# Managing religious conflict in therapy assignment

Running Head: MANAGING RELIGIOUS CONFLICT Managing Religious Conflict within Psychotherapy Ryan Hagen UMASS Lowell Abstract This paper discusses the relationship of religion and psychology within the setting of interpersonal dynamic psychotherapy. It raises the question of whether and to what extent religion should be included in a therapeutic setting. Varying perspectives on this issue are reviewed, followed by an examination of the consequences of addressing religion within therapy.

Several examples are offered of potential pit falls a therapist may encounter in this situation as well as suggestions for minimizing the likelihood of these occurrences. Two models are included which provide frameworks for assessing the degree in which a person an individual client may be religious. These models can be used in tandem and are helpful to the therapist in determining whether religion should be addressed with a particular client. They are also helpful in indicating whether their patients' religion is connected to their mental health, as well as how the therapist should adjust their approach accordingly.

Conflict can arise, when the values and beliefs of one's religion run contrary to those which are developed in a therapeutic setting. Although the purpose and the goals of therapy and religion are often aligned, their methods for achieving this are often incongruent, particularly when questions of morality and sin arise. In this paper, I aim to understand the nature of the kinds of resistance a therapist may encounter in these types of settings and explore tactics which allow the therapist to remain relatively neutral about their own particular biases, as well prevent the patient's religious bias from interfering with their own progress.

The second group of problems revolve around the therapist having only a very limited understanding their patients religion, which may restrict the therapist capacity for understanding a patient who has based much of their life's choices on their faith. For example, each religious division in the Christian faith has a particular kind of religious reasoning, which is usually drawn from different bible texts. It may be difficult to understand the reasoning of a patient without having this knowledge beforehand, and the therapist may be unable to ccurately assess the significance of certain behaviors or customs. The third set of problems has to do with a lack of strategies for approaching the first two sets. It is only recently that mental health programs have begun to incorporate a religious diversity course into their curriculum. Often, the patient's beliefs are so ingrained and complex, that if a therapist tries to breach a certain defense which is linked with a religious position using argument or logic, another religious position is already in place to reinforce the first.

Another problem can arise when a patient feels the therapist has given them an unpleasant interpretation of something, will quickly fall back on the fact that the therapist does not share their religious values. Several suggestions are made by Spero (1981) on how to avoid developing negative counter-transference: The therapist needs to learn to distinguish between mature and immature religious belief systems. The therapist must be willing to analyze personal religious beliefs and attitudes objectively and independently.

The therapist must develop a nonanxious, nonfamilial approach toward working with religiously similar clients. The therapist must learn to

distinguish between true commitment to religious values and such expression used as a defense to avoid warranted exploration of religious material. 5. The therapist should focus specifically on those areas of belief that have therapeutic value, and he or she needs to remember that the client's beliefs themselves are not the focus of therapy. Some patients, however, benefit from including religion or spirituality within therapy.

Shafransky and Gorsuch (1984) that therapists who had revealed a positive spiritual stance in therapy had a positive effect on the outcome. In 1989, Richards, in a study of 100 Mormon patients, found that they were more trusting of therapists who disclosed a belief in god. A lot of this depends on the patient. Quackenbos (et al 1986) outlined four viewpoints or degrees of involvement a person may have with their religion, and how it is used to interpret mental health. The four viewpoints are orthodox, moderate, neutralist and atheistic.

These lay on a continuum, where those with orthodox viewpoints believe mental problems are caused by sin, and on the other end, atheistic sees mental problems as purely psychological. Another framework was proposed by Batson and Ventis (1982). They argued that a therapist's need to understand the different ways of being religious in order to understand the impact that religion may or may not have on their patient. They created their framework around 3 dimensions, each of which has it's own continuum. The 3 dimensions are quest, ends and means.

The ' quest' continuum measures the degree of importance the individual places on existential questions, but does not necessarily feel an urgency to

have answered. An example of this would be an agnostic, or a philosopher who enjoys the process of examining these kinds of questions. A person on the high end of this continuum would tend to have doubts about religion, and be tentative about religious viewpoints. The ' means' continuum assesses religion in terms of its practical usefulness, in regards to meeting the needs of the person.

A person high on this spectrum may appreciate the moral structure and regular fellowship that their church provides, or even be a business man who feels church attendance is good for business. The ' end' continuum gauges the degree of dedication an individual puts into the practice and values of a specific religion. An example of someone on the high end of this spectrum would be a person who takes the bible very literally, attends church weekly and believes Jesus will bring their salvation.

These three dimensions are measured separately and are meant to give a framework for taking into account a patient's reliance or attachment to their religion. By using this framework as a guideline, the therapist is able to better understand the impact religion has on their patient's mental health, as well as what kind of therapeutic help would be most beneficial in light of this. Another framework was proposed by Spilka (1986) which examines the role of religion in an individual's life in view of primary and secondary control. Primary control refers to an individual's power to effectively act on external reality.

Secondary control refers to how we change our own cognitive framework to adjust or accommodate to reality. There are four kinds of secondary control,

according to Spilka, which are offered through religion; predictive, vicarious, illusory and interpretive. Predictive control draws on religious practices which are promised to produce positive results. Prayer is the ultimate example of this. The person prays for something to happen and believes it will because of their prayer, and often, in terms of smaller worldly goals the prophecy is self fulfilling. Vicarious control has to do with identification with a higher power.

This can be seen in those who speak of feeling Jesus within them. Often they will speak of God working through them, which it might be said may alleviate some of the anxiety that comes with having responsibility for one's actions. Illusory control is accepting that all reality is the product of God's divine plan. This can be a way for a person to explain painful phenomenon which there is no explanation for. It's a belief that is acceptance is important because we are unable to fully comprehend God's will. Interpretive control is a way of giving personal meaning to a problem as a way of trying to understand it.

A person who has befallen some tragedy may look for weaknesses in their own character which God may be punishing them for, allowing them the opportunity to redeem themselves by correcting this behavior. Understanding a patient within this framework can help a therapist determine the center of the patient's conflicts by observing which methods they particularly rely on as a means of secondary control. A person who relies heavily on an illusory form of control (focusing on acceptance of whatever comes their way as god's will) may have trouble being assertive in important areas of their life.

Returning to the therapists own values, establishing where they themselves fit inside Spilka's and Batson and Ventis's frameworks can help them get a better sense of what their own bias may be and be more aware of how it may affect therapy. By placing their patients within these frameworks through conversational questions or diagnostic tests, not only can therapists gain insight about their patient's internal conflicts but they can foresee value conflicts that may arise between the therapist and patient. The therapist's role in this situation is to encourage and facilitate, but not necessarily to confront or interpret.

Most articles on this subject make the same recommendation at one point or another: questions about religion are best handled in the same manner therapists handle other questions; candid but concise answers, with exploration as to what the answers mean to the patient and what it is that is important to the patient. Again, exploration of this are can help the therapist determine how to best help the client and can help the client to gain an understanding of their own mental health is connected with their religiousness. References Cox, R. H. 1973). An introduction to human guidance. In R. H. Cox (Ed. ), Religious systems and psychotherapy (pp. 3-12). Springfield, IL: Thomas. KEHOE, N. , & GUTHEIL, T. G. (1984). Shared religious belief as resistance in psychotherapy. American Journal of Psychotherapy, 38(4), 579-585. Lovinger, R. (1984). Working with religious issues in therapy. Northvale, NI: Jason Aronson. 147(4), 542. Quackenbos, S. , Privette, G. , & Klentz, B. (1986). Psychotherapy and religion: Rapprochement or antithesis? Journal of Counseling and Development, 65, 82-85.

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