

Can Religion Make You Crazy? Impact of Client and Therapist Religious Values on Clinical Judgments

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The influence of traditional Christian values of clinicians and clients on judgments of prognosis, psychopathology, and locus of client problems was investigated in a 2×3 factorial design. Religious and nonreligious clinicians viewed the same videotaped client. Client religiosity (nonreligious, moderately religious, or very religious) comprised the experimental manipulation. Both religious and nonreligious clinicians viewed the moderately religious client as having a more pessimistic prognosis and greater psychopathology. Religious therapists made more internal attributions for the nonreligious client than did nonreligious therapists, whereas nonreligious therapists made more internal attributions for the religious than the nonreligious client. It is suggested that judgments of prognosis and psychopathology were influenced by the degree of client doubt communicated. In contrast, attributions varied jointly with the relative match between affirmation or denial of religious values. Limitations of this and previous research are noted, and results are discussed in terms of recent controversies about religious values in psychotherapy.

Psychologists have long recognized the complex, often antagonistic, relation of psychology to religious tradition (Campbell, 1975). The general population has shown a renewed commitment to traditional religious values (*Religion in America*, 1981), whereas psychologists generally remain less religious by comparison (Ragan, Malony, & Beit-Hallahmi, 1980). Bergin (1980) asserted that clinical psychology has endorsed an antireligious, secular humanist philosophy and pointed out that this bias places clinical psychologists in a value conflict with many religious clients whose number are growing. To examine the empirical support for his critics' claims that religious belief causes emotional distress, Bergin (1983) conducted a meta-analysis of 24 studies that examined patient religious values and measures of psychopathology and concluded that there was little support that "religiousness is necessarily correlated with psychopathology" (p. 178).

In view of current controversy about causal relations of religious values to psychopathology, experiments are needed. Specifically, in context of suggestions that clinical psychologists are biased to see religious commitment as either correlates or causes of psychopathology, the important question is as follows: Do clinicians perceive religious clients as more pathological than comparable nonreligious clients? Moreover, if such biases exist, how are they affected by religious values of clinicians?

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Experiments on initial clinical judgment provide a paradigm for investigating these questions. These judgments have been empirically related to outcome (Brown, 1970), and Berman and Wenzlaff (1983) showed that they can determine outcome. By manipulating information presented, previous investigators have shown that clinical judgments are affected by therapist and client assumptive value systems, such as political philosophy (Schwartz & Abramowitz, 1975), sex role attitudes (Whitley, 1979), cognitive styles (Batson, 1975), and theoretical orientations (Houts, 1984). In general, the findings suggest that clinical judgments are more negative when therapist values and client values are incongruent (Beutler, 1981).

Two previous experiments addressed the impact of religious values on clinical judgment. Wadsworth and Checketts (1980) found that Mormon psychologists and other religious psychologists did not differ in assigning diagnostic labels to written case material, varied to portray a patient with either Mormon or other religious affiliation. However, they grouped all nonreligious therapists under a category of "other religion" and did not include material from nonreligious clients. Lewis (1983) presented audiotapes of a depressed female who either did or did not use religious language in describing her problem to psychologists who had either some or no religious affiliation. Both therapist groups projected a shorter course of therapy for the religious client, but Lewis (1983) did not find any trends for interpersonal attraction or therapeutic prognosis.

The present experiment extended investigation of religious values in clinical judgment by assessing religious and nonreligious clinicians' judgments of therapeutic prognosis, psychopathology, and attributional locus of a client's problem. The extent to which the client expressed commitment to fundamentalist values was manipulated. The central question was the following: Do religious and nonreligious clinicians render different clinical judgments as a function of a client's religious values?

