining a homosexual relationship, establishing/maintaining a de-facto relationship, and sexual relationships outside of marriage.

V. COUNSELLING PRACTICE.

This section of the questionnaire was to gain some insight into how therapists in the two groups conducted their counselling/therapy. The first question in this section asked respondents how important they felt it was "to address the emotional aspects in counselling a client". On a scale of 10 (1 = unimportant; 10 = very important) committed Christian therapists scored a group mean of 8.56. Similarly, non-committed therapists scored 9.75 indicating no great difference between the two groups.

Next, respondents were asked if they routinely disclosed to their clients personal information about themselves, their religious beliefs, and/or personal values/morals. Slightly more committed Christian therapists said they were likely to disclose personal and religious information to their clients than non-committed therapists (Figure 24).

Figure 24.
Only a third of all therapists from either group said they provided an after hours service for their clients. In addition, a third of all committed Christian therapists indicated a "home call" service. No therapists from the non-committed group provided such services (Figure 25).

Those who made visits cited as their reasons emergencies (50%), hospital visits (25%), and housebound clients (25%).

Whilst none of the respondents worked from their homes, committed Christian therapists were more likely than non-committed therapists to say they could be contacted at home occasionally; conversely, non-committed therapists were more likely than committed Christians to say that they could always be contacted at home (Figure 26).
All committed Christian therapists and almost all (93.33%) non-committed therapists counselled members of the opposite gender. Respondents were also asked to state what safeguards they employed (if any), when counselling members of the opposite gender. Table 7 details the safeguards employed and the percentage of each group who indicated using them.

Table 7.
Safeguards employed and how much by whom.

<table>
<thead>
<tr>
<th>Safeguard</th>
<th>Committed Christian therapists.</th>
<th>Non-committed therapists.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other occupants in building.</td>
<td>66.67%</td>
<td>42.86%</td>
</tr>
<tr>
<td>Therapist's code of ethics.</td>
<td>-</td>
<td>35.71%</td>
</tr>
<tr>
<td>Supervision.</td>
<td>16.67%</td>
<td>14.29%</td>
</tr>
<tr>
<td>Open door policy.</td>
<td>16.66%</td>
<td>-</td>
</tr>
<tr>
<td>No explanation given.</td>
<td>-</td>
<td>7.14%</td>
</tr>
</tbody>
</table>

Table 8 summarises how the therapists from each of the two groups were employed.
Table 8.

<table>
<thead>
<tr>
<th></th>
<th>Waged</th>
<th>Self-employed</th>
<th>Waged/self-employed</th>
<th>Free</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committed Christians</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Non-committed</td>
<td>1</td>
<td>4</td>
<td>10</td>
<td>-</td>
</tr>
<tr>
<td>therapists</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When a client was unable to afford the therapist’s fees, clients of the committed Christian therapists were given the options of either having their fees reduced or being seen free of charge. Non-committed therapists also offered fee reduction as an option but slightly less often. Non-committed therapists were more inclined to terminate therapy with their client with or without an ongoing referral (Figure 27).

![Graph: Cannot pay response]

Respondents were asked what information (if any) they would be willing to pass on to another therapist (excluding supervisors) when the occasion warranted it. Table 9 details what or how much information is passed on and what percentage from each group passed on information.
Table 9.  
Type of information forwarded onto another therapist.

<table>
<thead>
<tr>
<th></th>
<th>Committed Christian Therapists</th>
<th>Non-committed Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client determined.</td>
<td>33.33%</td>
<td>46.67%</td>
</tr>
<tr>
<td>Minimum required.</td>
<td>41.67%</td>
<td>26.67%</td>
</tr>
<tr>
<td>Full details.</td>
<td>8.33%</td>
<td>6.66%</td>
</tr>
<tr>
<td>No details.</td>
<td>16.67%</td>
<td>20.00%</td>
</tr>
</tbody>
</table>

It appears that non-committed therapists are more likely to pass on information only as the client dictates than are committed Christian therapists who are more likely to pass on (albeit minimal) details about their clients.

Therapists were also asked what (if anything) governed the amount of information likely to be shared with another (excluding supervisors). Table 10 details the results of this question.

Table 10.  
Constraints governing information "shared".

<table>
<thead>
<tr>
<th></th>
<th>Committed Christian Therapists</th>
<th>Non-committed Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client directed.</td>
<td>16.67%</td>
<td>60.00%</td>
</tr>
<tr>
<td>Code of Ethics.</td>
<td>75.00%</td>
<td>26.67%</td>
</tr>
<tr>
<td>Privacy Act (1993).</td>
<td>33.33%</td>
<td>26.67%</td>
</tr>
<tr>
<td>(No comments).</td>
<td>16.66%</td>
<td>-</td>
</tr>
</tbody>
</table>

Again, a difference appears to exist between committed Christian and non-committed therapists. Despite their greater willingness to divulge information to another, committed Christian therapists appear to also be guided more by their professional Code of Ethics whereas non-committed therapists appear to be guided more by what their clients are willing to allow them to share with another. One possible explanation for a low percentage being recorded for the Privacy Act (1993) by both groups could
be its recency and a possible lack of an understanding of its complex nature.

Committed Christian therapists were more inclined to "speak about their clients (albeit anonymously) to others outside" their practice than non-committed therapists (Figure 28).

Respondents were also asked to specify on what occasions this occurred. Committed Christian therapists stated that this occurred when sharing their clients' case-notes as an example from their practice (66.67%), and occasionally with their partner (33.33%). Non-committed therapists exclusively specified in sharing their clients' case-notes as examples of their practice only.

Therapists were asked which action they would take if their "religious beliefs, morals, or values" conflicted with their clients'. Both groups were more likely than not to continue working with their client while discussing differences of opinion (Figure 29).
If a clash of beliefs occurs

A much smaller percentage of both groups indicated that they would continue to work with their client but "without discussion" of their differences. An even smaller percentage from the non-committed group indicated that they would refer the client elsewhere.

Those who responded to the previous question were also asked how they would respond to their client's "point of view". Both committed Christian and non-committed therapists were most likely to accommodate the client's point of view within the ongoing therapeutic process (Figure 30).
A small percentage of therapists from both groups were less inclined to attempt an understanding of the client's point of view.

Committed Christian therapists were more likely than non-committed therapists to reveal their own beliefs when asked by their clients (Figure 31).

Non-committed therapists unanimously indicated (along with a small percentage of committed Christian therapists) that they would instead refer
their client to another person who (presumably) held similar beliefs to those held by the therapist.

Questions (47 and 48), were answered only by therapists who had previously indicated a Christian belief. Question 47 asked respondents whether they had ever quoted directly from the Bible to their clients and question 48 asked whether they had ever prayed with their clients and, if so, when and how often. Figure 32 indicates that the likelihood of these things is related to the strength of the therapist's Christian belief.

Figure 32.

![Bar Chart](image)

Tables 11 and 12 detail when the therapists were most likely to use Bible quotations and pray with their clients.

Table 11. Use of Bible quotations.

<table>
<thead>
<tr>
<th></th>
<th>Committed Christian therapists. (Conservatives/Moderates)</th>
<th>Non-committed therapists. (Liberals/Nominals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist initiated.</td>
<td>33.33%</td>
<td>100%</td>
</tr>
<tr>
<td>Client initiated.</td>
<td>22.22%</td>
<td>-</td>
</tr>
<tr>
<td>&quot;Holy Spirit&quot; inspired.</td>
<td>33.33%</td>
<td>-</td>
</tr>
<tr>
<td>Routinely.</td>
<td>11.12%</td>
<td>-</td>
</tr>
</tbody>
</table>

65
Table 12.
Occasions for use of prayer.

<table>
<thead>
<tr>
<th></th>
<th>Committed Christian therapists. (Conservatives/Moderates)</th>
<th>Non-committed therapists. (Liberals/Nominals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist initiated.</td>
<td>45.45%</td>
<td>100%</td>
</tr>
<tr>
<td>Client initiated.</td>
<td>27.27%</td>
<td>-</td>
</tr>
<tr>
<td>&quot;Holy Spirit&quot; inspired.</td>
<td>18.18%</td>
<td>-</td>
</tr>
<tr>
<td>Routinely.</td>
<td>9.10%</td>
<td>-</td>
</tr>
</tbody>
</table>

The responses would indicate that Liberal and Nominal Christians (which make up the non-committed group on this occasion) are more likely to determine if and when Biblical quotations and prayer are utilised. Conservative and Moderate Christians however, whilst still being the main initiators, are also likely to be more responsive to external cues such as responding to the client's request or "Holy Spirit inspiration".

Given many Christians' rejection of occult practices, one would expect their reaction to any mention of these practices to be rather different from non-committed therapists' reaction. Table 13 details the responses given by both the Committed Christian and non-committed therapist groups.

Table 13.
Responses to clients' involvement in the occult.

<table>
<thead>
<tr>
<th></th>
<th>Committed Christian Therapists.</th>
<th>Non-committed Therapists.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elicit a history of involvement.</td>
<td>33.33%</td>
<td>13.33%</td>
</tr>
<tr>
<td>Warn them of the dangers.</td>
<td>50.00%</td>
<td>-</td>
</tr>
<tr>
<td>Seek advice from supervisor.</td>
<td>25.00%</td>
<td>13.33%</td>
</tr>
<tr>
<td>Treat no differently from other issues.</td>
<td>50.00%</td>
<td>73.33%</td>
</tr>
<tr>
<td>Suspect a psychotic disorder</td>
<td>-</td>
<td>20.00%</td>
</tr>
</tbody>
</table>
It appears that committed Christian therapists are divided over whether they should directly intervene (by warning the client of their danger) or do nothing. Non-committed therapists, however, were more likely to treat this situation like other issues raised by the client.

Table 13a further illustrates a trend from direct intervention to no intervention as a reflection of the therapists' strength of Christian belief.

<table>
<thead>
<tr>
<th></th>
<th>Conservatives</th>
<th>Moderates</th>
<th>Liberals</th>
<th>Nominals</th>
<th>Non-Christians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warn them of dangers.</td>
<td>100%</td>
<td>33.33%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>No differently than</td>
<td>-</td>
<td>66.67%</td>
<td>100%*</td>
<td>85.71%</td>
<td>80%</td>
</tr>
<tr>
<td>other issues.</td>
<td>-</td>
<td>66.67%</td>
<td>100%*</td>
<td>85.71%</td>
<td>80%</td>
</tr>
<tr>
<td>No comments</td>
<td>14.29%</td>
<td>20%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* All the liberals stated that they would suspect a psychotic disorder and would therefore deal with this accordingly. For this purpose it was included in this table as "no differently than other issues".

All committed Christian therapists stated that they would be willing to accommodate new procedures into their ongoing therapy with a client, whilst the client retained the right to accept/reject these new procedures. In almost all cases, committed Christian therapists also indicated that they would forewarn their clients about any such changes (Figure 33).
Non-committed therapists were less inclined to introduce new procedures whilst working with a client. When this did occur, they were almost half as likely as their committed Christian counterparts to give their clients the right to accept/reject the new procedures or forewarn them of any changes in the therapy. It might be hypothesised, therefore, that non-committed therapists are less willing to accommodate the client’s wishes.

Therapists were asked what their actions would be if they felt satisfactory progress was not occurring with their clients. Table 14 details the responses given by both groups.
Table 14. Therapist actions when therapeutic progress stalls.

<table>
<thead>
<tr>
<th></th>
<th>Committed Christian Therapists.</th>
<th>Non-committed Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confer with supervisor.</td>
<td>66.67%</td>
<td>46.67%</td>
</tr>
<tr>
<td>Discuss with client.</td>
<td>41.67%</td>
<td>66.67%</td>
</tr>
<tr>
<td>Discuss with colleagues.</td>
<td>16.67%</td>
<td>6.67%</td>
</tr>
<tr>
<td>Try new approach.</td>
<td>16.67%</td>
<td>-</td>
</tr>
<tr>
<td>Pray.</td>
<td>25.00%</td>
<td>-</td>
</tr>
<tr>
<td>Terminate therapy.</td>
<td>16.67%</td>
<td>-</td>
</tr>
<tr>
<td>Read books on subject.</td>
<td>8.33%</td>
<td>-</td>
</tr>
<tr>
<td>Question own ability.</td>
<td>-</td>
<td>6.67%</td>
</tr>
</tbody>
</table>

Committed Christian and non-committed therapists were most inclined to confer with their supervisor and client over the lack of any perceived progress being made in therapy. Committed Christian therapists did, however, appear to utilise more strategies.

Recognising the possibility that therapists may not always be acting in a manner most beneficial to the client (although there is a sincere attempt to do so), therapists were asked how they gauge their own "appropriateness of approaches used with clients".

Table 15 details the responses.

Table 15. Therapist self-gauging techniques.

<table>
<thead>
<tr>
<th></th>
<th>Committed Christian Therapists.</th>
<th>Non-committed Therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client feedback.</td>
<td>91.67%</td>
<td>100%</td>
</tr>
<tr>
<td>Supervisor feedback.</td>
<td>33.33%</td>
<td>6.67%</td>
</tr>
<tr>
<td>Colleague feedback.</td>
<td>8.33%</td>
<td>-</td>
</tr>
<tr>
<td>Intuition.</td>
<td>16.67%</td>
<td>-</td>
</tr>
<tr>
<td>Personal standards.</td>
<td>8.33%</td>
<td>-</td>
</tr>
</tbody>
</table>
Again, feedback for both groups appears to come predominantly from their clients and supervisors. In this instance, however, committed Christian therapists seem to make far greater use of their supervisors as well as a wider variety of alternatives. One of these alternatives, "intuition", reflects the Christian belief that they are "led by the Holy Spirit" (as recorded in their answers to the questionnaire). The response to this question also raises the possibility that non-committed therapists are more reliant on choosing to limit their self appraisal in a manner whereby they judge themselves rather than a wider variety of sources.

It was earlier mentioned (in the Method section) that all the respondents were tertiary educated. Respondents were asked how much of this training they felt was still being actively used in their therapy with clients. This was asked on the premise that therapists would also gain skills from their practical experiences. Regrettably, due to there not having been a question which would have indicated the length of time a therapist had been practicing, a correlation between the length of time since tertiary training and its continuing influence could not be calculated. Both groups reported that approximately 72% of their tertiary education was still relevant to the manner in which they practiced.

At the time of drafting the counsellors' questionnaire, a Disabilities Allowance paid to welfare recipients that could be used to pay for counselling was axed. Because many therapists were affected by this cut, professional organisations such as the New Zealand Association of Counsellors asked the government to alter its stand. Respondents were asked whether they would personally take up a cause such as the one taken up by their association on behalf of their clients. On a scale of 10 (with 1 being unlikely; 10 = very likely), committed Christian therapists were more likely (6.94) than non-committed therapists (5.11) to do so.
1. **Section Summary.**

Both non-committed and committed Christian therapists felt it important to address the client's emotional needs.

Committed Christian therapists were a little more inclined than non-committed therapists to divulge personal information, religious beliefs and personal values/morals. Whilst not many therapists from either group offered an after-hours service, committed Christian therapists were the only ones to indicate that they would make home calls even though they were harder to contact at their home than non-committed therapists.

Most therapists from both groups counselled members of the opposite gender. Working in a public building and abiding to a code of ethics were the main safeguards in doing so.

Both groups had members who combined self and waged employment. Where the client could not pay, committed Christian therapists indicated a likelihood that they would reduce their fees to suit the client or see them free of charge. Non-committed therapists were more likely to terminate therapy with or without referral.

When the therapist had to refer a client to another professional, non-committed therapists were more likely to be guided by their clients as to how much information would be passed on. Committed Christian therapists tended to give only the minimum amount of information they felt to be required, as suggested by their code of ethics. Committed Christian therapists, however, did acknowledge that they were more likely to divulge information about their clients to people other than their supervisor's. Like their non-committed counterparts most of these occasions were within teaching contexts, however, they also admitted to speaking at times about their clients to spouses.

When a clash occurred between the religious views, morals or values of the client and therapist, therapists from both groups indicated that they
would continue to work with their clients after some discussion of their
differences and accommodation to the client's viewpoint. Should a client
begin to show an interest in the beliefs held by the therapist, however,
committed Christian therapists stated that they were more likely to discuss
this with their clients whereas non-committed therapists were more inclined
to refer their client to another resource.

Of the non-committed group, only Liberal and Nominal Christians
quoted from the Bible or prayed with their clients, and they did this less
often than committed Christian therapists. Its occurrence was generally a
response to a client's request.

Dealing with the occult was more accepted by committed Christian
therapists although a reasonable percentage from both groups also
professed a felt lack of competence in dealing with this issue.

Therapists from both groups acknowledged an openness to new forms
of therapeutic practice whilst working with a client. Committed Christian
therapist were more likely than non-committed therapists to do so only after
having first gained permission from their client.

If satisfactory progress with their client appears to have been impeded,
committed Christian therapists are more inclined to consult with supervisors
than non-committed therapists who were more inclined to discuss the matter
with their clients. The second option for each group was the same as the
first for the other group.

Client feedback was the predominant means of self evaluation for both
groups.

Tertiary education given to the therapists in both groups was still
considered highly relevant to their current ability to work with their clients.

Both committed Christian and non-committed therapists indicated a high
likelihood that they would take up a cause on behalf of their client should
they feel the matter had therapeutic importance.
VI. SUPERVISION.

Question 55 of the counsellors' questionnaire asked them about their clinical supervision. Table 16 summarises the responses.

Table 16. Respondent's Supervisors.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Knowledge of supervisor's therapeutic style</th>
<th>Knowledge of supervisor's training</th>
<th>Frequency of supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committed Christian therapists</td>
<td>Same (83.33%)</td>
<td>Yes</td>
<td>Weekly (63.64%)</td>
</tr>
<tr>
<td></td>
<td>Different (16.67%)</td>
<td>Yes</td>
<td>Fortnightly (18.18%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Monthly (18.18%)</td>
</tr>
<tr>
<td>Non-committed therapists</td>
<td>Same (60%)</td>
<td>Yes</td>
<td>Weekly (26.67%)</td>
</tr>
<tr>
<td></td>
<td>Different (40%)</td>
<td>Yes</td>
<td>Fortnightly (53.33%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Monthly (20%)</td>
</tr>
</tbody>
</table>

A factor in the frequency of supervision may be the amount supervisors are paid by the therapists. Committed Christian therapists may be paying less than their non-committed counterparts and therefore able to afford more regular supervision. Regrettably, this information was not asked for.

Half of the committed Christian therapists, and a smaller percentage of non-committed therapists, indicated that their supervisors were Christian (Figure 34). The choice also as to whether or not a supervisor is a Christian was more important to committed Christian therapists than non-committed ones.

Figure 34.

![Supervisors chart](chart.png)
Whether non-committed therapists who had Christian supervisors selected their supervisor in part because of their Christian beliefs or they represent the percentage of therapists who felt they had no choice of supervisor selection is not known.

Earlier, therapists from both groups had indicated a greater likelihood that they would discuss with their clients any differences they had in religious beliefs. Only one committed Christian therapist indicated that he would not discuss such differences if this arose between himself and his supervisor.

Therapists were asked to indicate from whom they would seek advice when faced with a problem affecting their work. Committed Christian therapists predominantly indicated "God" and their "supervisor" as the main sources from which they would seek assistance. Non-committed therapists also indicated that their main resource for assistance was their supervisor with a smaller percentage also indicating their "work colleagues" (Figure 35).
Smaller percentages of both groups sought assistance from a close friend and/or a minister.

1. Section Summary.

Supervisors for both groups tended to be the same gender as the therapist although some-cross gender supervision occurred, particularly among non-committed therapists. All the therapists knew what style their supervisors employed and the training they had received. Committed Christian therapists tended to see their supervisors weekly whereas non-committed therapists saw their supervisors fortnightly. The supervisors seeing committed Christian therapists were themselves more likely to be Christians and may in part have been specifically chosen for this reason. Some non-committed therapists also had Christian supervisors but it is not known whether this was their choice. A high percentage of therapists from both groups indicated that they had chosen their supervisor.

If a difference in religious beliefs arose between a therapist a supervisor, most committed Christian and all non-committed therapists were likely to discuss this issue with their supervisor. Supervisors and work colleagues
were seen by both groups as those they would most likely seek advice from if difficulties arose in the workplace. Committed Christian therapists also indicated God as a source from which they would seek advice.

VII. PROFESSIONAL DEVELOPMENT.

Non-committed therapists were more inclined to subscribe to counselling journals than committed Christian therapists (61% and 33.33% of the groups respectively). Of all the therapists from both groups who subscribed to journals, 66.67% subscribed to a journal that no other therapist in either group also subscribed to. Journals listed as being subscribed to by more than one therapist were the "New Zealand Association of Counsellors Journal" (subscribed to by 77.78% of the respondents), British Gestalt Journal (22.22%), and the Family Therapy Newsletter (22.22%). The latter two were subscribed by non-committed therapists only.

Committed Christian therapists listed a total of sixty-one books read over the past year and, non-committed therapists forty-three. Four titles were listed by two separate therapists. These were: "Getting The Love You Want"; "Object Relations Therapy"; "Men Who Hate Women And Women Who Love Them"; and "Women Who Love Too Much". Table 17 details the topics of the books read by each group and the percentage of that group who read them.
Table 17.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General Psychology</td>
<td>75.00%</td>
<td>80.00%</td>
</tr>
<tr>
<td>General counselling</td>
<td>58.33%</td>
<td>8.33%</td>
</tr>
<tr>
<td>Addiction</td>
<td>58.33%</td>
<td>20.00%</td>
</tr>
<tr>
<td>Abuse</td>
<td>50.00%</td>
<td>46.67%</td>
</tr>
<tr>
<td>Self concept issues</td>
<td>41.67%</td>
<td>26.67%</td>
</tr>
<tr>
<td>Religious counselling</td>
<td>41.67%</td>
<td>-</td>
</tr>
<tr>
<td>Child Psychology</td>
<td>25.00%</td>
<td>13.33%</td>
</tr>
<tr>
<td>Christianity</td>
<td>25.00%</td>
<td>6.67%</td>
</tr>
<tr>
<td>Family therapy</td>
<td>16.67%</td>
<td>13.33%</td>
</tr>
<tr>
<td>Psychology of religion</td>
<td>8.33%</td>
<td>6.67%</td>
</tr>
<tr>
<td>Grief</td>
<td>8.33%</td>
<td>-</td>
</tr>
<tr>
<td>Adolescence</td>
<td>8.33%</td>
<td>-</td>
</tr>
<tr>
<td>Conflict issues</td>
<td>8.33%</td>
<td>13.33%</td>
</tr>
<tr>
<td>Stress</td>
<td>8.33%</td>
<td>-</td>
</tr>
<tr>
<td>Co-Dependency</td>
<td>8.33%</td>
<td>-</td>
</tr>
<tr>
<td>Emotions</td>
<td>-</td>
<td>13.33%</td>
</tr>
<tr>
<td>Supervision</td>
<td>-</td>
<td>6.67%</td>
</tr>
<tr>
<td>Unknown (to researcher)</td>
<td>8 titles.</td>
<td>5 titles.</td>
</tr>
</tbody>
</table>

1. Section summary.

Non-committed therapists were more inclined to subscribe to counselling journals than committed Christian therapists. The majority of journals subscribed to were unique to a singular subscriber.

