Values and Religious Issues in Psychotherapy and Mental Health

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A decade of work by Bergin and others is reviewed and synthesized concerning two broad issues: (a) the role of values in psychotherapy and (b) the relation of religion to mental health. Trends have changed and there is now more professional support for addressing values issues in treatment. There is also more openness to the healthy potentialities of religious involvement, and therapists themselves manifest a new level of personal interest in such matters. Cautions and guidelines for dealing with such issues are considered in both empirical and clinical terms. The multifactorial nature of religion is documented, and healthy and unhealthy ways of being religious are described. Suggestions are given for including education in values and religious issues in the training of clinicians so that the vast population of religious clientele may be better served.

When I published an article on psychotherapy and religious values 10 years ago (Bergin, 1980a), the reaction was unusual in that I received more than 1,000 comments and requests for reprints. Although a few critics arose (Ellis, 1980; Walls, 1980) and there was not a consensus on specific details, the essential themes received widespread support. Comments by individuals such as Ellen Berscheid, Karl Menninger, Hans Strupp, Robert Sears, Albert Bandura, and Carl Rogers are documented in a previous publication (Bergin, 1985a), but I quote Rogers here as illustrative:

> I don't disagree as much as you might think. . . . I do believe there is some kind of a transcendent organizing influence in the universe which operates in man as well. . . . My present very tentative view [of humans] is that perhaps there is an essential person which persists through time, or even through eternity. (cited in Bergin, 1985a, p. 102)

Encouraged by such observations, I launched into a series of inquiries through the 1980s that addressed two major issues: (a) the role of values in psychotherapy, and (b) the relation of religion to mental health.

Values and Psychotherapy

There is a substantial literature on values and psychotherapy (Beutler, 1979, 1981; Kelly, 1990; Strupp & Hadley, 1977), but no consensus has been reached on which values are essential to the therapeutic enterprise or on how values should be implemented in the treatment context. This is a major problem, and the profession still has not adequately addressed the issues so well outlined by M. B. Smith (1969) more than 20 years ago. The growth of literature devoted to such topics illustrates the strength of interest in these phenomena, but a recent national survey may provide the best evidence that mental health professionals are concerned with values. The survey sampled mental health values of clinical psychologists, clinical social workers, marriage and family therapists, and psychiatrists in the United States (Bergin & Jensen, 1990; Jensen & Bergin, 1988). A total of 200 persons from each profession were contacted and about two thirds of each group replied, except psychiatrists, of whom 40% responded (a typical response for psychiatrists). Profiles of the four samples showed them to be representative of their professional societies.

Table 1 summarizes a set of findings showing that clinicians value certain attributes and attempt to develop them in their clients. Items representative of the 10 value themes in the survey are presented along with the response rates of professionals to the items. A factor analysis showed the first 8 themes (and 55 of 69 items) to weight heavily on a first main factor, which accounted for 28% of the variance and which we labeled *Positive Mental Health.* Responses to these 8 themes were very similar across the four professions. According to these data, therapists endorse certain values as vital to the change process and identify specific traits or behaviors as the desirable ones that characterize mental health.

In the value terms on which there was high consensus, mental health may be described as being a free agent;

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Table 1
Responses by Mental Health Professionals to 10 Value Themes

Theme/sample item	Important for a positive, mentally healthy life-style: Total % agree[a]	Important for a positive, mentally healthy life-style: % agree[b]	Important in guiding and evaluating psychotherapy with all or many clients: % agree
Theme 1 (5 items): Competent perception and expression of feelings	97	87	87
29. Increase sensitivity to others' feelings	98	93	92
39. Be open, genuine, and honest with others	96	86	87
Theme 2 (10 items): Freedom/autonomy/responsibility	96	88	85
7. Assume responsibility for one's actions	100	98	98
5. Increase one's alternatives at a choice point	99	96	96
Theme 3 (9 items): Integration, coping, and work	95	81	81
50. Develop effective strategies to cope with stress	99	97	97
53. Find fulfillment and satisfaction in work	97	86	82
Theme 4 (5 items): Self-awareness/growth	92	74	77
37. Become aware of inner potential and ability to grow	96	89	90
42. Discipline oneself for the sake of growth	82	54	59
Theme 5 (12 items): Human relatedness/interpersonal and family commitment	91	77	73
12. Develop ability to give and receive affection	97	94	95
19. Be committed to family needs and child rearing	90	80	76
Theme 6 (3 items): Self-maintenance/physical fitness	91	78	71
45. Practice habits of physical health	94	77	69
46. Apply self-discipline in use of alcohol, tobacco, and drugs	95	83	75
Theme 7 (6 items): Mature values	84	66	68
56. Have a sense of purpose for living	97	87	85
14. Regulate behavior by applying principles and ideals	96	81	78
Theme 8 (4 items): Forgiveness	85	64	62
60. Forgive others who have inflicted disturbance in oneself	93	77	78
62. Make restitution for one's negative influence	79	54	51
Theme 9 (9 items): Regulated sexual fulfillment	63	51	49
25. Prefer a heterosexual sex relationship	57	43	39
17. Be faithful to one's marriage partner	91	78	70
Theme 10 (6 items): Spirituality/religiosity	49	34	29
69. Seek spiritual understanding of one's place in the universe	68	53	41
67. Actively participate in a religious affiliation	44	28	25