Method

Subjects and Selection

Subjects were recruited by letter to participate in a study of clinical judgment. Letters ($N = 251$) were sent to practitioners listed either in the metropolitan Memphis yellow pages and/or with local listings in the *Directory of Psychologists and Psychological Examiners Licensed and Registered in Tennessee* (Board of Examiners, 1983). Sixty-six practicing clinicians (26%) returned consent forms and completed some demographic questionnaires about their training, experience, orientation, and current practice. Embedded in these was an abbreviated form of the King and Hunt Religious Attitudes Scale (RAS-S; King & Hunt, 1975). As part of the demographic questionnaires, prospective subjects indicated whether or not they considered themselves religious persons (a yes–no response) and what their current religious affiliation was.

The RAS-S contains 20 items that comprise four of the nine subscales of the original Religious Attitudes Scale: (a) Creedal Assent, (b) Devotionalism, (c) Orientation to Growth and Striving, and (d) Salience-Cognition. These four were chosen because they were intercorrelated in previous validation studies and measure a general factor of commitment to traditional or fundamentalist Christian values (Gorsuch, 1984; King & Hunt, 1975). RAS-S scores showed high internal consistency reliability (Cronbach's $\alpha = .99$), and a principal-components varimax rotated factor analysis yielded one factor that accounted for 74% of the variance.

Table 1
Demographic Characteristics of Religious and Nonreligious Clinician Groups

Characteristic	Religious	Nonreligious
Gender		
Male	20	20
Female	4	4
Degree		
Doctoral	9	12
Master's	15	12
Years of supervised clinical experience		
<i>M</i>	3.88	3.54
<i>SD</i>	3.17	2.11
Years of experience post degree		
<i>M</i>	5.13	7.00
<i>SD</i>	6.33	5.12
Theoretical orientation		
Psychodynamic	1	5
Cognitive-behavioral	6	1
Eclectic	9	12
Other	8	6
RAS-S sum score		
<i>M</i>	31.08	73.17
<i>SD</i>	8.26	5.34
Religious affiliation		
None	1	22
Episcopal	2	1
Evangelical Christian	10	0
Methodist	1	0
Presbyterian	3	0
Southern Baptist	5	0
Other	2	1

Note. RAS-S = Religious Attitudes Scale-Short Form.

RAS-S scores ranged from 20 to 80 and approximated a bimodal distribution. A median split at 55 established religious and nonreligious groups. In general, high scorers viewed themselves as religious persons with a particular religious affiliation, whereas low scorers did not view themselves as religious persons or have formal religious affiliations. Twelve subjects were eliminated because their RAS-S scores were inconsistent with their self-descriptions,¹ and another 6 were randomly excluded to accommodate equal cell frequencies within the design.

Twenty-four religious and 24 nonreligious clinician subjects participated. The sample included 40 men and 8 women, and all held a minimum of a master's degree in clinical or counseling psychology. Table 1 presents a summary of demographic characteristics of the two groups. The two groups did not differ significantly on any variables except RAS-S scores.

Experimental Conditions

Three scripts were written to depict 10 min of an intake interview between a male client and a male therapist.² The client was a college student experiencing depression and guilt related to his involvement with his girlfriend's pregnancy and recent abortion. The scripts contained identical wording (615 total words in the nonreligious condition) except for those portions systematically manipulating degree of affirmation of traditional Christian values: moderately religious (70 word changes) and very religious (65 word changes). Whereas the very religious and moderately religious conditions differed from the nonreligious condition with the client expressing either affirmation or denial of religious values, the moderately religious and very religious conditions varied in the degree to which the client expressed commitment to fundamentalist Christian values. For example, after presenting background information and describing the abortion:

Therapist: And you're feeling guilty about that?

Client: Yeah, anybody would, wouldn't they?

Nonreligious: I mean, I'm not even religious, but I still feel bad about it. . . . she ended up having to get an abortion, which is terrible to me.

Moderately religious: I mean, I'm not some religious fanatic, but I believe there's a God and that certain things are either right or wrong. . . . she ended up having to get an abortion, which is morally wrong to me.

Religious: I mean, I have strong religious beliefs. . . . she ended up having to get an abortion, which is a sin to me.