Similarly, specific books read by the therapists from both groups tended to be an individual choice. However, the most popular topics included general psychology, general counselling, addiction, abuse, and self concept issues.

VIII. TRAINING.

All non-committed therapists and almost all (91.67%) of the committed Christian therapists attended conferences/workshops throughout the year.

The mean number of attendances by therapists from both groups was similar (3.3 conferences/workshops for committed Christian therapists versus 4.1 conferences/workshops per year for non-committed therapists).

An earlier question had asked respondents to express what percentage of their tertiary education they felt was still being employed in their practice.
This question was to gauge how much therapists still applied their tertiary education to their actual practice. In this section of the questionnaire, therapists were asked how much of their training could be attributed to working with their clients. Committed Christian therapists recorded a group mean of 71.67% to knowledge gained through their practical experience. Non-committed therapists recorded a group mean of 60.56% to knowledge gained by them through practical experience. One explanation for the high percentages recorded for both questions could be that the respondents thought that both their tertiary training and their practical experiences were important contributors to their present work with clients.

A final question in this section, (how much of their Christian training was still being used in their therapeutic program), related to Christians only. Conservative Christians indicated that they felt a high percentage of their Christian training was still relevant in dealing with their clients (Figure 36).

![Figure 36](image)

Nominal Christians at the other extreme (of the indicated belief continuum), recorded the smallest percentages of previous Christian teaching being still relevant to their working with clients. Liberal Christians
indicated a predictable middle to low percentage but, Moderate Christians recorded an interesting and unexpected low percentage which went against the trend.

1. **Section Summary.**

Most of the therapists from both groups attended approximately four conferences/workshops each year. Committed Christian therapists were more likely than their non-committed counterparts to credit their practical experiences with clients as part of their ongoing training. They were, however, relatively varied in their belief that past Christian training also contributed to their current skills development.

IX. **SUPPORT.**

All of the non-committed therapists and a high percentage (77.78%) of the committed Christian therapists indicated that they had previous counselling themselves. A small percentage (22.86%) of the non-committed group stated that they were still receiving personal therapy currently. Table 18 details the reasons why these therapists had received counselling and the percentage within each group who had.

<table>
<thead>
<tr>
<th>Table 18. Reasons for receiving counselling and how many.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Committed Christian therapists.</strong></td>
</tr>
<tr>
<td>Self concept issues</td>
</tr>
<tr>
<td>Grief</td>
</tr>
<tr>
<td>Drug abuse</td>
</tr>
<tr>
<td>Family issues</td>
</tr>
<tr>
<td>Emotional difficulties</td>
</tr>
<tr>
<td>Sexual abuse</td>
</tr>
<tr>
<td>Marriage</td>
</tr>
<tr>
<td>Relationships</td>
</tr>
<tr>
<td>Unstated</td>
</tr>
</tbody>
</table>

A final question in this section also asked respondents to indicate whether they would wish to be a member of a "National Secular Counselling Association", "National Christian Counselling Association", or
"Both". Predicably, almost all of the non-committed therapists desired to be members of a secular National Association (Figure 37).

Figure 37.

Desired association membership

<table>
<thead>
<tr>
<th>% sample</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>0</td>
</tr>
</tbody>
</table>

Committed Christian therapists indicated a strong desire for membership in both a Secular and Christian National Association. This desire for dual membership may indicate that Committed Christian therapists feel that an exclusive Christian Association may be too narrow in its viewpoints in dealing with wider social issues. A small percentage from each group indicated a singular choice to belong to an Association different from their stated belief. Also, a small percentage of committed Christian therapists opted for a Christian-only National organisation.

1. **Section summary.**

A high percentage of therapists from both groups had previously received personal therapy, the most common reason being for self-concept issues. Some non-committed therapists were still receiving therapy. Non-committed therapists were overwhelmingly in favour of maintaining membership in a national secular counselling association whereas committed Christian therapists indicated a desire to also belong to a Christian national Association.
X. THERAPIST INTERVIEWS.

As recorded in the Method section, two therapists from each group were interviewed. Both committed Christian therapists approached consented to being interviewed. However, two therapists from the Non-Christian group declined prior to two others consenting.

The interviews were unstructured inasmuch that the therapists were permitted to express freely their views of the research and accompanying questionnaire.

Interviewees from each of the two groups consisted of a male and female therapist.

No significant additional research information was gained from the committed Christian interviewees who otherwise expressed very strong support for the research and a desire to receive a copy of the study results. This latter desire expressed by those interviewed also coincided with positive (unsolicited) comments regarding the research by 50% of all the respondents on their answer sheet. A third of the committed Christian respondents had also either attached personal notes of encouragement to their answer sheets or sent these separately by mail. From this response, the researcher perceived a need being expressed by committed Christian therapists for research of this type. It may have also indicated their perception that they have been a maligned and misunderstood group of therapists, particularly by those who do not share similar religious beliefs or understand them.

The two also shared a strong interest in the establishment of a National Christian Counselling Association for the purposes of being able to share with others viewpoints felt to be alien to non-committed therapists and the implications these viewpoints have for their work. It was felt that secular counselling Associations' conferences and workshops tended to encourage and endorse "New Age" forms of therapy which were not concomitant with
their own styles of practice, and there was little in the way of alternative styles of therapy more in accord with their own beliefs being permitted to be expressed. An affiliation with a National Secular professional body was, however, felt to be necessary in order to maintain credibility with the general public and, because such bodies are at present perceived to have a monopoly on resources not yet available to the Christian sector.

Non-committed therapists were not quite so positive. Contrasting with the good wishes of the committed Christian therapists, was the lack of co-operation by the non-committed therapists. In addition to those who refused to complete the questionnaire after first saying they would, there were some who returned their questionnaire with negative comments. One of the "kinder" comments written perhaps sums up the feelings often shared by this group:

"I only agree to do this part, [questionnaire] I am not available for another hour [referring to interview] and do not feel comfortable involving my clients".

Despite this, a confusing "picture" emerged after interviewing two therapists from the non-committed group.

The non-committed female therapist found the questionnaire "very interesting" and relevant at a time when the importance of spiritual awareness within a therapeutic process was becoming more apparent. She found the questionnaire useful as an instrument by which she could "explore herself" and gain some insight of her own perceptions regarding this area of spirituality. She was surprised to learn of many colleagues' hostility and could not explain it. The only negative comment this interviewee made regarding the questionnaire was on its length.

Length of the questionnaire was not one of the criticisms shared with the researcher by the male non-committed therapist. He felt that the questionnaire was "too prescriptive", and had a considerable bias toward
Christian beliefs which "forced" the respondent into answering in a Christian or secular manner inevitably causing a "dualistic situation to arise". He felt the questionnaire "steered" respondents into giving "Christianised" or "Jungian" answers and precluded any opportunity for the respondents to answer from "an Eastern religious or other philosophical point of view".

He felt that "the meaning of life" had nothing to do with a belief in "God". Such words as "God" and "Christian" should, in his opinion, have been omitted altogether allowing for a more "open response".

This response may be similar to those made by the therapists who indicated an unwillingness to complete the questionnaire due to spiritual, religious, or cultural incompatibility. He was also very critical of the questions relating to the occult feeling that such questions were irrelevant. Similarly he felt the questions regarding supervisors were also irrelevant since they had a right to believe whatever they choose, and it was of no relevance to the therapist what the supervisor believes since they choose the supervisor for supervision only and not because of their beliefs.

It is possible that the two very different views gained from these two non-committed therapists explain the low response rate for this group. Those who felt more inclined to share the female therapist's viewpoint responded, whereas those who shared the male therapist's viewpoint generally did not. If this is correct, more non-committed therapists share the male therapist's expressed viewpoint than the female's. However, because only two non-committed therapists were interviewed, their views must be interpreted with caution.

XI. CLIENT DATA.

It is always easy to retrospectively wish something different had been done in research and such is the case here with client data. Client evaluation was not initially considered to be a major factor in the current research and
was carried out only so that some cross checking could be done when compared to data given by the therapists and to establish any basis for future research in the area.

Regarding the former reason, it was intended to "see" whether what the therapist stated was supported by what the client reported as occurring. For example, if a therapist stated that they were able to be contacted at their own home, did the client confirm or deny this possibility?

From the data, three separate viewpoints were obtained. These viewpoints offer some unique perspectives and represent the viewpoints of two (female) Christian clients seeing a committed Christian therapist, two Christian clients (one male and one female) seeing a non-Christian therapist, and two non-committed (female) clients seeing a committed Christian therapist. No data from the perspective of a non-committed client seeing a non-committed therapist were obtained.

For ease of presentation and interpretation, client responses are recorded in this section in the same sequence as that established by the therapists questionnaire. Because the results are recorded out of sequence to the client's questionnaire, each sub section of the following report will begin with the question numbers referred to and the sequence in which they occur.

1. Demographic Data.

[cf (client questionnaire numbers) 46-47,1-5]

Table 19 details the demographic data of the responding clients used in this report.

<table>
<thead>
<tr>
<th></th>
<th>Mean age</th>
<th>Range</th>
<th>Female</th>
<th>Male</th>
<th>Number of sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian clients</td>
<td>40.75</td>
<td>34-46</td>
<td>3</td>
<td>1</td>
<td>54</td>
</tr>
<tr>
<td>Non-committed clients</td>
<td>30</td>
<td>26-34</td>
<td>2</td>
<td>0</td>
<td>17.5</td>
</tr>
</tbody>
</table>
Christian clients had been seeing their therapist for over three times the length non-committed clients had been. Does this indicate an incompetence associated with committed Christian therapists, a greater likelihood to address issues in a wider manner, a combination of both, a greater reluctance to terminate with clients, or some other factor?

Christian clients were more inclined to have been referred to their therapists through the church or by others making recommendations whereas non-committed clients indicated word of mouth or advertising as their reason for therapist choice. This may well serve to indicate that Christian clients are likely to be either more cautious about where to go by seeking recommendations from others or the church. Non-committed clients appear to be less concerned over the choice of their therapist. Five of the six clients indicated that the gender of the therapist was an important factor in their choice of therapist, and only one client felt they had no choice in this matter. All of these five stated a preference for a therapist of the opposite gender, whilst the sixth (Christian) client expressed no preference at all.

The mean cost of therapy was only slightly more expensive for Christian clients than non-committed ones, ($40-00 & $35-00 per session respectively).

2. Theoretical Orientation. [6-7,11,28,33].

Following an initial focus in the clients' questionnaire upon client choices, responses to their perception of their therapist was gained. Clients were asked whether or not they knew if their therapist was a Christian and if this was a factor in their choosing to see them.

All of those seeing a committed Christian therapist stated that they knew they were, but only those clients who were themselves Christian had
deliberately sought a committed Christian therapist. Clients seeing a non-Christian therapist did not know whether or not their therapist was a Christian and despite themselves being Christians, neither had they deliberately sought to find one since they felt that the therapist's own religious beliefs were irrelevant to the therapeutic process.

It appears, therefore, that a committed Christian therapist's beliefs are more likely to be known to their clients than those of a non-Christian therapist. This coincides with an earlier result given by the committed Christian therapists, who indicated a greater likelihood of disclosing their own beliefs. However, none of the clients were able to describe the style of therapy their therapist used.

Forgiveness of those who have caused offence is a strong Christian concept, as was borne out in the results given by committed Christian therapists. They were more than twice as likely to encourage their clients to forgive than were non-committed therapists. Not surprisingly, therefore, three of the four clients seeing committed Christian therapists reported that they had been instructed on at least one occasion to forgive those who had offended them. Neither of the two clients seeing non-Christian therapists had been similarly instructed. This not only reinforces the belief that such instruction is more likely to originate from committed Christian therapists but may also indicate that therapists attempt to influence their clients to adopt the therapist's own personal values.

In their responses, committed Christian therapists were more inclined than non-committed therapists to believe it essential to recall past events. All of the clients believed that recall of past events was important and therefore a potential for conflict between clients and therapists could occur. Clients may wish to divulge information of their past which they feel may be relevant whilst non-committed therapists in particular may attempt to keep their clients in the present. The intent to keep clients in the present is a
strong factor within Existential-Humanistic and Gestalt therapies, the two most used styles of therapy indicated by the non-committed therapist group.

3. **Beliefs.**

[12-17,19-21,27,26,22]

Christian clients seeing a non-Christian therapist tended to have held Christian beliefs longer than those seeing a committed Christian therapist. This may illustrate a possibility that Christians who are a little less mature in their faith may feel more secure with a committed Christian therapist. Conversely, more mature Christians may feel sufficiently secure in their faith so as to dispute or ignore any conflicts that may arise within a therapeutic situation. Another explanation may be that those Christian clients seeing a non-Christian therapist may be more liberal or nominal in their beliefs and, therefore (as previously indicated), less inclined to see Christian beliefs as being relevant in a therapy environment. This latter point may further explain also why the one of the two clients seeing the non-Christian therapist was not currently involved in any church activities.

Results gained from the committed Christian therapists demonstrated that not all who described themselves as Christians held a belief in entities/elements traditionally associated with Christian theology and worship.

Christian clients indicated a similar variance of beliefs (Table 20).
Table 20
Client beliefs.

<table>
<thead>
<tr>
<th>Belief in:</th>
<th>Committed Christian therapists</th>
<th>Christian clients</th>
<th>Non-Christian therapists</th>
<th>Non-committed therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demons</td>
<td>94.45%</td>
<td>75%</td>
<td>50%</td>
<td>39.68%</td>
</tr>
<tr>
<td>Angels</td>
<td>94.45%</td>
<td>100%</td>
<td>50%</td>
<td>32.24%</td>
</tr>
<tr>
<td>Satan</td>
<td>100%</td>
<td>75%</td>
<td>50%</td>
<td>19.05%</td>
</tr>
<tr>
<td>God</td>
<td>100%</td>
<td>100%</td>
<td>50%</td>
<td>57.46%</td>
</tr>
<tr>
<td>Heaven/Hell</td>
<td>94.45%</td>
<td>75%</td>
<td>50%</td>
<td>20.95%</td>
</tr>
</tbody>
</table>

At first sight it would appear that Christian clients do not have as strong a belief in certain Christian concepts as committed Christian therapists and that non-committed clients have a greater belief structure than non-committed therapists. It needs to be remembered, however, that the number of clients is small, possibly skewing the results. This may be particularly true for the non-committed client results where higher than expected percentages were achieved. Another confounding factor is the not knowing where the Christian clients are placed on the Christian spectrum. All that could possibly be interpreted from these results is that there appears to be a similarity of beliefs between committed Christian therapists and their clients as there is between non-committed therapists and their clients.

None of the committed Christian therapists saw God as "vindictive, irrational," or "inclined to induce guilt". One non-committed therapist did, however, and so did one of the four Christian clients. This particular client was seeing a non-Christian therapist and therefore her/his answer may indicate some hostility toward religion at the time.

All of the Christian clients believed that "Sin" was defined as "a state of alienation from God" which coincided with the high percentage of committed Christian therapists who indicated a similar belief. One of the non-committed clients however believed that sin was "an act or thought that robs people of their self esteem" and, the other, "an inherent condition that
lies at the core of our state." A parity between the beliefs of therapists and clients appears therefore to exist.

Being influenced by the Holy Spirit is likely to be seen as a Christian concept which was strongly upheld by the committed Christian therapists. All of the Christian clients felt similarly along with one of the non-committed clients. Given that a small percentage of non-committed therapists also indicated a similar belief, the non-committed clients' response may not be unusual.

Committed Christian therapists indicated a strong belief that their skills were "God given", which was reflected by the Christian clients. This strength of belief was, however, stronger for those Christian clients seeing a committed Christian therapist than those seeing a non-Christian therapist. This indicates that Christian clients are less inclined to attribute "God given" skills to non-Christians. The same reasoning also appears to occur for non-committed clients seeing a committed Christian therapist since the results obtained from the two in this study showed that they were even more likely to believe that their therapist's skills were "God given" than the Christian clients seeing a non-Christian therapist. The ability for therapists to subtly (or overtly) convey personal values again appears to be possible in this area.

Christian clients were more likely to believe that Christian counselling offered a better solution-finding environment than secular counselling, reinforcing the same beliefs held by committed Christian therapists. One of the two non-committed clients also believed that Christian counselling was better than secular counselling, but the other disagreed. The one believing it may be reflecting a good therapeutic relationship between herself and the therapist whereas the other may reflect the general opinion stated by the non-committed therapists. Table 21 details more fully the reasons given by
the clients for their answer and the numbers (in parentheses) who stated them.

<table>
<thead>
<tr>
<th>Christian clients</th>
<th>Non-committed clients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DOES.</strong></td>
<td></td>
</tr>
<tr>
<td>More understanding. (1)</td>
<td>More understanding. (1)</td>
</tr>
<tr>
<td>Less judgemental. (1)</td>
<td></td>
</tr>
<tr>
<td>&quot;Sent to me by God&quot;. (1)</td>
<td></td>
</tr>
<tr>
<td>God is the only leader. (1)</td>
<td></td>
</tr>
</tbody>
</table>

**DOES NOT.**

"Only need empathy". (1)

When asked whether the Bible should be used in counselling, three of the four Christian clients agreed along with one of the non-committed clients. The other non-committed client and a Christian client seeing a non-Christian therapist disagreed. Given that committed Christian therapists generally felt that the Bible should be used and non-committed therapists did not, these results would be unremarkable except that one non-committed client felt it important. Again, this could be a reflection of it actually having occurred and perhaps usefully. It also again reinforces the possibility that committed Christian therapists are more inclined to instil their set of values into a counselling situation.

Only the two Christian clients seeing a committed Christian therapist believed that they were being encouraged to "look outward to Christ" as a means of resolving issues whereas the other four clients were uncertain about what their therapist was encouraging them to do. Whilst the therapists' responses indicated that committed Christian therapists encouraged their clients to look outward and non-committed therapists encouraged their clients to look inwards, it appears the "message" is not getting through other than to Christian clients seeing a committed Christian therapist. Does this mean that therapists are not actually doing what they
say they are or are they too subtle in their message or are their clients not listening because of conflicting beliefs?

A little more than fifty percent of the committed Christian therapists and ten percent of non-committed therapists indicated that "deliverance" would be a part of their therapeutic program if this was felt to be relevant. Of the four clients seeing a committed Christian therapist, three agreed that this form of therapy was relevant (when applicable). Neither of the two clients seeing a non-Christian therapist did, which may serve further to reinforce the argument that these particular clients may be exhibiting some hostility toward traditional Christian practices.

4. Ethics.

[29-30,32,44]

Being able to appreciate and accept the client's viewpoint is of considerable ethical importance. Clients were asked to rate on a scale of 1 to 5 (1 = disregarded; 5 = highly regarded), whether they felt this occurred specifically regarding any religious beliefs they held. Those seen by a committed Christian therapist indicated a higher likelihood of this occurring than those seen by the non-Christian therapist (Figure 38).

Figure 38.
Given this perception, Christian clients seeing a non-committed therapist may be less inclined to self-discose details about their religious beliefs for fear of not being adequately understood. Despite an earlier finding that there was no significant difference between non-committed and committed Christian therapists appreciation for their clients spiritual concerns, non-Christian therapists do not appear to be portraying this sentiment to their clients.

Previously, committed Christian therapists had indicated a significantly greater reluctance to become involved with issues about abortion or homosexuality than their non-committed counterparts. This same reluctance was not extended to issues about de-facto relationships or sex outside of a marital relationship. Client's were asked whether or not they felt they could discuss these same issues with their therapists. None of the clients felt they could discuss with their therapists about having an abortion, and three of the Christian clients as well as one of the non-committed clients felt they could not discuss any of the other three issues either. Again, it would seem that whilst therapists say they a willing to talk about certain issues, this message is not being perceived always by the clients. It may also indicate a reluctance by Christian clients to share with non-Christian therapists certain issues for fear their Christianity may be questioned and, for non-committed clients to share issues with committed Christian therapists for fear of being morally judged.

Fifty percent of the committed Christian therapists but almost none of the non-committed therapists stated that they would see clients in a social capacity. As a cross check, clients were asked whether this had actually occurred. Three of the four clients seeing a committed Christian therapist stated this had occurred but neither of those seeing a non-Christian therapist had. This reinforces the results given by the therapists.
5. Therapeutic Practice.

[25,24,18,23,31,34-42,9,8,10,43]

A high percentage of committed Christian therapists had previously indicated that quoting from the Bible and praying for clients was an important part of the client's therapeutic program. This belief by committed Christian therapists appears to be limited to when they are working with Christian clients only, since they were the only ones to state that this had ever occurred. Non-committed clients seeing a committed Christian therapist denied this having ever happened.

Christian clients did feel, however, that it was slightly more important to be able to express their religious beliefs than non-committed clients.

Both committed Christian and non-committed therapists had strongly indicated in their results that they were likely to divulge their own religious beliefs to their clients. Clients were asked whether they divulged any of their religious beliefs with their therapist. All of the clients seeing a committed Christian therapist stated that they had done so whereas only one of the two clients seeing a non-Christian therapist said they had. This may further indicate a perceived difficulty Christian clients are believed to have in raising the topic of their beliefs with a non-committed therapist. It is, of course, equally possible that this client had deliberately chosen a non-Christian therapist so he/she would not have to discuss his/her beliefs. None of the clients felt, however, that they would knowingly attempt to alter their therapist's own personal beliefs.