Note. N = 425. The Mentally Healthy Life Style Scale provided for seven possible ratings: *Hi, Med,* and *Lo Agree; Uncertain;* and *Lo, Med,* and *Hi Disagree.* The Guiding and Evaluating Psychotherapy Scale provided for four categories: *Applicable to All, Many, Few,* or *No Clients.* The full scale included 69 items. From "Mental Health Values of Professional Therapists: A National Interdisciplinary Survey" by J. P. Jensen and A. E. Bergin, 1988, *Professional Psychology: Research and Practice, 19,* p. 293. Copyright 1988 by the American Psychological Association. Adapted by permission.

[a] *Hi, Med,* and *Lo.* [b] *Hi* and *Med* only.

having a sense of identity and feelings of worth; being skilled in interpersonal communication, sensitivity, nurturance, and trust; being genuine and honest; having self-control and personal responsibility; being committed in marriage, family, and social relationships; having a capacity to forgive others and oneself; having orienting values and meaningful purposes; having deepened self-awareness and motivation for growth; having adaptive coping strategies for managing stresses and crises; finding fulfillment in work; and practicing good habits of physical health (Jensen & Bergin, 1988, p. 295). To illustrate that divergence from this common core may occur, the survey items clustered under Themes 9 (sexuality) and 10 (spirituality) loaded on Factor 2, which we called *Traditional Morality,* and they did not yield such high consensus. There were differences of opinion within and between professions. These are the same areas in which therapists and clients also differ the most. Because such themes are salient in peoples' values systems, they need to be addressed sensitively and tentatively, as there is insufficient agreement on their mental health implications.

Information on the religious orientations of therapists was also gathered in the survey. The results are summarized in Table 2 along with similar information for

Table 2
Religious Preferences of Professional Groups Versus Public at Large

Variable	Marriage and family therapists	Clinical social workers	Psychiatrists	Clinical psychologists	Professionals (total)	General public[a]
N	118	106	71	119	414	29,216
Religious preference						
Protestant	49	40	30	32	38	57
Nonreligious[b]	15	9	24	31	20	9
Jewish	12	22	14	24	18	2
Catholic	14	20	21	9	15	28
Other	9	10	11	5	8	4
Religious service attendance						
Regular	50	44	32	33	41	40[c]
I try hard to live by my religious beliefs (% agree)[d]	85	83	74	65	77	84[c]
My whole approach to life is based on my religion (% agree)[d]	62	46	39	33	46	72[c]

Note. All numbers are percentages. From "Religiosity of Psychotherapists: A National Survey" by A. E. Bergin and J. P. Jensen, 1990, *Psychotherapy, 27,* p. 5. Copyright 1990 by the Division of Psychotherapy (29), American Psychological Association. Adapted by permission.
[a] Gallup Poll (*Religion in America,* 1985). [b] Nonreligious = Sum of agnostic, atheist, humanist, and none. [c] *N* = 1,500. [d] The Gallup Poll item's wording differed slightly from this.

the public at large. Therapists generally are more religious than would be expected, even though they are not as traditional as the general public. Psychologists are the least religious of the four groups of professionals who were surveyed, but even among them, one third attend religious services regularly.