Videotapes were made from each script, and the lines were delivered verbatim. The client was played by an actor who had actually experienced the role he was playing, and the tapes presented a full view of the client with the interviewer (a male graduate student) off camera.

Two premanipulation checks were conducted. First, two senior clinical psychologists (diplomates of the American Board of Professional Psychology) viewed all three videotapes and under conditions of seeing all three, judged the clinical picture to be comparable, rating all three (on a 5-point scale) as showing a client with moderately severe emotional dysfunction. They also correctly assigned them (100% agreement) to the categories of nonreligious, moderately religious, and very religious. Second, a panel of 15 graduate students in religion from a conservative Christian institution viewed all three videotapes in counterbalanced order and ranked them on the degree of doubt expressed about religious values. A

¹ Eliminations occurred when a subject's RAS-S score was below the median, yet the subject indicated that he or she was a religious person. This inconsistency was especially pronounced among Jewish clinicians because the RAS-S is biased in selecting as religious those who endorse traditional Christian beliefs.

² Copies of the three scripts are available from the first author on request.

Friedman test followed by sign test comparisons ($p < .05$) showed that the client in the moderately religious condition was perceived as expressing more doubt than in the nonreligious or very religious conditions, with the latter two not differing on this dimension.

Procedure

Following a 4-week delay from first contact, clinician subjects were randomly assigned to view one of the videotapes. Portable video equipment was used, and experimental sessions were conducted in the subject's regular practice setting.

Subjects were told that they would see the first few minutes of an interview with a male client. All read the same client demographic information that included his age, educational background, employment, and previous history of no psychological problems. Subjects were told to focus on the client (to view him clinically) and were informed that they would be asked to make some clinical judgments about him. At the end of the videotape, subjects completed the dependent measures, after which they were interviewed and were asked what they thought the purpose of the experiment was. Subjects were then debriefed and instructed not to discuss the experiment with colleagues. No subject evinced prior knowledge of the experimental manipulations or hypotheses.

Dependent Measures

Initial clinical impressions were assessed with the Clinical Judgment Scale (CJS),³ a 19-item, additive, bipolar scale that measures clinical impressions along a global dimension of pessimism–optimism for clinical prognosis (Houts, 1984; Houts & Galante, 1985). The 19 items include dimensions that have been empirically related to measures of outcome. Internal consistency reliability was .84 (Cronbach's alpha).

Clinicians' perceptions of client psychopathology were assessed with the Health Sickness Rating Scale (HSRS). The HSRS presents a 100-point continuum of increasing psychopathology anchored by detailed descriptors and behavioral examples appropriate to each level (Luborsky, 1962). Subjects were instructed to indicate the point on the scale that most nearly identified the degree of psychological dysfunction exhibited by the client.

Four questions about clinicians' attributions were included to assess the extent to which subjects attributed clinical problems to external, circumstantial factors versus internal, dispositional factors. Items consisted of 7-point bipolar ratings with higher scores indicating more external attribution. First, before viewing the videotape subjects were asked to indicate the type of attribution they themselves typically make about client problems. Second, subjects indicated their perceptions of how clients generally attribute the cause of their own problems. Third, after viewing the videotape subjects made an attribution judgment about the specific client they viewed. Fourth, subjects reported how they perceived the client's own attribution for his problems.

Finally, subjects completed a manipulation check rating of the religious values of the client on a 5-point bipolar scale ranging from *not religious* (5) to *extremely religious* (1).