Therapists from both groups indicated that when a clash of values, morals or religious values occurred between themselves and their clients, they were more apt to discuss these differences with them than to terminate the therapy. An attempt was made to measure how much authority clients felt their therapists had over them when contradictions between morals and values occurred. Three of the four clients seeing a committed Christian
therapist said they would immediately terminate their counselling and seek advice elsewhere. That does not give much opportunity for the therapist to "discuss the differences". Both clients seeing a non-Christian therapist and the remaining client seeing a committed Christian therapist stated that they would continue with their therapy but ignore the therapist's conflicting values. This does not leave much room for discussion either. It appears that Christian clients generally expect non-Christian therapists to be different and they accommodate to this. Those clients seeing a committed Christian therapist, however, whilst perceiving their therapists as having different values, are less likely to be tolerant if it is felt they are trying to be directed.

Both non-committed clients seeing a committed Christian therapist and both Christian clients seeing a non-Christian therapist felt they were able to express themselves emotionally. Both Christian clients seeing a committed Christian therapist however believed this was not possible. This contradicts the earlier finding that committed Christian therapists were strongly in favour of encouraging their clients to relate emotionally in therapy. One explanation for this finding may be that Christian clients seeing committed Christian therapists may believe that this is inappropriate behaviour and inconsistent with a stronger preaching/teaching style adopted by orthodox Christians.

Despite this, all of the clients seeing a committed Christian therapist did state that they felt their therapist would be considerate of their emotions and only those seeing a non-Christian therapist were apt to be seen as being a little less considerate. This may indicate that non-Christian therapists are perceived by their clients as being less empathic regarding emotive issues which would concur with the findings earlier displayed by non-committed therapists. This possibility of non-committed therapists being less empathic was again indicated when clients were asked how much concern they believed their therapist had toward their difficulties. Both clients seeing the
non-Christian therapist were only half (2.5 on a scale of 5) as likely to feel that their issue was of concern to their therapist than those who saw committed Christian therapists. One client seeing a non-Christian therapist stated that they had to be (less empathic) because, "she must remain professionally detached". The other said, "that is her job description".

Much of this section has so far indicated that what therapists said they were prepared to do, and what clients felt their therapists would do for them, differed in a number of areas. This appears to be particularly evident between non-committed therapists and their clients. Clients were asked a series of questions which enabled them to relate how they perceived their therapist functioning within a therapeutic session on a five point scale. (1 = Therapist does not do: 5 = Therapist always does).

Clients seeing a committed Christian therapist felt more comfortable with their therapist, were slightly more relaxed in session, believed their therapist to be able to express themselves better and appeared more confident in their attitude, but tended to lecture more, than clients seeing a non-Christian therapist (Figure 39).
Both committed Christian and non-committed therapists had earlier stated that they would be moderately likely to take a cause on behalf of their client if this was deemed appropriate. Clients were asked how confident they felt that their therapist would assist them in personal cause. Those clients seeing a committed Christian therapist all said that they felt confident their therapist would act on their behalf should the occasion call for this. Clients seeing the non-Christian therapist were, however, uncertain as to whether this would be the case. Once more it appears that despite non-committed therapists indicating in their own results that the difference between them and their committed Christian counterparts in some areas is not great, this is not the impression given by the clients they are working with.

Both committed Christian and non-committed therapists had earlier indicated that they would be prepared to go to their clients' homes. Three of the clients seeing a committed Christian therapist believed this would occur, whereas the two seeing a non-Christian therapist, and the remaining (non-
committed) client seeing a committed Christian therapist, were uncertain as to whether their therapist would.

Non-committed therapists had previously indicated that their clients could "always" call them at their home whereas committed Christian therapists could only be contacted "occasionally". As far as clients were concerned, a reversal of the therapists' results occurred with all four clients seeing a committed Christian therapist stating they had and felt they could call their therapist at her/his home. Those clients seeing a non-Christian therapist did not know their therapists' home number and felt they would not be able to call her/him there anyway.

Non-committed therapists had earlier stated that if they felt progress was not occurring with their clients, they were apt to discuss this with their clients. Committed Christian therapists indicated that they were more inclined to talk to their supervisors on such occasions. Clients also were asked what action they would take if they felt progress was not occurring in their counselling. All but one client stated that they would discuss their perceived lack of progress with their therapist. The one client who would not, said that she/he would believe the lack of progress lay with her/himself due to an unwillingness to make required changes.

A final question in the clients' questionnaire asked them if there were any further comments they wished to make regarding their therapists. Only two clients made further comments. One seeing a committed Christian therapist said that he was "a sweetie", and the other seeing a non-Christian therapist said "I need my counsellor to help clarify my thoughts and feelings. I already know right and wrong etc and therefore find a Christian emphasis in counselling not currently necessary."

These final two thoughts may well summarise the clients' perceptions of the two types of therapists researched in this study. Committed Christian therapists may be more perceived as being compassionate and sympathetic.
whereas the non-committed therapist is viewed as one who gets down to the task at hand.
CHAPTER IV

DISCUSSION.

Primarily, this research set out to determine whether or not differences existed between Christian and Secular counsellors. In order to accomplish this, a research project involving questionnaires and interviews was used. A wide spectrum of themes believed to be relevant within the normal practice of psychotherapists was investigated.

Questionnaires were only sent to those initially indicating a willingness to participate in this study; however, the return rate was disappointing. Previous overseas research in this area had recorded an apparent hostility between Christian and secular psychotherapists (Lowenthal, 1995). Regrettably, it appears that this same hostility exists among New Zealand therapists. Greater than fifty percent of those therapists believed to have non-Christian beliefs declined to participate in the research. Those who did frequently made negative comments either verbally or on their questionnaire. Such comments as "Christian values have contributed greatly to messing up people" summarised much of what was expressed.

However, it was reassuring to find since writing this paper, a brief article inviting members to respond to the question "Christian counselling: What is it?" (Webb, 1995), in the latest edition of the New Zealand Association of Counsellors Newsletter.

The remainder of this discussion section will be presented in the same sequence as data was collected by the questionnaires.

I. DEMOGRAPHIC DATA.

Eighty one percent of the research sample professed some measure of a belief in God. Whilst this at first may give the appearance of a Christian
bias within the results, this research sample may not differ greatly from the general population of psychotherapists. Bergin and Jensen (1990), found that a religious preference was expressed by 80% of 425 mental health workers surveyed in the United States of America. Their percentage of mental health workers who held such beliefs was not dissimilar to the national population. Bergin and Jensen did not state whether this "religious preference" embraced all religions or only specifically Christians. If it encompassed all religions (as intimated in their paper), then in proportion to the national population, those indicating a religious preference is not that dissimilar from the New Zealand population, 70% of whom stated they had a religious belief (New Zealand Year Book, 1995). Of these, 96% professed a Christian belief.

A possibly significant variable which does not appear to have been previously considered (including here), is the therapist's gender. With an increasing emphasis being placed upon feminist forms of therapy (Berliner, 1992), it may be that gender differences exist in much the same way as differences may occur between cultures.

Two thirds of the therapists in this research were female, which does not differ greatly from the percentage (71%) of female therapists listed as full members of the New Zealand Association of Counsellors (NZAC Membership Listing, 1995).

One other demographic variable noted for its absence both here and in other research is the therapist's type of practice. In this research an almost equal number of Christian therapists either worked in private practice or for an organisation. Almost all of the secular therapists, however, worked for an organisation. It may be possible, therefore, that some of the differences found are attributable in some unknown way to this variable.
1. Section Conclusion.

Whilst a high percentage of the research sample indicated a belief in a Judeo-Christian God, this may also reflect a similar percentage of belief within the general population.

Therapist gender and their type of practice may also have had confounding effects.

II. THEORETICAL APPROACHES.

1. Occupational Orientation.

Traditionally, therapeutic theory starts with the world view of the therapist; the therapist then assumes that view and applies the corresponding techniques to the client (Ivey, Ivey & Simek-Morgan, 1993).

Participants were given two choices to choose from to describe their style of orientation. These choices were, "Eclectic" and "Theoretical" (to indicate a predominantly multiple or singular theoretical approach, respectively).

Non-Christian therapists were more likely to identify themselves as theoretical in their orientation than Christians, who almost always described themselves as eclectic. Interestingly, however, those therapists who described themselves as being theoretical also later indicated that they used more than a one style of therapy. The number of alternative therapies (where stated) was, however, much lower for this group than for those identifying themselves as eclectic. The use of singular forms of therapy may be indicative of "in house" training, given that many of the theoretical therapists were also employed within an organisation.

With the inclusion of liberal and nominal Christians, each of the two research groups resulted in having almost equal numbers of non-committed and committed Christian therapists identifying themselves as eclectic.
According to Adam (1993), Conservative and Moderate Christians were more likely to be identified as being non-reductionists, a group largely willing to incorporate a range of ideas, styles and methods into their own practice. Adam also identified Liberal/Nominal Christians as more likely to demonstrate material reductionist qualities, a group identifiable by their general unwillingness to accept ideas, styles and methods other than their own. Regarding differences between Christian and non-Christian therapists, Adam's assertions appear to be supported in this study. Support was also found in this study for previous research which found non-Christian therapists to have a tendency to be committed to a single style of therapy (Bergin, 1980; Lovinger, 1984; Genia, 1995). The results obtained in this study indicated that most of the non-Christian therapists identified themselves as having a single theoretical approach.

Care needs to be taken in the interpretation of the results obtained in this study since not only were the numbers of participants very small, but the non-committed group contain both liberal and nominal Christians. Throughout the following text, two terms will be used to describe this "mixed" group. They will be referred to as either non-Christian when speaking only of the five therapists having no belief in God contained within this group or non-committed when spoken of as a whole group.

2. Therapist Theories.

How we view human beings is part of the world view that guides each of us in our thinking and determines how we will counsel. Some people believe that we are primarily rational beings, so their therapy is largely cognitive. Others stress the emotional ride of human nature and use therapies that are experiential and existential. If the therapist assumes we are controlled by stimulus/response mechanisms, therapy seeks to satisfy and redirect the satisfaction of these drives. (Behaviourism).
Whilst healing meetings were cited by Collins (1993) as being one strategy of Christian therapy, none of the research respondents indicated its employment. Other forms of Christian therapy such as prayer, use of Biblical Scripture, and Word of Knowledge (intuitive sense of God's directions) were, however, mentioned. Use of Biblical Scripture and prayer rated amongst the five most preferred forms of therapy by committed Christian therapists.

Religious practices such as prayer may be effective tools for alleviating feelings of tension, sadness or disappointment (Bishop, 1992). Prayer in therapy, combines intercessory prayer with a guided imagery of Jesus in order to promote the healing of psychological trauma. With appropriate caution this form of prayer has been shown to have positive therapeutic effects when facilitated by a sensitive therapist who has a good understanding of client needs (Genia, 1995). On the other hand, prayer can be used for the wrong reasons. Therapists who feel threatened and repelled by their clients' histories may attempt a quick healing. The use of prayer in such cases not only impedes the client's recovery, but also further entrenches his or her devalued sense of self (Genia, 1995).

Psychodynamic and Cognitive-Behavioural therapies were the only two styles of therapy indicated by committed Christian therapists as being more preferred than prayer and, with Developmental therapies made up the five most preferred styles of therapy by this group. These results are interesting in that the most preferred style (Psychodynamic) has traditionally been viewed as being anti-Christian in nature. Respondents who stated that they were unlikely to use such therapies did so on the grounds that they were anti-Biblical.

The doyen of psychoanalysis, Sigmund Freud, is generally viewed as having dismissed religion as an "illusion" and "obsessional neurosis" (e.g., Freud, 1927). Freud asserted that God was nothing more than a exalted
father-figure; instead of God creating man in His image, as narrated in
Genesis, man has created God in his image (Freud, 1927, 1928, 1939). It
is probably true to say that Freud thought that anything religion could do,
psychoanalysis could do better, and there was no place in psychoanalytic
theory and technique for religion.

Psychoanalyst Carl Jung also denied that God existed as an external
deity apart from human beings. In Jung's view, God could be reduced to
"an archetypical image of the Deity", a "God within" who is little more than
some kind of vague psychological entity. Jung rejected the idea of the
Trinity and proposed instead that God is a quaternity that includes the
Father, Son, Holy Spirit and Satan. Jung, in particular, felt that individuals
are not only capable of self-direction, but that movement toward
individuation is a vital instinct for achieving wholeness and growth
(Kaufmann, 1989).

Jung saw the journey towards true belief or knowledge as a process
which is simultaneously one of psychological and of religious exploration.
The wish to be good and perfect versus the "dark side" and its very socially
undesirable suggestions, and by acknowledging and harnessing the "dark
side", meant one was engaged in a religious process. Jungian psychology
has, however, been reported to be helpful in Christian counselling precisely
because it deals with adult development and takes into account spirituality
and adult concerns with direction and meaning in life (Lowenthal, 1995).
Given this latter point and that Developmental therapy equalled popularity
as a style of therapy with prayer, it may explain why committed Christian
therapist have appeared to ignore the foundation of psychodynamic theories
and integrated them into their own therapeutic practices.

Developmental therapy is in some ways similar to Psychodynamic
formulations in that the past is believed to affect the present. Developmental
therapy, however, sees clients from multiple perspectives and integrates
seemingly diverse approaches. Basic to the Developmental world view is the proposition that multicultural issues deeply influence the way we think about and construct reality. Developmental theory seeks to work with the client rather than on the client. In so doing, it is more accommodating of Christian beliefs and values than most other forms of therapy and hence possibly the reason for its popularity amongst committed Christian therapists.

Cognitive-Behavioural psychology has generally proposed that negative emotions and interpersonal problems stem from irrational beliefs that we have about ourselves or our world (Genia, 1995). The cognitive approach has therefore been more inclined to encourage the client to examine his or her seemingly erroneous beliefs including any religious idealism, and to believe it not only more right to challenge such idealism, but to feel more able to do so effectively (Holden, Watts & Brookshire, 1991). Its popularity amongst committed Christian therapists is therefore surprising, and calls for further research to be conducted so that a better understanding of how this style of theory has been integrated into committed Christian practices.

While preferred styles of therapy varied between committed Christian therapists and non-committed therapists, three of the five remained the same for both. The two differences were the substitution of Biblical Scripture and prayer for Existential-Humanistic and Gestalt therapies. These two therapies were the most predominantly used by therapists in the non-committed group. Predictably, as Foster and Bolsinger (1990) found in their study, non-committed therapists tended to regard Christian oriented forms of therapy as not being legitimate, an opinion openly expressed by a third of the non-committed therapists in this study.

Gestalt therapy encourages individuals to become aware of themselves and their experiences here and now. There is, therefore, a decrease in any
emphasis on the past or future. The focus of Gestalt is on individuals' making decisions alone - "doing their own thing". These direct affirmations of individual choice bring this form of therapy into serious conflict with Christians who tend to believe that decision making should be done in context rather than as a purely individual matter.

On the surface a Humanistic-Existential psychological orientation appears more compatible with religious or spiritual values than either the Psychoanalytic or the Behavioural perspective. Humanistic-Existentialists admonish their Behavioural and Psychoanalytic colleagues for being too deterministic and reductionistic and see much of human behaviour as self-determined and consciously directed. Individuals are thought to be propelled by an inner thrust toward growth and maturity. Because it is a loosely organised system of psychological thought, however, it lacks a coherent theory of spiritual belief. Humanist-Existentialists tend to regard the transcendent as nothing more than a higher level of consciousness and consequently Humanistic-Existentialists may be as unsympathetic toward traditionally religious clients as Psychoanalytic or Behaviourally oriented therapists.

An interesting feature of the results was the ability of therapists to not only specify their most preferred style of therapy but also to indicate the percentage of time they used each style. Generally, the five preferred therapies coincided with the five highest percentages of use, although ratings between styles preferred and percentage used differed. For example, the committed Christian therapists stated their most preferred style of therapy was Cognitive-Behavioural therapy, however, the style most used was Psychodynamic therapies. Likewise, non-committed therapists stated their most preferred style of therapy was Psychodynamic therapies, but the style most used was Gestalt therapies.
It is beyond the scope of this report however to establish an understanding as to how or why certain styles of therapy were preferred or used by each group. It is only intended at this point to examine whether any differences between them may exist.

3. Functional Forgiveness.

Most religious traditions urge their adherents to forgive those who have acted badly toward them (Genia, 1995). This was verified in the current research.

Religious therapists who view bitterness as an unsurmountable obstacle to cultivating an attitude of compassion and forgiveness may discourage expression of angry feelings. Such therapists distort the religious imperative to forgive. According to Genia (1995), a hasty pardon before the client fully absorbs and integrates the violations inflicted on him/her reinforces denial and halts progress toward establishing realistic concepts of the self and others. Being asked to become willing to make amends to all those that they have harmed, and to go to them "in a helpful and forgiving spirit, confessing former ill feeling and expressing regret" (Le, Ingvarson, and Page, 1995, p, 606), may serve to increase guilt as true feelings surface and the individual feels that he or she has failed, or is experiencing the wrong feelings. This task may, therefore, be therapeutically unsound in denying clients the right to their true feelings (Benjamin, 1987; Carkhuff, 1983; Maslow, 1968; Rogers, 1980). Clients may be being asked to take on feelings of sorrow and regret, regardless of what their true feelings may be. Genuine forgiveness requires a realistic assessment of the wrong-doing, followed by a conscious decision to release the transgressor from further obligations.

Whilst traditional psychotherapy does not usually address the issue of forgiveness, non-Christian therapists should not overlook the importance of
this step for religiously committed clients. Two points on this topic should, however, be mentioned. First, forgiveness is not exoneration. The client who chooses to forgive makes a conscious decision to pardon someone who has inflicted harm on him/herself. This does not mean that the violator is absolved of his or her actions or that all feelings of anger have dissipated. Second, forgiveness is not reconciliation. Forgiveness is not an undertaking to remain in an abusive relationship. Although forgiveness may be a first step in a conciliatory process, it need not necessarily lead to reconciliation. In order to re-establish the relationship, the offender must acknowledge wrong-doing and desist from behaviours that are damaging and reprehensible.

4. Recall Rationale.

Those who employ a Psychodynamic, Developmental or Cognitive-Behavioural therapeutic style are more inclined to encourage their clients to recall events of their past in order to understand the present (Ivey, Ivey, & Simek-Morgan, 1993). Given the patterns of preference for styles established earlier by the two groups, it was expected that committed Christian therapists, who used these three therapies more than their non-committed colleagues, would also be more likely to encourage their clients to recall past events. This supposition was supported by the results. All of the therapists who felt that recall was important, also believed it should be done in a cognitive and emotional manner which concurs with the predominant methodologies employed by these therapists.

5. Section Conclusion.

Therapists from both groups indicated the use of Psychodynamic, Cognitive-Behavioural, and Developmental styles of therapy. However, committed Christians also used Prayer and Biblical Scripture whereas non-
committed therapists used Gestalt and Existential-Humanistic styles of therapy.

The order of preference for styles of therapy did not match actual use of therapy although the five most styles preferred and used by each group remained the same. These discrepancies may have been due to a small research sample.

Committed Christian therapists were more inclined to encourage their clients to forgive those whom they have harmed and those who have harmed them. There are, however, some inherent dangers involved if clients are requested to consider this line of therapy prematurely.

Committed Christian therapists, who were more inclined to use Psychodynamic, Developmental, and Cognitive-Behavioural therapies than non-committed therapists, were also more likely to endorse, in accordance with the methodologies prescribed by these styles of therapy, to encourage clients to recall past events.

III. BELIEFS.

1. Fundamental Foundations.

Fundamentalist Christians insist that except for biologically-based difficulties, all problems result from the client's own sin. Therefore, the only way to counsel effectively is to excise the sin, confront the client with the principles and practices of Scripture, urge the person to confess the sin, and give "authoritative teaching" on how to avoid falling into similar sinful patterns in the future (Collins, 1993). This approach is confrontational and directive. Given that there were no self-identified Fundamentalist Christians in this research, it was not anticipated that any of the respondents would therefore believe that their clients' problems predominantly arose as a result of their sinful nature. This was, however, the case for one committed Christian therapist. One explanation for this may be that whilst the
respondent self-identified her/himself as being non-Fundamental, she/he may in actual fact have practiced as if she/he was. A slightly higher percentage for both groups indicated socio-economic factors as being the predominant cause for the client's developing problems. The greater majority, however, indicated that client difficulties arose due to a combination of factors, and it was the combination mix which set each of the two groups apart. Committed Christian therapists believed that client problems arose from a combination of bio-chemical, socio-economic factors and a person's inherent "sinful nature". These findings concur with those found by Collins (1993). Non-committed therapists also recognised bio-chemical and socio-economic factors as contributors to a client's problem but substituted sin for "spiritual factors". This establishes within both groups the recognition of a "third factor" which identifies them as being both similar and different. Whether the difference in perceptions has implications for their practice is a topic of discussion later in this paper and a suggestion for future research.

If our world view assumes humans to be innately good and living in a universe where there is no God, our counselling would be different from that of a therapist whose world view assumes that humans are the creations of a Holy God who has compassion and expectations for His people. Potential for conflict therefore occurs between Non-Christian and Christian therapists counselling clients who have opposing views on whether or not they are innately good. Whether such conflict occurs and its likely response are discussed later in this report. At this point, there were almost equal numbers of committed Christian therapists who believed humans were innately good and who did not. Non-committed therapists were more of the opinion that humans were innately good.

All new-age thinkers agree that we are moving to an era of global harmony, and most would agree that we realise this goal by becoming
enlightened regarding our divine potential (Collins, 1993). New Age advocates widely assume that the problem of humanity is ignorance and a lack of knowledge about our own potential. The solution to this problem for them is to have a change of consciousness so that with enlightenment, all become aware they are divine. Christians also affirm a need to change consciousness; however, they believe that the problem of humanity is not ignorance but that humans have rebelled against a Holy God and His moral law. Given such a belief, it was anticipated that non-committed therapists would be more likely to agree with the statement in the questionnaire that the problem of humanity today is ignorance and lack of knowledge about our own potential whereas committed Christian therapists were more likely to choose the option given in the questionnaire that "the problem of humanity is that we have rebelled against a Holy God and His moral law." The results of this research supports this expectation.

Their solutions to these "problems" were also significantly different for each of the two groups. Non-committed therapists endorsed a belief that the task before them (and their clients), was to shed the ignorance about oneself. This principle was endorsed by Albert Ellis (1978) who described the self as a collection of the empirical characteristics which really was not a self (in the sense of a responsible agent). He saw feelings of self-hood as that which is sensed from the coincidental co-occurrence of behaviours, traits, performances, thoughts, memories, and so forth. Ellis asserted that while we might appropriately judge or evaluate a specific performance, action or trait, we could never evaluate the self any more than one could judge the quality of one element the quality of a whole group of objects when gathered together by pure chance. For Christians the solution is not enlightenment or contingent upon any particular merit of actions or character, but in bringing glory to the Father through the obedient
manifestation of Christ's presence within their lives by word and deed. This response was endorsed in the respondents' answers.

2. Spiritual Sentiments.

Agee and Everts (1993) conducted a survey of New Zealand counsellor trainees asking them how much being a counsellor had to do with some kind of spiritual meaning in life for them. Forty-two percent said "a lot" and twenty-nine percent said "everything". What these researchers did not do was to identify whether these trainees were Christian or not. It may have been possible that those indicating a higher "meaning" may also have had Christian beliefs. In this research study only a small difference existed between committed Christian and non-committed therapists who found counselling spiritually meaningful for them. Therapists from both groups indicated that for them spiritual meaningfulness was of moderate importance. Their reasoning for this, however, differed between the two groups with committed Christian therapists stating that it was for them a religious experience whilst non-committed therapists felt it to be more a "communion between two souls". This again illustrates the necessity to be careful in not generalising spirituality as meaning the same for Christian and non-Christians. Christians cannot perceive their spirituality without the guidance of the Holy Spirit of God and the truth of the Word of God. The serious Biblical call to a devout and Holy life is at the core of Christian spirituality. Indicated by the results in this research, many non-committed therapists share the same interest in spirituality, but for a committed Christian spirituality means being called to be like Christ, to be Holy, to imitate Him (1 Corinthians 11:1; 1 Thessalonians 1:6) and to increasingly conform to His likeness (Romans 8:29). Christian spirituality does not ignore human potential, interpersonal relationships, meditation, or even personal success or concern for the environment. But neither does
Christian spirituality ignore the realities of sin, the significance of self-denial and self-control, or the centrality of obedience to God the Father and the formative influence of Jesus Christ, who is both redeemer and model. Christian spirituality is a process of becoming increasingly Christlike - a process that goes beyond mere self-reflection to find hope, forgiveness, redemption, and ultimate meaning in the living Christ. Christian spiritual growth involves introspection and self-examination but goes much further to include reading and obeying the Scriptures, attendance at worship services, self-sacrificing service, personal discipline, and a firm commitment to Christ. The committed Christian counsellor is in the process of growing in Christian spirituality and in helping others grow. This growth in spirituality involves developing a Christ-centred world view and orientation toward God, nature, society, and oneself.

Modern New-Age views of spirituality are less demanding and more vague. Perhaps the most unorthodox among the spiritually inquiring are Humanists who prefer to purge the spiritual dimension of the supernatural and search for the transcendent in the outer limits of human consciousness. Fromm's (1950) depiction of the individual's encounter with the All epitomises the humanistic perspective on transcendent experience. According to Fromm, we all have a psychospiritual need for an object of devotion. When feelings of reverence are aimed toward a higher power, we may feel spiritually connected and whole. However, Fromm believed that this higher power is found within the self and that God is but "a symbol of man's own power" (Fromm, 1950). This faith in God is simply faith in life and ourselves. New-Age advocates have come to distrust and often reject reason. For them it makes perfect sense to "unlock the mysteries of the universe" through aligning with angelic energy fields, feeling intense communication with your higher self or even seeking religious experiences through sex" (Collins, 1993).
How therapists understood spirituality was also asked, particularly since a recent upsurge in interest in Christianity has brought counsellors into a type of spirituality that involves "tapping into the unlimited power within us" (Collins, 1993). The results of this study confirmed this type of thinking amongst non-committed therapists (which included Christians). Committed Christian therapists, however, significantly endorsed the Christian concept of looking outward to Christ, a concept seen as being "narrow, insensitive, arrogant and uncompassionate in a world of pluralism, a world in which there are many worthwhile religious ways" (Bloesch, 1991, p22). Maslow, Rogers, and Ellis strongly advocated waking the client's untapped growth forces, no matter what the client's difficulty (Ellis, 1989). The new spirituality is subjective, mystical, feeling-orientated, intuitive, and devoted to urging people to look into themselves to find God, or to "get in contact with the higher self within" (Collins, 1993, p233). Many spirituality seekers would add that we are all gods or in the process of becoming gods, and some would suggest that the ultimate goal of spirituality is to experience unity with one another and with the universe (Berliner, 1992).


Christian counsellors often believe that the most beneficial and healthy behaviour is consistent with the Biblical imperatives (Collins, 1993). As a result, they encourage people to live according to Scriptural truths which often make little sense to non-Christian colleagues, unless they also understand the Biblical basics on which the recommended behaviour is built.

It is not surprising, therefore, to find that committed Christian respondents in this research also indicated a greater belief that Christian counselling offered better solutions than non-Christian counselling.
Interestingly, however, some committed Christian therapists also indicated a contrary belief. Their reason for this was that personal beliefs had no part to play in counselling, a result which concurs with those found by Gibson & Herron (1990), who found that therapists tended to believe that they could leave personal beliefs about religion "at the door of the therapy room" (p. 3). It may be useful for future research to investigate further how such therapists are able to "leave their beliefs at the door" and not view their clients through their own world views.

Non-committed therapists also indicated an opposition to the belief that Christian counselling offered a better solution, for the same reason as those committed Christians who were opposed to this notion.

Hood (1992) points out that different faith traditions and different individual and collective God concepts are associated with varying emphases on shame and guilt. Labelling parts of the self as defective may increase feelings of shame. Defect can imply failure, and may also establish guilt (Le, Ingvarson, & Page, 1995). People who see God as vindictive, irrational, or inclined to induce guilt have difficulty accepting His concepts of love and mercy (Collins, 1993). Feeling victimised by God may also be a re-enactment of pseudo-masochistic relationships with one's primary caretakers (Genia, 1995). Religious individuals who were the victims of their parents' rage and sadistic rampages may assume that God delights in humiliating and tormenting them. A lack of understanding of this by secular therapists may result in inadequate or inappropriate therapy. It was encouraging to note that nearly all of the respondents from both groups in this research did not see God as one who was inclined to induce guilt.

Important for mental health are Christian dogmas regarding sin. Eaton and Weil (1955) have suggested that the emphasis on viewing the self as sinful and guilty may have been the cause of a greater prevalence of depressive disorders. However, sin tends to be ignored or dismissed as an
archaic concept that implies violation of an objective moral code that does not even exist. How a therapist views sin may have a marked effect on counselling and on how the problems of society are viewed and solved (Collins, 1993). If it were felt that mankind was basically good, or at most morally neutral, the therapist would view the problems of society as stemming from an unwholesome environment. Alter the environment, and changes in individual humans and their behaviour will follow. If, on the other hand, the problems of society are rooted in the radically perverted mind and will of individual human beings, then the nature of these individuals will need to be altered, or they will continue to infect the whole.

In speaking on the subject of sin from a theological perspective Hauck (1985, p 239), stated that "there are no bad people in the world, only bad behaviour ... [Thus] it is wrong to judge people by their actions and total forgiveness is logically allowed; one need never damn others or oneself, and it is wrong to feel guilt at any time over any act". A Biblical view of sin does not see it as a misstep, an occasional lapse into unfortunate behaviour, or nothing more serious than "any act or thought that robs self or another of their self-esteem" (Schuller, 1982, p14). Instead, the Bible presents sin as an inner force, an inherent condition, a controlling power that lies at the core of one's being. This particular concept was not supported, however, in this research by Christian therapists who were more apt to define sin as "a state of alienation from God".

Either God exists or He does not. If God exists, there is some reason for order in the universe and an explanation for the purpose, dignity and destiny of human beings. In contrast, if God does not exist, we are left alone in an impersonal universe, "spinning on a planet that is controlled by chance, without purpose or ultimate destiny" (Collins, 1993, p63). As previously mentioned in this report, Bergin and Jensen (1990), found that 80% of the mental health workers they surveyed had a religious belief.
According to one American report, 90% claim to believe in God; 82% believe in an after life that includes both Heaven and Hell; and 55% believe in the existence of Satan (Collins, 1993). It appears, therefore, that concepts traditionally associated with Christian beliefs and practices may not be fully accepted by all those who identify themselves as Christians. Bergin and Jensen's results may have been flawed in that they may have embraced all religions rather than specifically focusing upon Christian beliefs. Another study which specifically asked participants if they believed in a Judeo-Christian God found that 59% of the participants did whilst 79% believed in a universal spiritual force (Goud, 1990). Sixty-seven percent of the New Zealand have proclaimed themselves as having Christian beliefs (New Zealand Year Book, 1995). A smaller percentage than that of the general population believing in God is anticipated within the psychotherapeutic community given the general anti-religious sentiment traditionally displayed (Genia, 1990).

A result in this research indicating 81% of the therapists having a belief in God was surprisingly high, but is likely to have been caused by the low return rate of those therapists who proclaimed themselves prior to the research as having no belief in God. The percentages obtained in this research could not, therefore, be generalised to the general public and is possibly more indicative of the Christian population instead. Other results obtained in this study were 51% believing in an after life which included both Heaven and Hell; 55% believing in Satan; 63% believing in demons; and 59% believing in angels. These results reinforce the opinion that to stereotype a religious client as having certain beliefs may be inaccurate. It would be fair, however, to expect committed Christian therapists as being more likely to hold such beliefs as those mentioned in this research than non-committed therapists.

Bergin (1980), found that 46% of the mental health professionals they surveyed believed that their whole approach to life was based upon their religion. From a Christian perspective all truth is God's truth, and the use of truth in counselling, whether derived from general or special revelation, is dependent upon God because He is the ultimate giver of all truth. Christians assume that God's existence and revelation both have an important bearing on their ability to counsel clients, and themselves. Unlike non-committed therapists, the effectiveness of spiritual interventions is presumed to depend primarily on God's healing power and not on the skilfulness of the therapist. It was, therefore, not surprising to find that committed Christian therapists in this research were significantly more likely than their non-committed colleagues to attribute their skills to being "God given" rather than institutionally learned.

Committed Christian therapists were also significantly more inclined than their non-committed counterparts to believe that the Bible should be used as a guide in their counselling. Committed Christian therapists appear to have developed a means of integrating Biblical Scripture along with psychological principles with neither being used to the exclusion of the other. The intent of Scripture for Christians is to give knowledge from the mind of God as to how to live a blameless life before Him and to communicate to others the resolution of life's most basic problem: being personally out of fellowship with God Himself (English, 1990).

If the Bible is to be used as a guide in forming a world view and in helping clients, therapists must be sure that they do not misquote or misinterpret Scripture. There is no one clear standard of rationality from a Christian perspective, though Christian faith does involve a reliance upon the Scriptures as an infallible source of truth (though not the only source). Regrettably, the infallible Scriptures must always be interpreted by very
fallible human beings living and working in very fallible societal and
community contexts. A recognition of this fallibility is perhaps apparent in
the moderate confidence ratings given by committed Christian therapists
when asked to state how confident they felt about their interpretations of
Scripture. Confidence in the ability to interpret the Bible positively
correlated with the strength of Christian belief held. Conservative
Christians indicated having the strongest confidence in their ability to
interpret accurately, whereas Nominal Christians had the least confidence.
The therapists' degree of confidence did not seem to be affected by the
amount of time spent studying Scripture, since no significant difference
existed between Conservative, Moderate, Liberal or Nominal Christians in
the amount of time they spent studying the Bible. Perhaps if the
Conservatives and Moderates had spent more time in study, a greater
confidence would have been recorded by them. Collins (1993) indicated in
his text on Christian counselling that therapists become like the people they
spend time with. When therapists and their clients therefore spent more
time with God, they would also get to know Him better and become more
like Him. Certainly, the pattern indicated in the results would tend to
confirm this, but further research is required in this area.

Most Christian counselling will involve both the teaching of Biblical
content and spiritual guidance in the acquisition of skills. In using Scripture
several questions could be asked, such as:

- Is there an example here for me to follow?
- Is there a sin to avoid?
- Is there a promise that can apply to me?
- Is there a prayer to repeat?
- Is there a command to obey?
- Is there a condition to meet?
- Is there an error to avoid?
- Is there a challenge to face?
- Is there something here that should be memorised?

Despite these possible questions being incorporated into a therapeutic program involving Biblical Scripture, it was disturbing to find that only a quarter of the committed Christian therapist group stated that they had a formula to work by. This is disturbing since earlier it had been recorded by this same group that use of Biblical Scripture was their second most used form of therapy. If they were not using a formula, then maybe a "this might apply" (hit and miss) technique was being employed. Such techniques combined with a lack of confidence in Biblical interpretation may serve to do more harm than good for the client, perhaps by increasing a client's sense of guilt. Further research in this area is needed.

A review of Biblical Scripture suggests that Christians can be confident that mental illness is, or can be, separate from demonic influence. A strong distinction is made at least seventeen times throughout Scripture between demonic influence and mental illness. Yet, whilst acknowledging that demonic influences may occur, many Christian counsellor programs have either ignored or appear to have been oblivious to the role of evil forces in the development and continuation of personal problems and interpersonal conflicts. In contrast to this majority, however, there are a few Christians who also appear to be obsessed with the demonic and have become so involved with fighting demons that they seem to know more about the devil than they know about Christ (Collins, 1993). Like with other styles of therapy, this is not the forum to decide the appropriateness or inappropriateness of such styles of therapy as deliverance. What the results of this study do indicate is that a high percentage of committed Christian therapists and a smaller percentage of non-committed therapists do employ this form of therapy when required. If, as aforementioned, this style of ministry is not widely taught, this researcher cannot help but wonder
whether therapists are at times not involved in a highly specialised style of therapy where the dangers of something going wrong, to the detriment of the client, is being practiced inappropriately. Further research is again indicated.

5. Section Conclusion.

The effective counsellor realises that people are complex and that problems often have a mixture of biological, psychological, social and spiritual components. For committed Christians, the spiritual component is described as sin whereas for non-committed therapists, this component remains indefinite.

Committed Christian therapists are divided in their belief as to whether humans are innately good whereas non-committed therapists are more of the opinion that they are. Non-committed therapists believe the problem of humanity lies in an ignorance and lack of knowledge people have of themselves and thus believe that they need to become "enlightened". Committed Christian therapists believe that the problem of humanity is due to a rebellious attitude towards a Holy God and is solvable only through repentance and redemption.

Therapists from both groups strongly felt counselling to be a spiritual experience even though their definitions of spirituality differed. Committed Christians felt it to be more of a religious experience and therefore sought to encourage their clients to look outward to Christ. Non-committed therapists believed it to be more of an interpersonal experience and therefore encouraged their clients to look within.

Not surprisingly, most committed Christian therapists felt they offered a better counselling strategy than their non-committed counterparts, a belief not accepted by non-committed therapists.
Nearly all of the therapists reported that they did not see God as one who was vindictive, irrational or inclined to induce guilt.

Committed Christian and non-committed therapists differed in their definition of sin. Committed Christians defined the concept of sin as an act of alienation from God whereas non-committed therapists defined it as an act or thought that robbed a person of their self esteem.

Beliefs generally attributed to Christianity were held by both committed Christians and some non-committed therapists. However, the percentage of those believing in these concepts is believed to be lower in the psychotherapeutic community than in the general population. Even so, such beliefs were found to be higher amongst Committed Christian therapists than non-committed therapists.

Predictably, committed Christians were more likely to call their skills God-given than non-committed therapists and to make greater use of the Bible as a guide. The Christian therapists’ confidence in interpretation of the Bible correlated positively with the strength of their belief, but not with the amount of time studying it.

Whilst use of Biblical Scripture was the second most used form of therapy by committed Christian therapists, few had a specific method of application. Such negligence could lead to a hit and miss approach with potentially destructive outcomes for the client.

All committed Christian therapists and some non-committed therapists felt they were guided by the Holy Spirit. This result (along with others), again highlights the possible extraneous effect produced by having Christians included in the non-committed group.

Mainly committed Christian therapists, but some non-committed therapists, stated that they would use deliverance as a style of therapy when it was felt to be appropriate. A question regarding qualifications and safety in using these procedures is still, however, needing to be addressed.
Nearly all of the therapists reported that they did not see God as one who was vindictive, irrational or inclined to induce guilt.

Committed Christian and non-committed therapists differed in their definition of sin. Committed Christians defined the concept of sin as an act of alienation from God whereas non-committed therapists defined it as an act or thought that robbed a person of their self esteem.

Beliefs generally attributed to Christianity were held by both committed Christians and some non-committed therapists. However, the percentage of those believing in these concepts is believed to be lower in the psychotherapeutic community than in the general population. Even so, such beliefs were found to be higher amongst Committed Christian therapists than non-committed therapists.

Predictably, committed Christians were more likely to call their skills God-given than non-committed therapists and to make greater use of the Bible as a guide. The Christian therapists' confidence in interpretation of the Bible correlated positively with the strength of their belief, but not with the amount of time studying it.

Whilst use of Biblical Scripture was the second most used form of therapy by committed Christian therapists, few had a specific method of application. Such negligence could lead to a hit and miss approach with potentially destructive outcomes for the client.

All committed Christian therapists and some non-committed therapists felt they were guided by the Holy Spirit. This result (along with others), again highlights the possible extraneous effect produced by having Christians included in the non-committed group.

Mainly committed Christian therapists, but some non-committed therapists, stated that they would use deliverance as a style of therapy when it was felt to be appropriate. A question regarding qualifications and safety in using these procedures is still, however, needing to be addressed.
IV. ETHICS.

1. **Actual Accountability.**

New Zealand is one of the countries in the world where therapists can practice without a license or registration of some sort. Whilst there was little difference between the two groups, committed Christian therapists were less likely to belong to a professional national association which made them more accountable to a standard code of ethics. Those who were not members explained that they felt sufficiently able to monitor their own actions so as not to compromise their own integrity or that of the client. Whilst this may be possible, it also allows for the ability to practice in an unrestricted and unethical manner. Some recent cases of this in New Zealand were published in a recent counselling newsletter (NZAC, 1995). It is beyond the scope of this report but perhaps future research could consider the necessity to license therapists in New Zealand in order to ensure greater client and professional safety.

2. **Spiritual Synergy.**

Counsellor training rarely mentions the spiritual dimension or includes instruction on how to work with clients in areas of spirituality (Miranti & Burke, 1995). Pate & Bondi (1992), felt that religious values and their importance should be presented, among other vital client differences, as an essential element of all counsellor education programs to ensure that counsellor education students understand cultural diversity. This was only moderately supported by all the therapists in both groups.

It is the belief of this researcher, that counsellor educators should incorporate into their curricula concepts of multicultural counselling that are important if they are to serve culturally, ethnically, racially, and religiously diverse populations. If counsellor education is silent about spirituality

124
(including religious values), then what is being implied is that a belief in God does not make any difference in anyone's lives.

Education in the psychology of religion and opportunities to encounter religious issues in practicum training should be augmented with some general knowledge of religious counselling. Acquiring these special skills does not imply that one automatically becomes a religious counsellor. Students in most counselling and professional psychology programs receive exposure to a broad range of theoretical approaches to individual psychotherapy. In addition, many seek specialised training in such areas as play therapy, marriage and family therapy, feminist therapy, sex therapy, substance abuse treatment, and multicultural counselling to increase their competence in working with particular client groups or problem areas. Genia (1994) offers some examples of how religious variables could be included into traditional courses:

(i) A course on professional ethics which could introduce research findings which indicate incongruency between most mental health professionals and traditionally religious clients. Students could then discuss the ethical implications of these findings.

(ii) Case vignettes of clients with divergent religious values along with the problems raised so that therapists-in-training could become aware of any personal feelings and, sense of competency whilst working with such individuals. This self-exploration would be particularly important for student-therapists who have anti-religious biases due to past negative religious experiences (Genia, 1995).

(iii) Personality theory, psychopathology, and developmental psychology could also provide fertile ground for discussing religious material. Multi-dimensional models of religiousness such as Allport's (1966) intrinsic-extrinsic paradigm and theories of faith development (eg., Fowler, 1981; Genia 1990) provide criteria to help therapists
distinguish between the healthy and maladaptive aspects of their client's religiosity.

Having a general knowledge of the basic concepts and core beliefs of the world's major religions is felt to be important for three reasons. First, therapists cannot appreciate the religious client's frame of understanding without some fundamental knowledge of his or her religious beliefs and practices. Second, an appreciation of the client's religious functioning requires consideration of the values, standards, and norms established by his or her religious group (Loving, 1984). In assessing whether mystical feelings reflect a pathological regression or a transcendent experience, the therapist must consider the religious context in which such feelings occur. Third, exposure to divergent ideologies will probably increase the therapist's appreciation of religious diversity.

One benefit of including religious values and practice in the multicultural sensitivity component of the curriculum is to reinforce the point that cultural awareness and sensitivity are imperative in all counselling. Clients may give an initial impression of being "just like us" yet, they may differ in fundamental ways which are important for the counselling relationship. Additionally, for those therapists who have a belief in God, the addition of a theological training component may facilitate the development of graduates to become lifelong integrators of their faith and practice.

Further research could also focus upon whether or not educators know their students' theology when they enter training programs. Educators often make concerted efforts to assess a student's baseline knowledge of psychology, estimate their capacity for sustained and pressured graduate school work, and their abilities to mature into further interpersonal effectiveness. However, do educators know much about their student's spiritual maturity, or theological astuteness?
Worthington (1989) identified five compelling reasons to give attention to the implications of religious faith in understanding both normal development and remediation:

(i) a high percentage of the population identifies itself as religious;
(ii) many people who are undergoing emotional crises consider religion as they manage their dilemmas, even if they have not been active in formal religion;
(iii) many Christian clients are reluctant to bring up their religious considerations as part of non-Christian therapy;
(iv) in general, therapists are not as religiously-oriented as their clients and,
(v) as a result of being less religiously-oriented than their clients, many therapists might not be informed about religion as would be ideally helpful for many of their clients.