Results

Table 2 presents mean scores on the CJS and HSRS for the religious and nonreligious clinicians in each experimental condition. The results were submitted to two separate two-way analyses of variance (ANOVAs).⁴

The analysis of CJS sum scores indicated that client religious values influenced clinicians' judgments irrespective of clinicians' religious values, $F(2, 42) = 4.82, p < .05$. Newman-Keuls follow-up tests ($p < .05$) showed that all clinicians judged the client in

Table 2
Means and Standard Deviations of CJS and HSRS for Religious and Nonreligious Clinicians by Experimental Condition

Clinician group	Experimental condition		
	Nonreligious	Moderately religious	Very religious
Religious ($n = 24$)			
CJS			
<i>M</i>	91.88	93.25	89.50
<i>SD</i>	5.96	5.68	8.40
HSRS			
<i>M</i>	57.13	56.63	51.88
<i>SD</i>	15.09	11.24	11.00
Nonreligious ($n = 24$)			
CJS			
<i>M</i>	85.63	97.75	86.00
<i>SD</i>	10.07	5.73	9.04
HSRS			
<i>M</i>	55.38	65.63	49.63
<i>SD</i>	10.78	7.43	8.00

Note. Higher scores on the Clinical Judgment Scale (CJS) show more pessimistic therapeutic prognosis (possible range = 19 to 133). Higher scores on the Health Sickness rating Scale (HSRS) indicate more psychopathology (possible range = 0 to 100).

the moderately religious condition to have a more pessimistic therapeutic prognosis than in either the very religious or nonreligious conditions, which did not differ from each other. Similarly, the analysis of HSRS ratings also yielded an effect for client religious values, $F(2, 42) = 3.64, p < .05$. Newman-Keuls tests ($p < .05$) showed that both clinician groups saw the moderately religious client as more disturbed than the very religious client.

Before viewing a videotape, the two groups indicated how they generally see the cause of client problems as well as how they generally perceive clients to attribute the cause of problems. Both religious ($M = 4.92, SD = 1.18$) and nonreligious therapists ($M = 4.79, SD = 1.14$) reported that they generally view client problems as more often caused by external, circumstantial factors than by internal, personality factors. The two groups did not differ on this general attribution item, $t(46) = 0.37, ns$. A similar trend was noted for how the two groups generally perceive clients to attribute their problems, and religious therapists ($M = 3.54, SD = 1.14$) did not differ from nonreligious therapists ($M = 4.00, SD = 1.18$) on this general attribution item, $t(46) = 1.37, ns$.

Table 3 shows the responses of religious and nonreligious clinicians to two attribution items after viewing a specific client

³ Copies of the Clinical Judgment Scale are available from the first author on request.

⁴ Because CJS sum scores and HSRS ratings were intercorrelated ($r = .47, p < .01$), a 2×3 multivariate analysis of variance was performed on these two measures. Results paralleled those of univariate ANOVA with a significant multivariate main effect for experimental condition only, $F(4, 82) = 3.07, p < .05$.

Table 3
Means and Standard Deviations of Religious and Nonreligious Clinicians' Attribution for Client's Problems and Perceived Client Attribution by Experimental Condition

Clinician group	Experimental condition		
	Nonreligious	Moderately religious	Very religious
Religious (<i>n</i> = 24)			
Clinician attribution for client's problems			
<i>M</i>	2.63	3.25	3.50
<i>SD</i>	.75	.71	1.07
Perceived client attribution			
<i>M</i>	5.00	5.25	5.38
<i>SD</i>	1.69	1.39	1.06
Nonreligious (<i>n</i> = 24)			
Clinician attribution for client's problems			
<i>M</i>	4.00	3.88	2.88
<i>SD</i>	.76	.84	1.13
Perceived client attribution			
<i>M</i>	4.88	4.00	3.63
<i>SD</i>	1.36	1.07	1.85

Note. Both attribution items are 7-point bipolar ratings with higher scores indicating more external attributions.

within the experiment. The ANOVA on clinicians' attributions for the cause of the client's problem showed that attributions varied jointly as a function of client and clinician religious values, $F(2, 42) = 5.18, p < .01$. Religious therapists made more internal attributions for the nonreligious client than did nonreligious therapists, whereas within the nonreligious group, the very religious client elicited more internal attributions than did the nonreligious client (Newman-Keuls, $p < .05$).

Analysis of how subjects perceived the client's own attributions for his problems showed significant differences between clinician groups, $F(2, 42) = 36.76, p < .01$. Regardless of client religious values, nonreligious therapists perceived the client as attributing his problems more to internal, personality factors than did religious therapists (Newman-Keuls, $p < .05$).