It was disappointing, therefore, to find that the respondents of this study from both groups indicated only a moderate importance being attached to dealing with a client's spiritual concerns in therapy. The cultural development of many clients has involved religion; thus to omit this aspect of their client's lives from counselling is felt to omit a significant part of their identity.

Religious therapists who take their spiritual concerns at face value and fail to address any underlying pathology are unlikely to promote significant improvement in the client's outlook. On the other hand, non-Christian therapists who undermine all religious belief and fail to acknowledge that disordered religiousness coexists with healthy spiritual striving devalue the client's experience and overlook valuable resources for emotional healing.

The ability to foster a therapeutic alliance depends on the therapist's capacity to understand a client's world view. When therapists hold a world view different from their clients' and are unaware of the basis for this
difference, they are most likely to impute negative traits to clients" (Sue and Sue, 1990).

Respondents were asked to detail how they elicit information about spirituality from their clients. Committed Christian therapists were more inclined to raise the subject directly without waiting for the client to initiate the topic whereas non-committed therapists were more inclined to remain silent until prompted by their clients. This may indicate either a discomfort associated with the topic of spirituality or a hostility toward religion by non-committed therapists. There may of course be other possibilities which only further research could establish. A greater understanding is needed to discover why committed Christian and non-committed therapists appear to have different approaches regarding the topic of spirituality and whether this applies only in regard to religion.

3. Practice Philosophies.

Committed Christian therapists indicated a higher likelihood that they would be prepared to counsel distant family members, friends, and individuals socially known to them. Non-committed therapists would do likewise with the exception of counselling a close friend, which they would not do. Non-committed therapists were, however, also far less inclined to involve themselves in such situations than their committed Christian counterparts reflecting, perhaps, the different philosophies held by both parties. Such differences may be explained in Lowenthal's (1995) findings which indicated that committed Christian therapists were more inclined to adopt a family style of commitment in their therapeutic processing. It may be possible, therefore, that such a philosophical commitment means that committed Christian therapists are more willing to counsel members non-committed therapists are less inclined to see for ethical reasons.
Previous research had indicated differences between Christian and non-Christian therapists with respect to their willingness to see clients in a social capacity or within a perceived social environment such as the therapist's own home (Pope, Tabachnick, & Keith-Spiegel, 1987; Oordt, 1990). In their study, they found Christian therapists to be more likely to socialise with their clients than non-Christian therapists were. This same study gave similar results with committed Christian therapists indicating that they were far more likely than non-committed therapists to meet with their clients in a social capacity. The largest percentage of such occasions occurred within a church gathering with the next percentage being recorded as "accidental". This latter reason also applied to three quarters of the non-committed therapists who stated that they had met their clients socially. Committed Christian therapists were the only ones, however, to state that they had invited clients to their home. This further supports the notion that committed Christian therapists may have some manner of conflict between appropriate therapeutic practice and Christian hospitality.

Ellis (1978) argues that no particular aspect of behaviour or character can properly become the standard by which the acceptance of the whole person is judged, because there is no whole person, no substantive self, to be judged. We should evaluate each part of our person (the "atoms" of our being) in isolation from the whole. Clearly this view has the advantage of prohibiting clients from spuriously passing judgment on their whole selves based on some quite inconsequential or superficial aspect of their behaviour, but this view carries with it quite a disadvantage from a Christian perspective. The traditional Christian view is that people rebel against or disobey God's moral law. Christian denominations cite seven scriptural passages as the basis for their moral positions and traditional religious stories of saints and biblical heroes accentuate heterosexual values, values of virginity, and sexual repression. It was expected,
therefore, that committed Christian therapists would indicate a lesser commitment to assisting their clients in working through some specific issues. This would have proved to be the case if clients had approached the committed Christian therapists in this study on issues of abortion and homosexuality. This supports previous research which has found that therapists from a background of traditional religion have often hurt gay clients by wearing a moral and historical tapestry of guilt, shame and repression (Ritter & O'Neil, 1995). Based on Biblical support (eg. Lev. 18:22; 1 Kings 14:24; Rom. 1:24; 26-27) Christian therapists have often advocated the necessity for homosexuals to change their life-styles (Foster & Bolsinger, 1990). A lesser reluctance to advise on issues dealing with de-facto relationships and sexual relations outside marriage, whilst still higher than their non-committed colleagues, appears to exist. Perhaps this reflects a comment made by Lowenthal (1995, p 82), who remarks, "the agony aunts of the 1950's and 1960's, were able to tell their correspondents that if boyfriends loved them, they could say gently but firmly no - and the boyfriends' respect for them would grow. By the 1970's the agony aunts could not see why a nice girl could not say yes, and by the 1980's the agony aunts apparently were not getting that sort of letter any more. Premarital sex had become acceptable, it would seem".

4. **Section Summary.**

Nearly all of the therapists belonged to and were therefore accountable to, a professional national association. Those who did not were committed Christian therapists who felt they were able to monitor their own efficiencies. The ability to practice in this manner may prompt calls/action to license therapists to ensure greater safety standards being established.

If counsellors are to guard the individual rights and personal dignity of the client, they must learn during their professional education to respect the
importance of spirituality and religion in the lives of clients and how to incorporate that respect in their practice. Yet results in this research indicate only a moderate importance being placed on including spirituality in a training curriculum or within therapy by therapists from both groups. When encountering a deeply committed religious client, the therapist may need to deal with unfamiliar beliefs and values. To be effective, non-committed therapists must learn to respect spiritual orientations that may be different from their own.

Non-committed therapists indicated a greater reluctance to raise the topic of spirituality unless prompted to do so by their clients. Committed Christian therapists were, on the other hand, more inclined to raise the topic directly without being prompted.

Committed Christian therapists were more inclined to counsel distant family members, friends, and individuals socially known to them than non-committed therapists. The reasons why were not examined in this report but may be associated with the greater family concept adopted within Christian philosophies. A dilemma seems possible for committed Christian therapists when faced with conflicting values as to whether or not they should practice appropriate perceived ethics and not see their clients socially or extend Christian hospitality to them. Results in this study appear to indicate that committed Christian therapists attempt to straddle both concepts in their practice far more than their non-committed counterparts.

Abortion and homosexual relationships were two topics committed Christian therapists were significantly less likely than non-committed therapists to assist their clients in dealing with. They were also less likely to assist their clients through issues dealing with de-facto relationships and sex outside marriage than their non-committed counterparts, but not significantly so. Their reasons for this indicated that reluctance may be
based upon the interpretations they have of the Biblical standards they apply to their own and others lives.

V. COUNSELLING PRACTICE.

1. Emotional Empathy.

Therapists from both groups placed a high importance on addressing the emotional aspects of clients during therapy. The manner in which this concept is addressed, however, may be different for each group and further research is needed to reveal whether or not this is the case.

It is common in our society to conceive of emotions as non moral, irreducible, unexplainable and involuntary phenomena. "Feelings are neither right nor wrong, they just are!" (Jones, 1989, p.112). Christians have not, however, taken easily to this understanding of emotions. Christians are often exhorted to exhibit or develop emotions (Roberts, 1982, 1988). Roberts (1982, 1988) developed a formal and sophisticated view of emotion which was formulated specifically to be compatible with a Christian understanding of persons and their emotions. He argues that all emotions are predicated upon concerns, upon the individual caring about or having some significant interest in something. We do not have emotions in areas where we have no concerns. But a concern is not an emotion; rather "An emotion is a construal of one's circumstances in a manner relevant to some such concern" (1982, p 15). That is, an emotion is an interpretation about a concern or object of value in light of our view of the event. One way in which Roberts' view of emotion differs from the common view of emotion is that whilst many believe that a belief leads to or causes emotions, for Roberts the emotion is a construal. "The fact that emotions are construals goes a long way toward explaining how we have control over them. ... To succeed in bringing myself into a certain emotional state is to succeed in coming to see my situation in certain terms" (1982,
p, 21-22). Christians who come to think and believe deeply in a Christian way or from God's point of view will begin to feel Christian emotions.

2. Daring Disclosure.

Oordt (1990) found that 90% of the Christian respondents in his study reported that they routinely self-disclosed as part of their therapeutic regimen. An earlier study by Pope, Tabachnick, & Keith-Spiegel (1987) drew the same conclusions.

In this study, respondents were asked to state not only whether they self-disclosed, but also the topic of such disclosures. Like the previous studies cited, committed Christian therapists in this study were more likely to self-disclose than their non-committed colleagues. This occurred in all three of the domains (personal, religious, values) offered to them to make comment upon. Genia (1995) found that clients with strong religious beliefs often inquired about the therapist's religious preferences during the initial phases of therapy. Yet few therapists appear to advertise their own religiosity, or the way in which they may be able and willing to explore religious issues in counselling or psychotherapy (Lowenthal, 1995).

Genia (1995) believed that a therapist offering an evasive answer served only to heighten the client's anxiety and could lead to a premature termination. Also, religious clients with problems to resolve may seek help from religious counsellors such as priests or ministers and only go to professional therapists when they perceived there was no improvement. Even then, professionals with similar religious views to the client would normally be preferred (Lowenthal, 1995). Bishop (1992) advocated that an open communication about religious values should be established as part of client - counsellor exchange early in the therapeutic process. He suggested that broad statements about the therapist's general approach to religious values could be included within initial orientation statements.
Collins (1993) also believes that Christian therapists have both the opportunity and the responsibility to tell clients about the inner and interpersonal peace that is available through Jesus Christ. He perceived this as being no less ethical than to share information about some effective medication or established counselling method. He argues that it always remains the client's right to accept or reject the counsel as guidance and that the introduction of Christian concepts was unethical only when the client was pressured or manipulated to accept something they did not want to accept.

Some therapists have argued that they are afraid of imposing their own values on clients (Georgia, 1994). Yet therapist values including spirituality are implicit in the therapeutic process (Patterson, 1992). Valuing is an integral component of therapy. Wyatt and Johnson (1990) proposed that it was essential for therapists to make their values known to clients before therapy since they found that it was impossible for a therapeutic relationship to be completely value free. This notion is especially supported by religious believers (e.g., Bergin, 1980) and feminists (e.g., Gilbert, 1980). Therapists were found to partially adopt this practice by identifying themselves as being Christian or feminists. It is therefore believed that therapists should make known to their clients their own religious beliefs and values since such an openness can only serve to lessen the likelihood of severe conflicts. When conflicts do occur, however, an opportunity for exploration and resolution of the conflict has been established.

3. "Outside" Obligations.

An almost equal, but small, percentage of therapists from both groups offered an after hours service. However, only the committed Christian therapists indicated a "home call" service. It appears, therefore, that committed Christian therapists may offer a more extensive service for their
clients than that offered by non-committed therapists. There are, however, some anomalies in the results which may indicate that there were no differences in the services available, just in the way they are managed. The committed Christian therapists offered as their reasons for making home calls "emergencies", "hospital visits", and "agoraphobic clients". If the last two reasons are ignored (as equally the least recorded reasons by the therapists), we are left pondering whether non-committed therapists do not have client emergencies. It is possible that non-committed therapists felt it unethical to make home calls and would, therefore, possibly refer the client to a crisis organisation. It may also be possible that the clients of non-committed therapists felt that they would be less likely than clients of committed Christian therapists to receive the attention they want at such times, and, therefore, not contact their therapist. A following response to the next question in the questionnaire may, however, give a clue to what may be happening. Non-committed therapists were the only ones to indicate that they were "always" able to be contacted on their home phone. Christian therapists were more inclined to answer "occasionally". Is it possible therefore that committed Christian therapists make themselves more available during working hours to make home calls whereas non-committed therapists make themselves more available after hours as telephone counsellors? These questions, and possibly others, require further research.

4. Cross Gender Counselling.

Almost all of the therapists from both groups counselled members of the opposite gender to themselves. A few non-committed therapists reported working with same gender clients only. With considerable concern being raised over the past few years regarding safety procedures associated with counselling, respondents were asked to detail what (if any) precautions they took when counselling opposite gender clients. Unanimously, therapists
from both groups indicated their main safeguard as being other
therapists/staff in the same building while they worked. The percentage of
non-committed therapists who gave this response was smaller than those in
the committed Christian therapist group. An alternative reason given by the
non-committed therapists but not by the committed Christian therapists was
an adherence to their own professional code of ethics. Instead, supervision
was mentioned as the second most recognised safeguard by the committed
Christian therapists and the third by non-committed therapists. These
results may indicate that committed Christian therapists are more reliant
upon "others" as a means of safety whereas non-committed therapists use a
combination of others and regulations.

5. Financial Factors.

There was an almost equal balance between the number of therapists
who worked for a wage or were self employed within both groups. It is
felt, therefore, that the results gained within this research were unlikely to
have been significantly affected by the therapist's type of employment.
Therapists were also asked what actions they would take if the client was
unable to afford the fee. Committed Christian therapists were inclined to
give fewer options although these options were more in the client's favour
than those offered by non-committed therapists. Committed Christian
therapists stated that they would either suggest to their clients a lower fee or
offer free counselling. Non-committed therapists also stated a willingness
to reduce their fee although the majority indicated they were more likely to
either terminate the therapy without referral or refer their client on to another
agency. These results concur to some extent with those found by Pope,
Tabachnick, and Keith-Spiegel (1987) who found in their study that
Christian therapists were less concerned over matters of financial gain than
Non-Christian therapists.
6. **Imparting Information.**

In referring clients to another, for whatever reason, a dilemma appears to exist in that a decision needs to be made as to how much (if any) information is passed on and to whom. Should the client be referred on to another therapist, is the client again required to share from the beginning all that they had previously divulged with their former therapist, or is the new therapist given some background details in order to both prevent the client from starting from scratch and establish a functional foundation from which to begin? Non-committed therapists indicated a greater likelihood to be guided by their clients in both what and how much information is passed on. Committed Christian therapists were more inclined to pass on minimal details and felt more governed by their code of ethics and the Privacy Act (1993). These results are a little surprising in that up till now, committed Christian therapists had indicated a greater orientation toward being person (client) centred whereas non-committed therapists had been more inclined to be directed "by the book". In the case of client referrals, the reverse appears to be the case. Perhaps this indicates an area where committed Christian therapists are more concerned with their own thoughts of failure. For a committed Christian therapist to refer a client, it may seem to them that they have failed in their basic effort to help a fellow human. To ensure a better deal for the client they believe they have failed, the therapist may be more inclined to function according to "the book". More research is needed to answer this question.

Therapists from both groups indicated that there were occasions when they talked about their clients to someone other than their supervisor. Whilst committed Christian therapists appeared to have done this more than their non-committed colleagues, both indicated that these occasions were predominantly within teaching/training situations.
7. Conflict Collaboration.

When occasions of conflict between therapist and client arise, the therapist has at least three options: the client's religious beliefs or values may be supported, ignored, or challenged.

A small percentage of non-committed therapists indicated that they would refer their clients to another therapist if they felt there was a clash of religious values between themselves and their client. Naturally, if serious value conflicts persist in the face of open discussion, the client should be referred to another therapist. However, guidelines are needed to help therapists determine when a referral for religious counselling may be indicated and when such a referral may not be in the client's best interest (Domino, 1990). Such guidelines could best be established through the collaborative efforts of both therapists and religious professionals who are willing to engage in honest dialogue, admit their limitations, and make referrals when indicated (Genia, 1994). Therapists should not only see religious therapists as allies at appropriate times but they should also know the ethical and professional limits of working with religious therapists. Therapists need to know that whilst some religious therapists use concepts and techniques identical to those taught in general psychotherapeutic courses, others will simply quote Scripture in response to client problems.

None of the therapists from either group in this study indicated that they would advise their clients to seek help elsewhere; however, many traditional therapists have expressed the opinion that spiritual issues should be addressed exclusively in the religious arena (Ingersoll, 1994). Critics disagree, noting that organised religion is often grounded in social stratification and reflects an external locus of control (Fox, 1991; Schaeff, 1992; Spong, 1992). Previous research has in fact indicated that requesting the client to seek advice on religious matters from another source whilst
continuing therapy with their therapist may leave some clients confused and angry or torn between contradictory world views (Genia, 1990).

Although the majority of therapists from both groups indicated that they were likely to continue working with their clients even when conflicts occurred, a small, almost identical percentage from both groups stated that they would do so without further discussion of their differences. One reason may be that therapists, whilst empathic toward religious perspectives, may not feel competent to address such issues. If this is the case, their lack of confidence is possibly due partly to the fact that non-Christian psychotherapists receive limited, if any, formal religious training, education in the psychology of religion, or preparation for dealing with religious issues in clinical practice. Thus, the reluctance of some psychotherapists to tackle religious issues reflects a realistic response to their limited education and training in the area of psychotherapy and religion. A responsible assessment of one's own competency is in conformity with professional ethics. However, therapists who do not openly discuss or integrate religious values as part of the therapeutic process also run the risk of conveying unintended messages about their client's religious values (Beutler, Pollock & Jobe, 1978). Wyatt and Johnson (1990) found that in situations where therapists did not openly discuss or integrate religious values as part of the therapeutic process, clients trying to establish trust in the early counselling relationship may feel distressed and not be sure why. Basch (1980) found that clients might also tend to accept responsibility for these situations, even when the tension emanates from the therapist.

It is generally well-established that in successful counselling, clients often change their values to more closely approximate those of their counsellors (Morrow, Worthington, & McCullough, 1993). Beutler and Bergan (1991) have suggested that religious values are particularly
susceptible to such influence. Ridley (1985) believes that when religious value differences exist, it is the responsibility of the therapist to be educated about the values held by the clients they work with and to place the clients' value differences within a cross-cultural context. The client's values should be openly and overtly explored as a usual part of the therapeutic process. Through careful exploring of the client's religious values, the therapist is able to convey acceptance and understanding of the client's problem and thus promote a positive therapeutic outcome. Therapists working with clients committed to a particular spiritual or religious expression can enhance the therapeutic process by first affirming the importance of the client's spirituality in their lives and secondly, by attempting to enter the client's world views. It was comforting to find that the majority of therapists from both groups in this study felt similarly.

Although religious individuals, especially those from theologically conservative groups, are often concerned that their beliefs will be misunderstood or criticised by non-religious therapists (Worthington, 1986), there is little evidence to suggest that most secular therapists directly challenge religious values and lifestyles (Genia, 1994). Likewise, many of the therapists in this study indicated that they would either attempt to understand the viewpoint of their client or seek to accommodate their client's point of view within the general context of the therapeutic program. Spilka (1986) suggested that religion related to mental disorder as an expression of abnormality as a socialising and suppressing force, as a haven, as a therapy, and as a hazard. It was felt, therefore, important by him to assert that both the therapist and client needed to be aware of all these possible effects. By becoming knowledgeable about the client's faith, this effort not only strengthens the therapeutic bond, but also helps the practitioner distinguish distortions in the client's religious ideology from healthier components. Non-Christian therapists need to avoid any desires to
"cleanse" their clients of concepts of sin, repentance and atonement. Feelings of accountability to God and participation in rituals are not in themselves unhealthy or indicative of deeper emotional conflicts unless they become masochistic and self-punishing or when the client's beliefs consistently fail to ameliorate feelings of guilt (Genia, 1995). Therapists also need to be able to understand and communicate within the language of Christianity and its diversity of meanings so that a wide range of different people can be reached. This would achieve better communication and empathy between both the therapist and the client even when they do not adhere to the same belief system (Beutler, Pollock and Jobe, 1978).

Therapists are not obliged to change their own values to work effectively with clients who have particular religious values but they are in a position which can promote a positive image to clients with respect to religious values if they can convey acceptance of the client's values.


Only the committed Christian therapists in this study indicated that they had quoted Biblical Scripture and prayed with their clients. The use of such techniques was, however, also directly proportional to the "strength" of the therapist's religious beliefs. That is, the more fundamental in their beliefs Christian therapists were, the more inclined they were to use Scripture and prayer as part of their therapeutic regime.

Jones (1989) felt Christian therapists could profitably use Scriptural references as disputational aids against irrational beliefs held by Christian clients. He found that in so using Scripture, therapy was far more effective than when based on secular reasoning alone. In the same way that introducing non-Christian clients to Christian concepts prematurely may cause harm, so too can the inappropriate use of Biblical Scripture. The Christian therapist may be tempted to reassure the client by quoting
Scriptural passages that convey God's accessibility and responsiveness to human need just as the non-Christian therapist may try to liberate their Christian clients from their divine tormentor by cajoling them into believing that God is an illusion. Both approaches trivialise the client's experience.

Prayer is a fundamental activity of Christian worship and a common practice among Christian therapists (Foster & Bolsinger, 1990). Johnson (1956, cited in Lowenthal, 1995, p 201) gave the following suggestions about the psychological effects of prayer. It:

(i) "Makes us aware of our needs and of realities, as we face the one who knows all, and as we examine ourselves".

(ii) " Allows confession and a sense of forgiveness as we see ourselves, but as inadequate, since self-sufficiency is self-deception".

(iii) "Engenders faith and hope that relaxes tensions, worries and fears and brings confidence and peace of mind".

(iv) "Puts our lives in perspective as our meditations solve problems and produce practical plans of action".

(v) "Clarifies goals to which we can dedicate ourselves, focus our lives and unleash latent powers to achieve".

(vi) "Renews emotional energy through the euphoria of communication with the divine".

(vii) "Makes us responsive to the needs of other persons and channels our social and altruistic motives".

(viii) "Affirms our values and prepares us to accept with joy whatever happens".

(ix) "Fosters our loyalty to the ultimate and perseverance in devotion".

(x) "Integrates our personalities through focusing upon a supreme loyalty".
This seems to include everything one could hope for from psychotherapy - and then some. While prayer can be a powerful force in the service of psychospiritual healing, as with the other forms of treatment traditionally used by Christian therapists, its limitations and potential personal effects with clients should be carefully considered. First, prayer can be used for the wrong reasons. Therapists may feel threatened and repelled by their client's histories and these uncomfortable feelings may prompt the therapist to attempt a "quick healing". Secondly, therapists who use prayer defensively turn away from the suffering of their clients. These inappropriate occasions not only impede the client's recovery but also further entrench their devalued sense of self.

The occult has traditionally been seen by Christians as an area to avoid at all costs. Coupled with a belief that such activities are demonic, it was not surprising that all the conservative Christian respondents in this study indicated that on being made aware that their clients were involved in such activities, they would warn them of the dangers of doing so. Apart from a surprising result recorded by moderate Christians, who indicated a general likelihood to ignore any involvement their client had in the occult, the tendency to warn clients of the dangers involved with occult practices diminished in correlation with a therapist's lessening strength of Christian beliefs. Why moderate Christians responded in this way is not known.


If therapists were to routinely assess the client progress by comparing their own perceptions with client feedback, a repertoire of different responses could be established which would be consistent with the needs of the client. Such therapists may be open not only to a wider variety of responses but be better able to empower the client to move onwards. Given such feedback, an opportunity also arises to change forms of therapy to
better suit the therapeutic climate. With this in mind, therapists were asked whether or not they accommodated new procedures when they felt it appropriate to do so, and whether this occurred concurrently in ongoing therapy.

All of the committed Christian therapists indicated that they would adopt new procedures into a current therapy if they felt this appropriate and beneficial. This would only occur, however, following the client's prior approval since it was felt they had the right to accept or reject such changes. Non-committed therapists were less inclined to introduce new procedures into an ongoing therapy but if done, it was likely to be introduced without prior discussion with their clients.

If committed Christian therapists felt they were not progressing with their clients, they were more inclined to speak to their supervisors about this matter than were non-committed therapists. Non-committed therapists indicated instead a greater inclination to speak to their clients about such concerns. Committed Christian therapists were also more inclined to use wider feedback methods in order to better understand their lack of progress. It may be possible, therefore, that what is being uncovered at this point is that non-committed therapists appear to be more threatened by the possibility that they are failing in their quest to help the client. Are non-committed therapists more insecure than committed Christian therapists? Only further research could answer this question, but a pattern does appear to be emerging that committed Christian therapists appear to be more open to clients and colleagues alike regarding their perceived successes and failures whereas non-committed therapists prefer to keep "records" of their progress nearer to hand.

Therapists in this study, from both groups, placed a very high reliance upon their clients to give them feedback about the effectiveness of their therapy. Again, however, as when they perceived difficulties to be
occurring in therapy, committed Christian therapists were also more inclined than their non-committed colleagues to seek feedback from a wider range of sources. This further raises the question of self-reassurance between therapists of the two groups.

10. **Enduring Education.**

All of the therapists in this study were tertiary educated and currently felt that this training still played a highly significant part in their practice. Whilst the intention behind seeking this information was to determine how much therapists were inclined to attribute their present skills to academic learning and how much to practical experience, the question seeking this information was inadequately worded. The specific information sought was therefore not obtained.

11. **Client Advocacy.**

Using a Biblical basis (Proverbs 28:13) Christian therapists are often exhorted to assist clients who are seen to be powerless in dealing with injustices in their lives. Therapists are called to take a stand and speak up for the rights of clients who cannot speak for themselves (Collins, 1993). Such a "calling" appears to have been heeded more by committed Christian therapists although their non-committed colleagues were only slightly less inclined to follow suit.

12. **Section Conclusion.**

Therapists from both groups placed a high importance on addressing the emotional aspects of their clients. Committed Christian therapists were more inclined to self disclose in areas of personal background, religion and values than non-committed therapists. The reluctance of non-committed therapists to do so may,
however, place the client in a dilemma ultimately leading to premature terminations. An argument was presented to endorse the concept of self-disclosure within appropriate contexts.

A small percentage from both groups offered an after-hours service but only committed Christian therapists offered a home call service. Non-committed therapists indicated that they were always able to be contacted on their home phone whereas committed Christian therapists were only occasionally able to be. It is possible that non-committed therapists offer a telephone emergency service whilst committed Christian therapists offer a home call emergency service. Further research is needed in this area.

Almost all of the therapists from both groups counselled members of the opposite gender. Committed Christian therapists were more apt to rely upon others being present as a safeguard whereas non-committed therapists were more inclined to use a combination of others present and a code of ethics.

No great differences were found between the type of employment therapist were in and their beliefs. Committed Christian therapists were more likely to offer ongoing therapy if the client could no longer afford the fees than were non-committed therapists who were more inclined to discharge the client from their care.

Non-committed therapists were more inclined to be guided by their clients as to how much and what sort of information was passed on in cases when their client was referred to another therapist. Committed Christian therapists were more inclined to be guided by their code of ethics and the Privacy Act (1993).

Therapists from both groups admitted to speaking about their clients to others than their supervisors, but this was almost always in a teaching/training context.

Non-committed therapists were the only ones to indicate that they would refer their clients to another agency if a clash of religious values occurred.
between themselves and their clients. This was representative of only a small percentage of the group, however, with the majority of therapists from both groups indicating that they would continue therapy with their clients. Even then, a small percentage from both groups indicated that they would not enter into any further discussion of their differences with their clients. Such practices may have an adverse effect for the client.

Most of the therapists from both groups did, however, indicate that they would not only continue working with their client, but would also be willing to enter into discussion with them about the differences perceived. This willingness indicated by therapists from both groups ranged from attempts to understand the client's point of view to active accommodation of the client's beliefs into the therapeutic regime.

Committed Christian therapists indicated that they were more likely to accept an invitation by their clients to talk about their own personal religious beliefs than non-committed therapists who stated that they would direct their clients to make enquiries elsewhere.

Committed Christian therapists were the only ones who indicated a history of having used Biblical quotations and prayer as part of their therapeutic regime. Whilst previous research has indicated the usefulness of these techniques in therapy, there are also some inherent dangers if used at inappropriate times or by incompetent professionals.

Conservative Christian therapists indicated that they would always warn their clients of the dangers attached to occult activities with the likelihood of this warning diminishing along with the therapists' own declining strength of Christian beliefs. Moderate Christian therapists, however, went against the trend and indicated a greater unlikelihood to warn their clients of occult dangers than would have been expected of them.

Committed Christian therapists were more inclined than their non-committed counterparts to introduce new procedures into current therapy.
When this occurred, committed Christian therapists were also more likely to confer first with their clients about such an introduction whereas non-committed therapists would simply introduce it without such dialogue.

When progress was not felt to be occurring with their clients or as a general means of self assessment, committed Christian therapists were more likely to seek feedback from a wider variety of sources than their non-committed counterparts. Such diverse actions between the two groups of therapists raises the question as to whether non-committed therapists are less confident about their procedures than committed Christian therapists.

All the therapists were tertiary educated which was felt to be highly significant in their abilities to practice.

Therapists from both groups were almost equally likely to support their clients in matters they felt were relevant to ongoing client welfare.

VI. SUPERVISION.

1. Supervisor Survey.

Professional accountability should be of primary importance to everyone involved in counselling. Supervision is one means by which this can be achieved, not only for the professional development of the therapist but also to enable them to best meet the needs of their clients in accordance and in conjunction with their professional Code of Ethics.

Supervision includes maintaining, developing, and supporting therapists, and to this end is concerned with:

(i) the relationship between the therapist and client;
(ii) the relationship between therapist and supervisor;
(iii) the relationship between therapist, supervisor, and wider parties concerned;
(iv) ensuring ethical standards are maintained.
A recommended formula of time spent in supervision by the New Zealand Association of Counsellors is ordinarily one hour per fortnight for full-time workers and no less than one hour per month, proportional to that worked by part time therapists. No criteria are recommended for the preferred gender, religious affiliation, or training of the supervisor. It is recommended, however, that supervisors be skilled full time therapists themselves who are members of a national professional organisation.

This study sought to examine the types of supervisors therapists were likely to use, how frequently, and how much they knew about them. Whilst some cross gender supervision occurred, therapists from both groups predominantly had supervisors who were the same gender as themselves. It is not known whether this was a preferred or forced choice. All the therapists knew what styles of therapy their supervisors employed and what training they had received. Whether this was a factor in their choice of supervisor, explained to them in an initial meeting, or simply somehow known is not known.

All of the therapists in this study were full time workers and therefore would be expected by the NZAC to receive supervision at least fortnightly. This was the case for the great majority of the therapists involved in this study with a small percentage indicating monthly supervision only. Committed Christian therapists were, however, more inclined to receive supervision weekly as opposed to non-committed therapists who indicated a greater likelihood of fortnightly supervision.

Genia (1995) recommends that non-Christian therapists receive supervised experience in confronting religious material within clinical practice. She does not state whether or not supervisors themselves should have similar religious values or whether this is even relevant. In this study, therapists were asked if they were aware whether or not their supervisor was a Christian and whether this was a factor in their choice of supervisor.
Half of the committed Christian therapists indicated that their supervisors were also Christians with a strong percentage of them indicating that this was their choice. Non-committed therapists also indicated a strong choice in their selection of a supervisor who had no Christian beliefs. Why each of the two groups felt the choices they made were correct was not determined as part of this study and would require further research to establish.

If differences of opinion arose as a result of their different beliefs, only a very small percentage of the committed Christian therapists stated that they would withhold information from their supervisor. Given the very small number of respondents used in this study, it would be unfair, however, to assume this was a significant and therefore dangerous trait of Christian therapists. Again, further research is needed.

2. Work Worries.

Should a problem occur that affects the therapist's practice, all of the committed Christian therapists stated that they would seek advice from God with a lesser percentage also seeking advice from their supervisor. All non-committed therapists stated that they would seek advice from their supervisor with a lesser percentage seeking advice from their colleagues. For both groups, smaller percentages also included friends and ministers as possible resources but in both cases committed Christian therapists were likely to make greater use of them than non-committed therapists. Again, this appears to reinforce a previous speculation that committed Christian therapists consult a wider range of sources of help than do non-committed therapists.

3. Section Conclusion.

Most therapists had supervisors of the same gender as themselves, knew the styles of therapy endorsed by them, and training they had
received. Committed Christian therapists tended to see their supervisor weekly whereas non-committed therapists were more likely to have supervision fortnightly.

Both non-committed and committed Christian therapists indicated an active choice on their part in determining whether or not they would have a Christian supervisor, with a preference for like-mindedness being recorded. Even if they were not like-minded, only a very small percentage of the committed Christian therapists indicated a likely withholding of controversial information from their supervisors.

Committed Christian therapists were most likely to seek advice from God and their supervisor when problems occurred that were affecting their work. Non-committed therapists would also seek the advice of their supervisor but replaced God with their colleagues.

VII. PROFESSIONAL DEVELOPMENT.

1. Professional Reading.

Non-committed therapists were more likely to subscribe to therapy-related journals than committed Christian therapists. However, two thirds of the journals subscribed to by both groups were ones that no other therapist in this study subscribed to. It would appear that many of the therapists have a favourite which they read. Many of the titles are unknown to this researcher and, therefore, their contents could only be guessed at. It may be useful for future research to examine the contents of these journals and to see if there are similarities or dissimilarities between the groups as to what is being read. Equally interesting is the question whether the content of these journals has any significant impact upon the therapeutic styles employed by the therapists. Given that committed Christian therapists seem more inclined to scan a wider field and are more willing to incorporate new
procedures into their therapeutic regime, these journals may have a greater impact upon this group than upon their non-committed counterparts.

Committed Christian therapists indicated having read more work-related books over the previous twelve months than non-committed therapists. Again many of the titles were unique to a singular therapist with only four books (of the hundred separate titles listed), having been read by two therapists. This may partly have been the result of having a small research population but, it may also indicate a real difference between the two groups of therapists. Topics of interest did not vary markedly between the therapists of each group, with both indicating general psychology, general counselling, addiction, and self concept issues as the four most favoured topics of interest.

2. Section Conclusion.

Non-committed therapists were more likely to subscribe to journals than committed Christian therapists. The majority of those journals subscribed to, were unique to a single reader. Any impact the content of these journals may have is unknown and suggests further research on this topic may be useful. Committed Christian therapists read a greater number of books than their non-committed colleagues, although the four most favoured topics were identical for both groups.

VIII. TRAINING.

1. Continuing Education.

Genia (1995) encourages non-Christian therapists to attend workshops and conferences that focus on topics related to religion and mental health so that they can become more skilled in working with religious clients. Sadly, very little, if any, of this type of training is offered. Therapists from both groups indicated that they attended approximately four
conferences/workshops a year. To the researcher's knowledge, only one conference in New Zealand has ever addressed the topic of religion in psychotherapeutic practice. Given the hostility indicated by the lack of response from non-Christian therapists towards this research, this researcher remains sceptical as to whether any training has occurred for this group either in their academic training or ongoing training "in house". A survey of the number who would be interested in examining a religion-orientated topic at a conference would be interesting.

In a previous section therapists were asked to state how much of their tertiary education they felt was still being used in their current practice. In this section, respondents were asked how much of their training they would attribute to practical experiences and any previous Christian training. Committed Christian therapists were more inclined to attribute their current skills to both practical experiences and previous Christian training than non-committed therapists. It was also generally found to be directly correlated with the strength of religious belief held by the therapist, that is, the stronger the therapists' religious beliefs, the more likely they were to acknowledge practical experience as a learning experience. The only sub-group to go against this trend, for inexplicable reasons, were the moderate Christians who were equally divided between agreement and disagreement.

2. Section Conclusion.

Therapists from both groups attended approximately four conferences each year. Presentation of religious orientated topics at conferences is, however, a rare occurrence.

Committed Christian therapists were more likely than non-committed therapists to acknowledge practical experience and former Christian training as factors contributing to their current therapeutic skills. Generally the therapists' acknowledgment of these factors correlated positively with their
strength of religious belief. Moderate Christians, however, defied the trend for as yet unknown reasons.

IX. SUPPORT.

1. Self Support.

It would be totally unrealistic to believe that therapists have not had at some stage an issue of personal difficulty. What is not known is how much transference and counter transference occurs because of these issues. Whilst not a crucial question within the context of this present study, it was desired to know how many therapists had received or were still receiving personal therapy. All of the non-committed therapists and a high percentage of the committed Christian therapists said they had received or were receiving therapy. The reasons why varied considerably among therapists of both groups although self-concept issues were the most frequently cited reason.

Collins (1993, p 36), indicated that when the lives of therapists and their therapeutic practice was built only on personal experiences there could be:

"No stability to our beliefs, because what we think will change with our changing emotions.

No enduring ethical standards, because what is right and wrong will change, depending on the situation, on how we feel, and on prevailing attitudes in the society.

No way to validate one's conclusions, because experiences are not subject to testing and there are no standards other than oneself.

No basis for concluding that another person is right or wrong, since one person's experiences and views are assumed to be as valid as those of any other.

No real hope for the future, because my only hope is built on the passing conclusions in my own mind".

154
Given the high percentage of therapists having had, or still undergoing, personal therapy, it may be beneficial to understand whether counter-transference was occurring. This study, however, serves only to understand whether differences exist between committed Christian and non-committed therapists which does not appear to be case. It does, however, raise questions needing further exploration.

The therapists in this study were asked whether they had a preference to belong to a national secular counselling association, a national Christian counselling association or both. Predicably, non-committed therapists opted for a secular association but committed Christian therapists indicated a desire to belong to both, a option which is not currently available. This preference, indicated by committed Christian therapists, may reflect their desire to integrate into already established organisations and practices, a task which may not be easy if traditionally anti-religious hostile segments are found to be existing within such structures. Their choice may, therefore, reflect the frustrations of committed Christian therapists attempting to be acknowledged as a unique segment within a whole, much in the same way as chocolate and vanilla ice creams are still ice creams but have unique flavours.

2. Section Conclusion.

All non-committed and a high percentage of committed Christian therapists had previously sought personal therapy. Some non-committed therapists were still receiving this for themselves. A question of transference and counter transference was raised with a suggestion that further research in this area be conducted.

Committed Christian therapists indicated a desire to have dual membership with both a secular and Christian national counselling association. Non-committed therapists were content to maintain a membership with only a secular national counselling association.
X. THERAPIST INTERVIEWS.

Two therapists from each of the two groups were interviewed. Two of the five non-Christian therapists had by this time also indicated no further desire to participate in the research beyond the questionnaire, leaving a total of three potential interviewees from this group.

Other than asking them why they felt there had been such a low response rate from non-Christian therapists, and their own impressions of the questionnaire and its content there were no pre-determined questions.

The two committed Christian therapists expressed a generally positive attitude toward the questionnaire which coincided with the many positive comments written on the returned answer sheets. They felt that such research was needed since they had long felt that they had been frequently perceived as "Bible bashing" therapists, only interested in steering their clients towards Christianity, rather than as professional therapists interested in the client's welfare. The chance, therefore, to demonstrate their compatibility with traditional perceptions of psychotherapy was welcomed enthusiastically. This enthusiasm was further reflected in their desire to be given a copy of the final results of this study so that they could "share it with others". Their only negative comment was about the length of the questionnaire, which they felt took too long to answer. They had, however, no objections to any of the questions asked, other than feeling restricted when asked to answer in a forced style. This latter comment may give some understanding as to why many of the committed Christian therapists wrote reasonably lengthy answers to questions which otherwise asked for a simple choice response. It may also be another indication that committed Christian therapists have long felt unable to express their opinions unless such an opportunity as this presents itself.

The quest by committed Christian therapists to be better understood and their belief that there is resistance to this by traditional therapists appears to
be reflected in the two very different attitudes encountered when the two non-Christian therapists were interviewed.

A desire to better understand was reflected by the female non-Christian therapist interviewed, who also wanted to better understand her own perception of spirituality. For her, the questionnaire provided a means of self-exploration, enabling her to become aware of her own attitudes toward the greater area of spirituality as a concern and, her responses to situations where this was applicable.

Like the Christian therapists interviewed, she also found the questionnaire lengthy but the questions asked relevant. She could not, however, explain why many of her non-Christian colleagues refused the opportunity to be involved with this research.

This particular therapist appears to epitomise those secular therapists who had previously indicated in their responses a willingness to discuss religious differences with their clients without feeling threatened. Regrettably, she may also be representative of those non-Christian therapists who appear to be in the minority.

The fear expressed by committed Christian therapists that their viewpoint might not be considered seriously within a therapeutic setting, may have been reflected by the other non-Christian therapist interviewed. This therapist's views were different from those offered by his colleague. For him, the questionnaire's length was not an issue but its content and structure were. He felt that the questions were "too prescriptive" in that he felt they did not allow for alternative answers other than from a non-Christian or Christian point of view. One example (of many) he cited was question twelve which asked therapists whether they encourage their clients to "tap into an unlimited power within themselves" or "look outward to Christ". He felt that the questionnaire lacked an ability for non-Christian therapists to express their beliefs in Eastern religions and philosophies. For
this therapist, all words associated with Christianity such as "God" and "Christian" should have been excluded and replaced with words such as "spirit" and "meaning". This therapist was also very critical of specific Christian beliefs and practices such as prayer, Bible quoting, and deliverance being associated with traditional forms of psychotherapy. It was for these reasons that he felt his colleagues had not participated. If this were true, one wonders if he was not reflecting the opinion of the majority of non-Christian therapists (based upon the poor return rate), giving credence to the committed Christian therapists' beliefs that they are being stereotyped, perhaps unfairly.

XI. CLIENT FEEDBACK.

Client confirmation of therapist beliefs and practices was never intended to be a major part of this research and was done only cursorily. As a result of the small amount of data gathered, however, several interesting observations have arisen along with an obvious need for further research in this area.

The manner in which this data was collected is open to much criticism especially concerning population size, and the fact that the therapists were able to decide which clients would participate. Given that four of the six clients participating were Christians, therapists may have deliberately chosen clients who were not only likely to give good reports about the therapist but also speak from a Christian perspective since the research may have been perceived this way. Despite these possible confounding factors, the data is worth discussing.

1. Demographics.

Ten clients were asked by their therapists to participate in this research by completing a questionnaire. Each of the four therapists interviewed was given two copies of the questionnaire to be distributed to clients of their
choice. Two additional copies of the clients questionnaire were given to the female non-Christian therapist (to pass on to another colleague) after the clients of the male non-Christian therapist failed to respond. These latter two copies were not returned. This left the researcher with six returns. Three female and one male client professed themselves to be Christians. Two (both female) were seeing a committed Christian therapist whilst the remaining two were seeing a non-Christian therapist. Two self professed non-Christians (both female) were seeing a committed Christian therapist.

Those clients seeing a committed Christian therapist had been in therapy three times longer than clients seeing a non-Christian therapist. This may indicate a greater reluctance by committed Christian therapists to terminate with their clients than non-committed therapists which would raise questions about client dependency upon an empathic therapist. It may also have been that the clients seen by the committed Christian therapists had more severe problems. These questions remain unanswered and require further research.

Christian clients were more inclined to have been referred to their therapists by the church they associated with or on the recommendation of previous clients whereas non-Christian clients relied more upon advertising as well as verbal recommendations. This may indicate a greater caution being displayed by Christian clients who fear their values and beliefs may be threatened if they were to make a wrong choice of therapist.

The two Christian clients who were seeing a committed Christian therapist had been Christians themselves for a shorter period of time than those seeing a non-Christian therapist. This may reflect a desire by less mature Christians to preserve any religious vulnerability they may have by actively seeking Christian counsel. Mature Christians on the other hand may feel more secure in their beliefs and be more prepared to defend them if the occasion calls for this. They are therefore less threatened by non-
Christian therapists. This may be seen in the comments of one client who said, "I know right from wrong and find a Christian emphasis in counselling not currently necessary".

An alternative view may be that the Christian clients seeing a non-Christian therapist either felt that the religious attitude of their therapist was irrelevant or that they no longer felt a strong inclination to be involved in Christian practices. One of the clients seeing a non-Christian therapist did state that they had no current involvement with a church at the time of their responding to the questionnaire.

All but one client expressed a desire to have a therapist of the opposite gender to themselves which might indicate a desire by clients to receive an opinion from those perceived to be different from themselves. Further research is needed to understand why, if this is the case, this occurs.

2. A Client's View Of Their Therapist.

Asked how they perceived their therapists during sessions, clients seeing a committed Christian therapist described the experience as being more "comfortable" and "relaxed" than those clients seeing a non-Christian therapist. Clients seeing a committed Christian therapist also described their therapist as being able to express themselves better and were more confident in their appearance than clients seeing a non-Christian therapist. The only negative description clients seeing a committed Christian therapist made was that they felt their therapist tended to lecture more than non-Christian therapists.

Clients seeing a committed Christian therapist were aware of their therapist's religious orientations but those seeing a non-Christian therapist were not.