Each therapist rated the religious values of the client as a manipulation check. Ratings for each experimental condition were as follows: nonreligious, $M = 4.19, SD = .54$; moderately religious, $M = 2.88, SD = .62$; and very religious $M = 2.25, SD = .86$. Subjects perceived the religious values of the client as significantly different according to experimental conditions, $F(2, 45) = 33.23, p < .01$, and Newman-Keuls tests ($p < .05$) showed that all three conditions differed reliably in the intended direction.

Discussion

Overall, this investigation supports Bergin's (1980, 1983) call for clinical psychologists to attend to the influence of religious values in psychotherapy. Yet, the results do not provide support for Bergin's concern that secular clinicians may routinely perceive religious individuals as more disturbed. Consistent with previous

investigations (Lewis, 1983; Wadworth & Checketts, 1980), this is now the third experiment to fail to find this bias. To be sure, neither this nor previous studies had sufficient statistical power to warrant accepting a null hypothesis. Furthermore, neither this study nor the previous two comprised a national probability sample of clinicians, so it remains unclear how generalizable their null findings are. Still, the heterogeneity of samples in the three studies and the consistent failure to detect bias across studies suggest that such bias may not be widespread.

Our data do provide a consistent, if novel, pattern that both challenges simple intuitions of how religious values impact clinical judgment and calls for further research. Both religious and nonreligious clinicians perceived the moderately religious client as having a more pessimistic prognosis and greater psychopathology than the very religious client, yet both clients affirmed traditional Christian values. The major difference between them was the strength of conviction they expressed in endorsing those values. Because the present findings are limited by only having one client exemplar, it is important to exercise caution in generalizing from these data. Nevertheless, the results do suggest that it may not be simple affirmation or denial of religious values that influences judgments of prognosis and psychopathology, but rather the degree to which that affirmation or denial is communicated as stemming from perceived genuine conviction. Consistent with the cultural legacy of viewing religious belief as a crutch, the individual who expresses less than convincing endorsement of religious beliefs (perhaps including atheism) may be more prone to being viewed as disingenuous and disturbed. Indeed, it may be that religious doubt is in fact correlated with more objective measures of therapeutic prognosis and psychopathology. To test these speculative hypotheses in future research, it will be necessary to investigate the role of religious doubt as an influence on both subjective clinical judgments and more objective indicators of prognosis and psychopathology.

Unlike their clinical judgments, the clinicians' attributions did vary according to dyadic match for affirmation or denial of religious values. Religious therapists made more internal attributions than nonreligious therapists when the client strongly denied any religious beliefs. Similarly, nonreligious therapists attributed the problems more to the client when he strongly affirmed religious values. A tendency for ingroup members of one religious sect to make dispositional attributions for problematic behavior of outgroup members of another sect has been noted before (Taylor & Jaggi, 1974). This could have implications for treatment. For example, when a client holds different religious beliefs from a therapist, the therapist, inclined toward more dispositional causal ascriptions, may target those beliefs for change. More research is needed to replicate this phenomenon with dyads of different religious orientations, and the relation of initial causal attribution to subsequent focus of treatment will need to be established.

What the present study points to is the role of conviction about religious beliefs. Both religious and secular clinicians' judgments of pathology and prognosis appear to have been influenced less by a client's simple affirmation or denial of religious values than by the conviction with which they were expressed. On the one hand, both clinician groups exhibited a certain tolerance toward their respective polar opposite clients. On the other

hand, they rendered more negative judgments when the client expressed less than convincing endorsement of his beliefs. Future research should examine the impact of client doubt and uncertainty about religious beliefs on clinical judgments and on person perception in general. If authentic religious faith is "the courageous standing of uncertainty" as the Protestant theologian Tillich (1957, p. 16) once argued, then it may indeed be the faithful who are most at risk for negative evaluation.

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