Both committed Christian and non-committed therapists believed it was important to divulge any religious beliefs they held to their clients.
however, did not feel this to be as important for them. It was possible that clients may feel threatened if they were to divulge such information for fear of being ridiculed or challenged on issues they are still uncertain in. Therapist self-disclosure does not, however, appear to extend to the style of therapy they use since none of the clients were able to state what style of therapy their therapist used. It may be that the therapists felt such information was either irrelevant, or too technical for their client. Neither were two of the clients seeing a committed Christian therapist certain as to whether they were being asked to "look outward to Christ" or to "look within". Given that committed Christian therapists had earlier declared that they encourage their clients to look "outward", the message does not appear to be getting through, or the therapist is giving no message at all.

Despite a probable desire by therapists to remain neutral, Wyatt and Johnson (1990) found in their studies that this was an impossible task when it came to value exchanges between therapist and client. Non-committed and committed Christian therapists had stated in their responses that they were unlikely to try and alter a client's point of view when clashes occurred between the two on issues of values, morals and religion. Were clashes to occur, the therapists stated a willingness to discuss these differences with a view to accommodating them in ongoing therapy. According to their responses, committed Christian therapists were more likely than their non-committed counterparts to discuss this perceived lack of progress with their supervisor. Non-committed therapists on the other hand indicated that they would be more inclined to keep such discussions between themselves and their client. A question exists, therefore, as to whether or not clients of non-Christian therapists are being given the benefit of the wider network of resource available to clients of committed Christian therapists. Again, further research is required.
Whilst the therapists indicated by their results a willingness to talk to their clients about any perceived difficulties incurred in therapy, the clients viewed the therapist's likely reaction differently. All but one of the clients felt that their therapist would attempt to impose his/her values/morals/beliefs on them. Those seeing a committed Christian therapist said their response would be to terminate further sessions with them, whilst those seeing a non-Christian therapist said they would simply ignore the therapist's advice. Neither option leaves much room for the discussion therapists desired. The clients' responses may indicate an awareness that differences do exist between themselves and their therapists and that these differences are acceptable, unless they feel that the therapist is attempting to impose her/his standards upon them. It is possible, therefore, that certain beliefs thought to be held strongly by the therapist may influence the client to become like-minded.

One such belief, earlier indicated to be strong amongst committed Christian therapists, is forgiveness. Three of the four clients seeing a committed Christian therapist, indicated that it had been suggested to them on at least one occasion, that they should forgive those who had previously offended them. Such instructions had not ever been given to clients seeing a non-Christian therapist. Sin is another fundamental concept associated with Christian beliefs. Predicably, therefore, Christian clients were found to view sin as "a state of alienation from God" whereas non-Christian clients described sin as being either "an act or thought which robs people of their self-esteem" or "an inherent condition that lies at the core of our state". These beliefs concurred with those professed by the therapists according to their own profession of beliefs.

Non-committed therapists had indicated in their results a strong inclination to use Existential-Humanistic and Gestalt therapies. Correspondingly, this same group of therapists felt it less important than
their committed Christian counterparts to recall past events. All of the clients in this study, however, felt it was important to recall events from their past. Such differences of opinion between clients and especially non-committed therapists, may result in a conflict of needs.

3. Values.

All of the clients seeing a committed Christian therapist in this study believed that Christian counselling offered a better therapeutic environment than non-Christian counselling. This same belief was not upheld by non-committed therapists themselves.

Clients seeing a committed Christian therapist were more inclined to believe that the therapist showed more regard for their beliefs than the two clients seeing a non-Christian therapist. In their results, therapists from both groups indicated a willingness to speak about any differences that may occur between themselves and their clients, but again it appears that this message may not be getting through to the clients of non-Christian therapists. When a therapist was perceived to have less regard for the client's beliefs, the client may be less forthcoming in expressing themselves.

Being labelled a Christian may induce a stereotypical view by others as to what is believed and practiced. It was found, however, that Christians do not always believe in the same beliefs as those traditionally ascribed to them. For example, not all believe in demons or heaven and hell. Likewise, non-Christian therapists were found to have a belief in some of the same concepts as their Christian counterparts. Christian and non-Christian clients were also found to have similar patterns of beliefs as those indicated by the respective therapists. Committed Christian therapists and clients were, however, more inclined to show a greater belief in God, Satan, angels, demons, heaven and hell than non-Christian therapists and clients.
Christian clients generally concurred with committed Christian therapists that God was not vindictive, irrational or, inclined to induce guilt. Being influenced by the Holy Spirit was also a belief strongly held by both Christian clients and therapists.

Christian and non-Christian clients seeing a Christian therapist were more inclined to attribute the skills of their therapist to being God-given than those clients seeing a non-Christian therapist, possibly indicating, particularly amongst non-Christians, a transmission of Christian values from therapist to client either subtly or overtly. Since some of the clients seeing a Christian therapist were non-Christian and the two Christian clients seeing a non-Christian therapist had deliberately sought to do so, it may again reinforce the argument that value transmission does not only occur, but it is actively sought by some clients.

Another example of possible value transmission was reflected in the response given by a non-Christian clients who along with most Christian clients believed that it was acceptable for their (committed Christian) therapist to quote from the Bible as part of their therapeutic practice. Committed Christian therapists had stated in their response a high likelihood that they would both quote from the Bible and pray with their clients. This inclusion in therapy, however, appears to be restricted to times when committed Christian therapists are working with Christian clients since this was the only combination to indicate its occurrence. Equally, non-Christian clients seeing a committed Christian therapist were also inclined to believe along with the majority of committed Christian therapists that deliverance (freeing one from demons) was an acceptable practice when the occasion called for this. This belief, however, was not held by the two Christian clients seeing a Non-Christian therapist.

Committed Christian therapists had indicated in their responses a reluctance to deal with topics of abortion and homosexuality with their clients. In these instances, this reluctance was also known to the clients seeing such therapists. It is possible that rather than the therapists having expressed their reluctance to their clients, it may have been assumed they would not discuss them because of their Christian beliefs. Some evidence of this stereotyping may have been demonstrated in the conflicting results obtained between therapists and clients when asked about the willingness to deal with the issues of de-facto relationships and sex outside marriage. Therapists from both groups had stated a willingness to discuss these issues if they arose, but this openness was not perceived by their clients.

Non-Christian clients seeing a committed Christian therapist and Christian clients seeing a non-Christian therapist believed they were freely able to express their emotions in therapy. This would coincide with an equal encouragement to do so expressed by the therapists in their responses. Christian clients seeing a committed Christian therapist, however, felt they could not. One explanation for this may again reflect the clients' perceptions of their therapists, and how this affects their ability to express themselves. Such clients may feel it inappropriate to express their emotions in accordance with more orthodox styles of Christianity. Such beliefs may become more accentuated between Christian clients and committed Christian therapists since each person has their own personal beliefs as to the meaning of Christianity for them. Thus Christian clients may more actively avoid becoming emotionally entangled with their therapist either to avoid conflict of beliefs or in an attempt to emulate perceived orthodox styles of approaches toward Christianity as displayed by the therapist, another example of possible value transmission. All of the clients did state that they felt their therapist would be accommodating of any
emotionality displayed by them. However, this perceived empathy may have been reinterpreted by Christian clients as being a tolerance for behaviour not yet brought under appropriate control. Clients seeing a non-Christian therapist were also inclined to perceive their therapist as being less empathic than those seeing a committed Christian therapist. One such client may have aptly summarised this when she recorded his/her therapist as being "professionally detached".

Despite therapists from both groups declaring a high likelihood that they would take up causes on behalf of their clients when appropriate, the possibility of this happening was believed only by those clients seeing a committed Christian therapist, again reinforcing the client perception that non-Christian therapists tend to be "professionally detached" from their clients.

Differences of perception occur over the issue as to whether therapists would come to the client's home. Therapists from both groups generally stated that they would make such visits when warranted but only those clients seeing a committed Christian therapist believed this would happen, once again reinforcing the belief (by clients anyway) that committed Christian therapists were inclined to be more empathic to client situations than non-Christian therapists. Likewise, non-Christian therapists had stated in their results that they could always be contacted at their home if needed whereas committed Christian therapists were able to be contacted in this way only occasionally. Clients seeing a non-Christian therapist, however, felt they would never be able to contact their therapist at home whereas all of the clients seeing a committed Christian therapist knew the therapist's home number and felt they could contact her/him there if required, another case of mixed messages.

Mutual social activities between themselves and their clients were
recorded by half of the committed Christian therapists and by almost none of the non-committed therapists. This likelihood was confirmed by three of the four clients seeing a committed Christian therapist who stated that this had occurred on at least one occasion. Neither of the two clients seeing a non-Christian therapist had attended a mutual social event. Boundaries set for what is deemed to be "acceptable" contact, therefore, appear to differ between the two groups of therapists.
CHAPTER V.

CONCLUSION.

The purpose of this research was to find out whether Christian therapists differed in beliefs and therapeutic practices from non-Christian therapists and, if so, what these differences were and how they were reflected in their therapeutic practice.

A conclusion has already been given at the end of each section and so the findings shall not again be repeated here. However, there are some other aspects of this research which still need comment.

1. Research Finding Implications.

Despite some limitations later mentioned in this section, differences between committed Christian and non-committed therapists were found to exist. These differences may indicate a number of implications. Firstly, they demonstrate that whilst differences do occur between committed Christian therapists and non-committed therapists, formal therapist education courses (including workshops and conferences) have largely ignored them. Given that a large percentage of the general population declares themselves as having some form of religious belief, it is surprising to find that those who are in the business of helping members from this general population remain oblivious to a major socially influencing variable. For clients particularly, especially those who may not yet have a strong religious belief, the prospect of seeing a therapist who may be perceived as being either hostile, unsympathetic or lacking in knowledge about their belief must be frightening. True, non-committed therapists in this study stated a willingness to talk about religious differences with their clients but,
given that they appear to lack knowledge about the subject, any ensuing conversation must be very one sided. This can surely only lead to a situation where the client feels either more intimidated by their lack of knowledge or, if they do not terminate with their therapist, they become silent on the topic. This perceived lack of understanding by non-Christians may also cause clients to deliberately seek assistance from committed Christian therapists, as was tentatively shown in the present study. Even so, this may not be the most appropriate action to take since Christian therapy could also be destructive for the client. Committed Christian therapists who mean well could place the client in a position whereby they end up feeling guilty because they have not prayed enough or read sufficient Scripture.

Differences between the two groups do exist, and whilst it would be too simple to conclude that non-committed therapists are anti-religious or, for that matter, committed Christian therapists are against traditional forms of psychotherapy, there remains a lack of understanding about the other’s perspective. The fact that there are different perspectives, has been shown in this research.

2. Questionnaire Limitations.

Data for this study was gained largely through the use of questionnaires. Due to a lack of information on many topics covered in this research, and because of its scope, no suitable instrument of measurement had been previously established. One requirement of this research study was therefore to construct such an instrument. Whilst the questionnaire underwent many drafts and evaluations by both Christian and non-Christian therapists, it still contains a number of flaws which may have affected the results of this study. Firstly, the questionnaire was lengthy, requiring at least forty-five minutes to complete. For those therapists running a busy
practice, this may have been a daunting task which they would not willingly undertake. This would be even more apparent if the topic was perceived by them to be either uninteresting or irrelevant. Such sentiments were expressed by both the non-Christian therapists interviewed. Secondly, because the questionnaire deliberately sought to make comparisons between Christian and non-Christian therapists, the content of the questionnaire may have been viewed with disdain by some therapists. This was best illustrated by those who returned blank questionnaires citing cultural insensitivity or Christian bias as their reasons for not completing it. A third factor may be because of the closed nature of the questions asked. Whilst deliberately constructed in this manner to aid with data collation, some therapists may have felt too constricted in their responses. This may explain why committed Christian therapists in particular, wrote answers on their answer sheets in excess of what was asked for. Non-committed therapists on the other hand may have opted for the path of "least resistance" and wrote nothing at all. This was one of the reasons the male non-Christian therapist interviewed gave for a poor return rate from non-Christians. Wording of the questions may also have been a fourth limiting factor. In addition to a lack of options being given, some of the questions seem in retrospect to have been misplaced. For example, question 23 ("is there a "formula" you use when using Scripture.") may have been better placed after question 47 ("have you on occasions quoted directly from the Bible"). Other questions may have been perceived as variations of the same question. A lack of understanding of either what the question was asking of the respondent or a lack of knowledge about religious beliefs may also have provided a fifth reason why therapists failed to respond. One final but disturbing factor may be that the perceived hostility indicated by previous researchers and some of the committed Christian respondents of this study may prove to be accurate. Because the questionnaire clearly had a Christian bias, anti-religious
sentiment may have been able to be expressed through a deliberate lack of co-operation.

There is no question that the questionnaire requires further refinement and may, therefore, in its current state have contributed to a lower response than was desired. The clients' questionnaire was a shortened, modified version of the counsellor questionnaire. The same criticisms of the counsellor questionnaire may also hold valid for the clients questionnaire.

3. Subjects Limitations.

As has been mentioned several times throughout the text of this report, subject numbers were very low. This was especially so for non-Christian therapists. Because of this, some therapists with Christian beliefs were included in the group used to compare against committed Christian therapists. The results in this study may not, therefore, accurately reflect the views of non-Christians. Also, given that this group of Christians included in the non-committed group were significantly different in their beliefs from committed Christian therapists, but are also fundamentally different in their beliefs from non-Christians, this group may in fact represent a significant third group.

It needs to be remembered that this research was primarily exploratory rather than confirmatory. Its results, therefore, can only be used as baseline data that needs to be added to and extended.
ACKNOWLEDGMENTS.

This researcher wishes to acknowledge the following:
Dr's Robert Manthei and Colin McGeorge who provided supervision and
guidance throughout the research.
Peter Larsen and Murray Winn for their time and assistance in establishing
and drafting of the counsellor's questionnaire.
My wife (Ann-Shirley), who much of the time must have wondered if she
still had a husband.
Some very special friends who supported me during times when I felt like
giving up. In many years of research, this has to be the most difficult one
yet conducted. I deeply valued the support you gave me.
My clients, who have had to make many sacrifices of time and attention
whilst I was involved with this research project. Your loyalty and
understanding has been greatly appreciated.
Finally, all of the therapists and clients who participated in this study. They
are the ones who spent considerable time and energy answering a myriad of
questions so that some basic understandings could be achieved. Many of
them also gave me the impetus to continue in the midst of many
disappointments during the data gathering phases.
BIBLIOGRAPHY.


25 March 1994

Arend van den Bos
43 Kathleen Crescent
CHRISTCHURCH 4

Dear Arend,

The Departmental Research Supervision and Ethics Committee has conditionally approved your application for the Research Proposal *Christian Counselling: An Analysis of the Title* to be completed as an M.A. Thesis. Bob Manthei has been appointed as your supervisor. A second supervisor is yet to be appointed, and a third assessor from outside the Department is to be arranged by Bob Manthei.

Research may not begin prior to approval of the University's Human Subjects Ethics Committee and other relevant Boards. Appropriate forms are included in the booklet "A Guide for Students Doing Research in the Education Department, 1994", available from the Secretaries Office, Room 602, Education Department. Your completed thesis is due as indicated in the booklet.

Our best wishes for successful research.

Sincerely,

[Signature]

Kathleen A. Liberty, Ph.D
Chair
Departmental Research Supervision & Ethics Committee

c.c. Bob Manthei
Committee
3 October 1994

Mr A van den Bos
C/- Dr R Manthei
Department of Education
University of Canterbury
CHRISTCHURCH

Dear Mr van den Bos

The Human Ethics Committee has considered and approved your research proposal 'Christian Counselling: An Analysis of Beliefs and Practices', but asks that 'questionnaire' be spelled with two 'n's.

Yours sincerely

[Signature]

S M Holstein (Mrs)
Secretary
APPENDIX C.

Information Sheet.

You are invited to participate as a subject in the research project on
"Christian Counselling: An Analysis Of Beliefs And Practices".
The aim of this research is to examine whether any differences exist
between secular and Christian counsellors and their styles of practice and
what impact (if any) these have on the clients of such practitioners.
Your involvement in this project will involve answering a questionnaire.
A return self envelope will be supplied with the questionnaires so that it can
be forwarded directly to the researcher once completed.
The time needed to complete the questionnaire will be approximately thirty
minutes.
As a follow-up to this investigation, some of you will be asked to consent
to an interview which will involve exploring further some of the answers
given in the questionnaire.
The interview will be no longer than one hour.
Some of you will also be asked to forward to two clients a separate
questionnaire designed to ascertain their views of you as their counsellor.
Their responses will also be mailed directly back to the researcher.
The results of the project may be published, but you may be assured of
complete confidentiality.
The identity of any participants will not be made public.
To ensure anonymity and confidentiality, all participants will be assigned a
code number which will become their only means of identification.
Matches between code numbers and participant names will be known only
to the researcher. The research is being carried out by Arend van den Bos
who can be contacted at 349-2467.
He or his supervisor, Dr Robert Manthei (who can be contacted on
364-2266) will be pleased to discuss any concerns you may have about
participating in the research.
The research has been reviewed and approved by the University of
Canterbury Human Ethics Committee.
APPENDIX D.

Counsellor Questionnaire.

You will be asked to answer the following questions in a variety of ways. Therefore, please read each question carefully and respond on the separate answer sheet provided.

Some questions may not be applicable to you. In such cases, please write N/A at the end of the question.

Every question must be answered even if only with an N/A.

Thank you for your patience, time and co-operation.

Theoretical Approaches.

1. Do you maintain a particular theoretical focus in your training, or are you eclectic in your approach?

2. From the following list, identify the five therapies you most often employ, in order of preference. Below each answer, indicate the percentage of time used. Overlap of time is permitted. For example:

   80% 40%
   a. Trait and Facto   g. Gestalt
   b. Developmental    h. Biblical Scripture
   c. Psychodynamic    i. Prayer
   d. Cognitive-Behavioural  j. Healing meetings
   e. Rational-Emotive  k. Word of knowledge
   f. Existential-Humanistic

3. From the list in question 2, are there any therapies you would not be happy to use. If so, list and briefly explain why not.

4. Do you believe victims should be encouraged to forgive those who have offended them?

5. Do you believe it is essential to encourage clients to recall past incidents?
   If so,
      a. On an emotional basis only?
      b. On a cognitive basis only?
      c. On both an emotional and cognitive basis?

Beliefs.

6. Do you believe that client problems predominantly arise as a result of
   b. Socio-economic factors.
   c. Combination of "a" and "b".
   d. Spiritual factors.
   e. Sinful nature of man.
   f. Other (please specify)____________________________

7. Do you believe that human beings are innately good?
8. Which of the following two statements do you agree most with?:
   A. "The problem of humanity is the ignorance and lack of knowledge we have about our own potential. The solution therefore is to change our consciousness so we become enlightened and realise we are divine."
   B. "The problem of humanity is that we have rebelled against a Holy God and His moral law. The solution is to repent and have faith in Jesus Christ who came to redeem and restore us, so that we would have a right relationship with God the Father."

9. How much do you agree with the following statement: "Once we know more about ourselves and the universe, we will shed our ignorance and life will become better."

10. Do you believe that Christian counselling offers a better solution for clients than secular counselling? Why/why not?

11. How much does being a counsellor have to do with some kind of spiritual meaning in life for you? Explain briefly.

12. In understanding spirituality, are you encouraging your client to:
   a. Tap into an unlimited power within themselves.
   b. Look outward to Christ?

13. Do you "see" God as one who is vindictive, irrational, and inclined to pile on the guilt?

14. Which of the following three definitions of sin would you agree with?
   a. An act or thought that robs a person of their self-esteem.
   b. An inherent condition that lies at the core of our being.
   c. A state of alienation from God.

15. Do you believe in:
   a. Demons (evil spiritual forces)?
   b. Angels?
   c. The existence of satan?
   d. God (in a Christian context)?
   e. An after life that includes both heaven and hell?

16. If you currently consider yourself to be a Christian, how long have you been one?

17. Given the five definitions of the Christian spectrum (attached), which group do you feel most aligned with?

18. Are you currently involved in a Christian fellowship?

19. How much of your counselling skills do you believe is God given?

20. Do you believe the Bible should be used as a guide for counselling?

21. How confident are you that your interpretation of biblical passages is correct?

22. How much time would you spend weekly in studying scripture?
23. Is there a "formula" you use when using scripture as part of the 
therapeutic process?
If so, what?

24. Do you feel you are guided by the Holy Spirit?

25. Is deliverance (freeing a person of demonic influences), an accepted 
part of your therapy (where applicable).

**Ethics.**

26. Which professional association's code of ethics (if any) do you abide 
by?

27. How important is it that the client's spirituality be included as part of a 
counsellor education programme?

28. How important is it that the client's spirituality be dealt with in 
therapy?

29. If you consider the client's spirituality as an important consideration in 
therapy, how do you elicit this information from the client?

30. Would you counsel a:
   a. Close family member?
   b. Distant family member?
   c. Close friend?
   d. Distant friend?
   e. Member in your congregation.
   (You may indicate more than one answer).

31. Would you meet with clients in a social capacity?
   If so, describe in what situations.

32. If you were to have a client seek your advice on the following topics, 
how committed would you be to encouraging them to:
   a. Obtain an abortion?
   b. Establish/maintain a homosexual relationship?
   c. Establish/maintain a de-facto relationship?
   d. Have sexual relations outside of marriage?

**Counselling Practice.**

33. How important is it to address the emotional aspect in counselling a 
client?

34. Do you self disclose any of the following:
   a. Personal information about you that is felt to be relevant to the client's 
problem?
   b. Your religious beliefs?
   c. Your personal values/morals?
   (you may indicate more than one answer)

35. Do you see clients professionally, outside of the recognised business 
hours?
36. Do you make house calls?
   If so, on what occasions?

37. Are clients able to contact you at your home?

38. Do you counsel members of the opposite sex?
   If so, detail what safeguards (if any) you employ when counselling?

39. What proportion of your income from counselling is from:
   a. Self-employment?
   b. Waged employment?

40. If a client is unable to afford your fees, would you:
   a. Refer your client to another counsellor?
   b. Seek restitution from your client through other means?
   c. Refuse to continue seeing your client?
   d. Continue to see your client free of charge?

41. In referring clients to another counsellor, how much information is passed on?

42. What (if anything) governs the amount of information you share/don't share with other counsellors?

43. Do you speak about your clients (albeit anonymously) to others outside of your practice? (For Christians, this would include at prayer meetings other than with your client).
   If you have/do, state frequency of and occasion when.

44. If your religious beliefs, morals, or values conflict with those of the client, would you:
   a. Refer your client to another counsellor?
   b. Continue working with your client without discussion of these differences?
   c. Continue working with the client with discussion of these differences?
   d. Ask them to seek advice elsewhere?

45. If you answered "continue working with the client..." in question 44, would you attempt to:
   a. Understand their point of view?
   b. Ignore their point of view?
   c. Accommodate their point of view in the therapeutic process?

46. If you were a Christian counsellor, and a previously secular client began to show an interest in Christianity, would you:
   a. Spend time counselling (with their permission) to share your beliefs with them?
   b. Invite them to your church/home group?
   c. Refer them to another for ministry in this area?

47. During therapy, have you on occasions quoted directly from the Bible?
   If you have/do, state frequency of and occasion when.

48. During therapy time, have you on occasions prayed (in a Christian manner), with/for your clients?
   If you have/do, state frequency of and occasion when.
49. A client is found to be involved in the occult. What are your actions?

50. Do you accommodate new procedures into your therapy? If so:
   a. Is this done during ongoing therapy with a client?
   b. Is your client forewarned of such plans?
   c. Does your client have the right to accept/reject your decision?

51. If you feel you are not progressing with your client, what would be your action?

52. How do you gauge the appropriateness of the techniques used on your client?

53. If you have received any tertiary education related to counselling, what percentage of this is now still, being actively used in your therapy?

54. How likely are you to take up a cause on behalf of a client if they feel they are unable to do so?
   e.g., the current axing of a client’s Disabilities Allowance.

**Supervision.**

55. Please answer the following details about your supervisor:
   a. Male/Female?
   b. Style of therapy employed by her/him?
   c. Training they have received.
   d. Frequency of supervision.

56. Is your supervisor a Christian?
   Was this your choice?

57. If you and your client held the same religious beliefs, but these differed from those of your supervisor, would you refrain from discussing these differences from them.

58. If you have a problem which affects your work in general, from whom do you seek advice:
   a. Supervisor?
   b. Close friend?
   c. Minister?
   d. Work colleague?
   e. God?
   (you may indicate more than one answer)

**Professional Development.**

59. Do you subscribe to any counselling/therapy journals?
   Give title of those you do.

60. List titles, authors, and how long since you have read your last five books concerning counselling.

**Training.**

61. Do you attend conferences and workshops?
   How frequently (per year)?
62. How much of your training would you attribute to the experiences of working with your clients?

63. How much of any Christian training you have received is now actively used in your practice?
   a. 80-100%
   b. 50-79%
   c. 25-49%
   d. 10-24%
   e. less than 10%

**Support.**

64. Have you ever received counselling for yourself? If so, could you briefly disclose the reason why.

65. Are you currently receiving counselling for yourself?

66. Given the opportunity to become a member of a national counselling association, would you prefer:
   a. A secular association?
   b. A Christian association?
   c. Both?

**Respondant's Demography.**

67. a. Your age:
   b. Your gender:
APPENDIX E.
Counsellor Questionnaire Answer Sheet.

Theoretical Approaches.
1. Theoretical  Ecclectic (delete non appropriate answer).
2. __ __ __ __ __
3. __________________________
   __________________________
   __________________________
4. Yes No (circle your answer)
5. A B C (circle your answer)

Beliefs.
6. A B C D E F (circle your answer)
7. Yes No (circle your answer)
8. A B (circle your answer)
9. [1_2_3_4_5_6_7_8_9_10_1] (circle your answer)
   Disagree Agree
10. Yes No (circle your answer)
    __________________________
    __________________________
11. [1_2_3_4_5_6_7_8_9_10_1] (circle your answer)
    Little Much
    __________________________
    __________________________
    __________________________
12. A B (circle your answer)
13. Yes No (circle your answer)
14. A B C (circle your answer)
15a. Yes No Don’t know (circle your answer)
15b. Yes No Don’t know (circle your answer)
15c. Yes No Don’t know (circle your answer)
15d. Yes No Don’t know (circle your answer)
15e. Yes No Don’t know (circle your answer)
16. __________________________
17. __________________________
18. Yes  No  (circle your answer)

19. [1_2_3_4_5_6_7_8_9_10_] (circle your answer)
   Little              Much

20. Yes  No  (circle your answer)

21. [1_2_3_4_5_6_7_8_9_10_] (circle your answer)
   Not confident       Very confident

22. ________________________________
   ________________________________

23. Yes  No  (circle your answer)
   ________________________________
   ________________________________

24. Yes  No  Don't know  (circle your answer)

25. Yes  No  (circle your answer)

Ethics.

26. ________________________________
   ________________________________

27. [1_2_3_4_5_6_7_8_9_10_] (circle your answer)
   Unimportant             Very important

28. [1_2_3_4_5_6_7_8_10_] (circle your answer)
   Unimportant             Very important

29. ________________________________
   ________________________________
   ________________________________

30. A.  B  C  D  E  (circle your answer)

31. Yes  No  (circle your answer)
   ________________________________
32. a. [1_2_3_4_5_6_7_8_9_10_] (circle answer)
   Uncommitted Very committed

   b.[1_2_3_4_5_6_7_8_9_10_] (circle answer)
   Uncommitted Very committed

   c.[1_2_3_4_5_6_7_8_9_10_] (circle answer)
   Uncommitted Very committed

   d.[1_2_3_4_5_6_7_8_9_10_] (circle answer)
   Uncommitted Very committed

**Counselling Practice.**

33. [1_2_3_4_5_6_7_8_9_10_] (circle your answer)
   Unimportant Very important

34. A B C (circle your answer)

35. Yes No (circle your answer)

36. Yes No (circle your answer)

37. Never Occasionally Often Always (circle your answer)

38. Yes No (circle your answer)

39. a. Self employment?
    b. Waged employment?

40. A B C D (circle your answer)

41. 

42. 

190
43. Yes  No  (circle your answer)

44. A  B  C  D  (circle your answer)

45. A  B  C  (circle your answer)

46. A  B  C  (circle your answer)

47. Yes  No  (circle your answer)

48. Yes  No  (circle your answer)

49. 

50. a. Yes  No  (circle your answer)
   b. Yes  No  (circle your answer)
   c. Yes  No  (circle your answer)

51. 

52. 

53. 

54. [1 2 3 4 5 6 7 8 9 10]  (circle your answer)

55. a. Male  Female  (circle your answer)
   
56. a. Yes  No  (circle your answer)
   b. Yes  No  (circle your answer)

57. Yes  No  (circle your answer)
58. A B C D E
   (circle your answer)

Professional Development.
59. Yes No (circle your answer)


60.________________________________________


Training.
61. Yes No (circle your answer)


62.________________________________________

63. A B C D E
   (circle your answer)

Support.
64. Yes No (circle your answer)


65. Yes No (circle your answer)

66. A B C (circle your answer)

Respondant's Demography.
67. a. Age:
    b. Gender:
APPENDIX F.

Christian Spectrum Sheet.

Definition:
Christian: One who has made a conscious commitment to a way of life as exemplified by the teachings and commandments of Jesus Christ.

CHRISTIAN SPECTRUM

Within the Christian sub-culture, there are a number of intra-group differences.
For the purposes of this research, as Christian's, you will be asked to categorise yourself as belonging to one of the five following groups.

Fundamentalists:

Those who believe the authority of the Bible is absolute. It is the inerrant literal Word of God in all spheres of knowledge. Regarding counselling, with the exception of biologically based difficulties, all problems result from the client's own sin.

Conservatives:
These have many similarities to Fundamentalists. For example, the authority of the Bible is still absolute but scholarship within limits is encouraged.
Concerning counselling, there is a greater acceptance of a psychological basis to some problems experienced by clients.

Moderates:
This group is close to the traditional of most mainstream denominations. Their faith is more flexible and they may often have different interpretations of the Bible.
There is some emphasis on the "social" gospel and people are seen more as people than souls to be saved.
Like Conservatives, counsellors are likely to adopt selected portions of secular teachings pertaining to psychology and counselling in their practice.

Liberals:
This group emphasises the Bible's human origins and their perception of doctrine is accordingly much more flexible.
Activity in the moral and social renewal of the world is seen as important. Counsellors in this group are more receptive to a wide variety of secular training approaches but attempt to reconcile these theories and skills with their Christian beliefs.

Nominals:
Those who believe in God, and a historical Christ.
They seldom attend church and may also have other beliefs that co-exist with their Christian ones.
APPENDIX G.

CLIENT'S QUESTIONNAIRE.

You will be asked to answer the following questions in a variety of ways. Therefore, please read each question carefully and respond on the separate answer sheet provided. Some questions may not be applicable to you. In such cases, please write N/A at the end of the question (on the answer sheet). Every question must be answered even if only with a N/A. Thank you for your patience, time and co-operation.

1. How many sessions of counselling have you received from your counsellor?

2. How did you find your counsellor?

3a. Is your counsellor a male or female?
   b. Is this by your choice?

4. Would you prefer a male or female counsellor?

5. How much do you pay for your counselling?

6a. Is your counsellor a Christian?
   b. Was this your choice?
      If yes, state why.

7. Are you aware of your counsellor's religious beliefs (if any)?

8. Would your counsellor be prepared to see you in your home?

9. If you were to face a personal crisis outside the counselling room, such as a domestic dispute, legal challenge, benefit cut, etc, could you call your counsellor in to assist you in dealing with these matters?

10. Do you know your counsellor's home phone number?

11. Do you know what style of therapy your counsellor is using? If so, please state.

12. If you currently consider yourself to be a Christian, how long have you been one?

13. Are you currently involved in a Christian fellowship?

14. Do you believe in:
   a. Demons (evil spiritual forces)?
   b. Angels?
   c. The existence of satan?
   d. God (in a Christian context)?
   e. An after life that includes both heaven and hell?

15. Do you "see" God as one who is vindictive, irrational, and inclined to induce guilt?
16. Which of the following three definitions of sin would you agree with?
   a. An act or thought that robs people of their self-esteem.
   b. An inherent condition that lies at the core of our being.
   c. A state of alienation from God.

17. Do you feel you are influenced by the Holy Spirit?

18. Have you shared with your counsellor any religious beliefs you may hold?

19. How much do you believe that your counsellor's skills are God given?

20. Do you believe that Christian counselling offers a better solution for you than non-Christian counselling? Why/why not?

21. Do you believe the Bible should be used in counselling?

22. Do you believe deliverance (freeing a person of demonic influences), would be an accepted part of your therapy (if applicable)?

23. If you were a Christian and your counsellor was not, would you attempt to alter his/her beliefs?

24. How important do you feel it is to express your view regards religious beliefs to your counsellor?

25. During counselling, has your counsellor ever:
   a. Quoted to you directly from the Bible?
   b. Prayed for you (in a Christian manner)?

26. Does your counsellor encourage you to:
   a. Tap into an unlimited power within yourself?
   b. Look outward to Christ?
   c. Uncertain as to what she/he does?

27. Does your counsellor use the Bible as a guide for counselling?

28. Have you ever been instructed by your counsellor to forgive those who have offended you?

29. How much do you believe your counsellor has taken into consideration your viewpoint regarding religious beliefs?

30. How much does your counsellor attempt to moralise with you?

31. If you felt your counsellor was asking you to do something against your values/morals, would your action be to:
   a. Go along without question with what your counsellor suggests since he/she knows what is best for you?
   b. Agree with what she/he suggests after some discussion but without changing the counsellor's opinion?
   c. Refuse to do as the counsellor requests but continue to see him/her.
   d. Terminate with her/him and seek counselling elsewhere?
   e. Terminate counselling altogether?
32. Do you feel you could discuss with, and receive support from, your counsellor on the following issues:
   a. Obtaining an abortion?
   b. Establishing/maintaining a homosexual relationship?
   c. Establishing/maintaining a de-facto relationship?
   d. Sexual relations outside marriage?

33. Are you encouraged to recall past incidents,
   a. On an emotional basis only?
   b. On a rational basis only?
   c. On both an emotional and rational basis?

34. Do you feel you are able to express yourself emotionally and without inhibitions to your counsellor?

35. How much consideration does your counsellor have towards your own emotional feelings?

36. How much concern do you believe your counsellor has for you and your difficulties? Explain your answer.

37. How much does your counsellor attempt to make you feel relaxed and comfortable in your sessions?

38. Do you feel your counsellor gives you sufficient time to speak about your problems?

39. How relaxed and spontaneous do you feel your counsellor is in sessions with you?

40. How self-confident does your counsellor appear to be with you?

41. How clearly does your counsellor express herself/himself to you?

42. How much does your counsellor tend to lecture you rather than listen to what you have to say?

43. If you feel you are not progressing in counselling, would you:
   a. Accept that the problem lies with your difficulties to change?
   b. Discuss the lack of progress with your counsellor?
   c. Terminate any further counselling?
   d. Seek another counsellor?

44. Do you meet with your counsellor in a social capacity? If so, describe in what situations.

45. Any other comments you would like to make about your counsellor? If so, please state them.

46. Your age?

47. Your gender?
APPENDIX H.

Client's Questionnaire Answer Sheet

1. 

2. Through:
   a. Advertisement?
   b. Word of mouth?
   c. Other organization (e.g. Citizens Advice)?
   d. Another counsellor?
   e. Other? (specify) ____________________________
      (circle your answer)

3. a. Male  Female
    b. Yes    No
       (circle your answers)

4. Male  Female
       (circle your answer).

5. $________________________

6. a. Yes    No
      (circle your answer)
      Don't know
    b. Yes    No
      (circle your answer)

7. Yes    No
       (circle your answer)

8. Yes    No
       (circle your answer)
      Don't know

9. Yes    No
       (circle your answer)
      Don't know

10. Yes   No
      (circle your answer)

11. Yes   No
     (circle your answer)

12. __________________________
     __________________________
     __________________________

13. Yes   No
     (circle your answer)

197
14. a. Yes No
   b. Yes No
   c. Yes No
   d. Yes No
   e. Yes No (circle your answers)

15. Yes No (circle your answer)

16. A B C (circle your answer)

17. Yes No (circle your answer)

18. Yes No (circle your answer)

19. 1 2 3 4 5
    not much very much

20. Yes No (circle your answer)

21. Yes No (circle your answer)

22. Yes No (circle your answer)

23. Yes No (circle your answer)

24. 1 2 3 4 5
    not important very important

25. a. Yes No
    b. Yes No (circle your answers)

26. A B C (circle one answer only)

27. Yes No (circle your answer)
28. Yes  No
(circle your answer)

29. 1 2 3 4 5
not much  very much

30. 1 2 3 4 5
not much  very much

31. A  B  C  D  E
(circle your answer)

32. a. Yes  No
b. Yes  No
c. Yes  No
d. Yes  No
(circle your answers)

33. A  B  C
(circle your answer)

34. 1 2 3 4 5
never  always

35. 1 2 3 4 5
not much  very much

36. 1 2 3 4 5
not much  very much

37. 1 2 3 4 5
not much  very much

38. 1 2 3 4 5
never  always

39. 1 2 3 4 5
never  always

199
40. | 1 | 2 | 3 | 4 | 5 |
   | never | always |
41. | 1 | 2 | 3 | 4 | 5 |
   | never | always |
42. | 1 | 2 | 3 | 4 | 5 |
   | not much | very much |
43. A   B   C   D
   (circle your answer)
44. Yes   No
   (circle your answer)
45. __________________________
   __________________________
   __________________________
   __________________________
46. Age:
47. Gender:
APPENDIX I.

Statistical Division of The Two Research Therapist Groups.

Due to the very low number of responses received, particularly from non-Christian therapists, it was decided to attempt to gain two relatively equal groups by examining the belief structures of three groups. The first group consisted of those who had indicated a Conservative or Moderate perspective in response to question seventeen of the "Counsellor's Questionnaire". A second group consisted of those who had indicated a Liberal or Nominal perspective in their response to question seventeen. A third group consisted of those who indicated no Christian beliefs at all.

In order to determine any significant difference between these groups, the answers given to select questions within the "Belief" section of the questionnaire was used as a data basis. The questions chosen were mutually selected by the researcher and his senior supervisor, and were felt to best reflect the belief values of each individual participant. The following results were obtained.

Q8. "Which of the following two statements do you agree most with?:

A. "The problem of humanity is the ignorance and lack of knowledge we have about our own potential. The solution therefore is to change our consciousness so we become enlightened and realise we are divine."

B. "The problem of humanity is that we have rebelled against a Holy God and His moral law. The solution is to repent and have faith in Jesus Christ who came to redeem and restore us, so that we would have a right relationship with God the Father."

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>3</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>B.</td>
<td>9</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>10</td>
<td>22</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 8.983 p < .01

<table>
<thead>
<tr>
<th></th>
<th>Lib/Nom</th>
<th>Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>8</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>B.</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 3.534 n.s.

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom/Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>3</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>B.</td>
<td>9</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>15</td>
<td>27</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 13.210 p < .05
Q10. "Do you believe that Christian counselling offers a better solution for clients than secular counselling?"

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>No.</td>
<td>6</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>10</td>
<td>22</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 2.390 *n.s.*

<table>
<thead>
<tr>
<th></th>
<th>Lib/Nom</th>
<th>Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>No.</td>
<td>9</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Totals</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 0.134 *n.s.*

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom/Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>No.</td>
<td>6</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>15</td>
<td>27</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 4.457 *p < .05*

Q12. "In understanding spirituality, are you encouraging your client to:
   a. Tap into an unlimited power within themselves.
   b. Look outward to Christ?"

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>3</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>B.</td>
<td>9</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>10</td>
<td>22</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 12.102 *p < .001*

<table>
<thead>
<tr>
<th></th>
<th>Lib/Nom</th>
<th>Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>9</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>B.</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 3.348 *n.s.*

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom/Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>3</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>B.</td>
<td>9</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>15</td>
<td>27</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 16.440 *p < .001*
Q14. "Which of the following three definitions of sin would you agree with?"
   a. An act or thought that robs a person of their self-esteem.
   b. An inherent condition that lies at the core of our being.
   c. A state of alienation from God."

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>4</td>
<td>10</td>
<td>14</td>
</tr>
<tr>
<td>B.</td>
<td>8</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>10</td>
<td>23</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 13.555 p < .001

<table>
<thead>
<tr>
<th></th>
<th>Lib/Nom</th>
<th>No</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>10</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>B.</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>10</td>
<td>1</td>
<td>11</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 0.00 n.s.

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom/Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>4</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>B.</td>
<td>8</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>11</td>
<td>23</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 14.375 p < .001

Q18. "Are you currently involved in a Christian fellowship?"

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes.</td>
<td>12</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>No.</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>10</td>
<td>22</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 5.179 p < .05

<table>
<thead>
<tr>
<th></th>
<th>Lib/Nom</th>
<th>Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes.</td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>No.</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Totals</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 1.838 n.s.

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom/Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes.</td>
<td>12</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>No.</td>
<td>0</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>15</td>
<td>27</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 10.008 p < .01

Q19. "How much of your counselling skills do you believe is God given?"

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom</th>
<th>Con/Mod</th>
<th>Non</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observations</td>
<td>12</td>
<td>10</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Mean level</td>
<td>8.83</td>
<td>3.8</td>
<td>3.8</td>
<td>2.8</td>
</tr>
</tbody>
</table>

$t$ (critical two-tail) = 3.823 p < .01 $t$ (critical two-tail) = 0.613 n.s.

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom/Non</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observations</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Mean level</td>
<td>8.83</td>
<td>3.47</td>
</tr>
</tbody>
</table>

$t$ (critical two-tail) = 5.219 p < .001
Q20. "Do you believe the Bible should be used as a guide for counselling?"

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>8</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>No.</td>
<td>4</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>10</td>
<td>22</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 5.091 p < .05

<table>
<thead>
<tr>
<th></th>
<th>Lib/Nom</th>
<th>Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>No.</td>
<td>9</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Totals</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 0.134 n.s.

Q22. "How much time would you spend weekly in studying scripture?"

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom</th>
<th>Non</th>
<th>Con/Mod</th>
<th>Lib/Nom/Non</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observations</td>
<td>12</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Mean hours</td>
<td>6.09</td>
<td>0.10</td>
<td>0.10</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

\( t \) (critical two-tail) = 1.879 n.s. \( t \) (critical two-tail) = 1.307 n.s.

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom/Non</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observations</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Mean hours</td>
<td>6.09</td>
<td>0.09</td>
</tr>
</tbody>
</table>

\( t \) (critical two-tail) = 1.894 n.s.

Q23. "Is there a "formula" you use when using scripture as part of the therapeutic process? If so, what?"

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>No.</td>
<td>9</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>10</td>
<td>22</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 0.125 n.s.

<table>
<thead>
<tr>
<th></th>
<th>Lib/Nom</th>
<th>Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>No.</td>
<td>9</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Totals</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 0.134 n.s.

<table>
<thead>
<tr>
<th></th>
<th>Con/Mod</th>
<th>Lib/Nom/Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>No.</td>
<td>9</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>15</td>
<td>27</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 0.574 n.s.
Q24. "Do you feel you are guided by the Holy Spirit?"

<table>
<thead>
<tr>
<th>Con/Mod</th>
<th>Lib/Nom</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>No.</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>10</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 4.541 p < .05

<table>
<thead>
<tr>
<th>Lib/Nom</th>
<th>Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>No.</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Totals</td>
<td>10</td>
<td>5</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 0.038 n.s.

<table>
<thead>
<tr>
<th>Con/Mod</th>
<th>Lib/Nom/Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes.</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>No.</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>15</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 7.135 p < .01

Q25. "Is deliverance (freeing a person of demonic influences), an accepted part of your therapy (where applicable)."

<table>
<thead>
<tr>
<th>Con/Mod</th>
<th>Lib/Nom</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes.</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>No.</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>10</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 3.616 n.s.

<table>
<thead>
<tr>
<th>Lib/Nom</th>
<th>Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes.</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>No.</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Totals</td>
<td>10</td>
<td>5</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 0.134 n.s.

<table>
<thead>
<tr>
<th>Con/Mod</th>
<th>Lib/Nom/Non</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes.</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>No.</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>15</td>
</tr>
</tbody>
</table>

Chi (with Yate's correction) = 6.237 p < .05