Professionals thus show an unexpected personal investment in religion. This may be noted in an item listed in Table 2 in which 77% of those surveyed agreed with the statement, "I try hard to live by my religious beliefs," and 46% agreed with the statement, "My whole approach to life is based on my religion." In light of these findings, it was surprising that only 29% of therapists rated religious content as important in treatment with all or many clients (Theme 10, Table 1). This discrepancy probably reflects the fact that such matters have not been incorporated into clinical training as have other modern issues such as gender, ethnicity, and race.

It may be that there is a professional "religiosity gap," as Gallup surveys show that two thirds of the population of the United States consider religion to be important or very important in their lives (*Religion in America,* 1985). Purely secular psychotherapy may be alien to these people's way of thinking, and they may prefer approaches that are sympathetic to spiritual values. It may be this gap that causes people in distress to prefer counsel from clergy to counsel from mental health professionals (Veroff, Kulka, & Douvan, 1981). Perhaps psychologists could respond better to this public need (Bergin, 1988a, 1988b). The possibility for greater empathy with religious clients is suggested by the substantial but professionally unexpressed religiosity that exists among therapists. There is a blend of humanistic philosophy and spirituality that needs a clear formulation. Perhaps this spiritual humanism would add a valuable dimension to the therapeutic repertoire if it were more clearly expressed and overtly translated into practice (Bergin & Jensen, 1990 p. 7).

Values and Practice

Given the resurgent concern over the importance of values in psychotherapy, how can they be ethically and effectively applied in practice? Although some professionals consider it unethical to influence clients in specific value directions, for the majority who do consider it ethical, there are two orienting principles that should guide any planned value intervention. These concern client self-determination and the role of universals.

Therapist values and client self-determination. The professional tradition of isolating one's values from the psychotherapy process is based on the assumption, originally articulated by Freud, that psychotherapy is a technical procedure, like surgery, that does not involve the values or life-style of the treatment agent. It has been demonstrated, however, that values are constantly at play in psychotherapy (Bergin, 1980a; London, 1986; Lowe, 1976; Strupp & Hadley, 1977). The real issue is how to use values to therapeutic advantage without abusing the therapist's power and the client's vulnerability (Frank, 1973; Thompson, 1990).

It is a delicate matter to preserve client autonomy and simultaneously manage the inevitable values issues that arise during treatment. I have commented on this issue at length elsewhere (Bergin, 1985a) and will simply summarize my views here. During treatment, therapists must make important decisions about how to enhance clients' functioning on the basis of professional values that are frequently implicit. At these decision points, therapist, client, and concerned others should collaborate in arriving at the goals toward which change is directed.

It is essential to be explicit about this valuational

process because it always occurs, but often unwittingly. The more open a therapist is about his or her values, the more likely the client will be able to elect responses to the value choices underlying the goals and procedures of treatment. The strategy of trying to be noncommittal or objective does not work because (a) it often amounts to taking a value position in that silence may be viewed as consent for certain actions, and (b) one subtly communicates one's inclinations at critical points essentially involuntarily, as research on Carl Rogers's therapy has shown (Murray, 1956; Truax, 1966). If Carl Rogers, a person known for his nondirective approach, was nevertheless unable to accomplish this objectivity, then it is unlikely that other therapists will succeed. My view is as follows:

> We have to be patient while people struggle with their choices and may have to watch them make bad decisions without interference, but it is irresponsible to fail to inform them of our educated opinions about the alternatives. . . . We need to be honest and open about our views, collaborate with the client in setting goals that fit his or her needs, then step aside and allow the person to exercise autonomy and face consequences. Our expertise should help shape the goals of treatment according to our best judgment of how the disorder can most effectively be modified and how the change can best be maintained. To do less than this is to pretend we do not care about the outcome or to expend effort in behalf of goals we do not value, which is self-defeating. (Bergin, 1985a, p. 107)

In his 1989 APA award address, M. Brewster Smith (1990) lucidly argued a similar thesis with regard to social contexts, such as the politics of APA advocacy.

It is the nature of pathology that clients lose a degree of autonomy because of their symptoms and often become vulnerable and dependent. The therapist's nurturance and control may seem antithetical to autonomy on the surface, but it is unlikely that a client can improve without going through a period of dependence on the therapist. This dependency relationship is natural to good therapy and therapists should not fear it, but to be ethical it must be managed in behalf of the eventual independence of the client.

Emotional conflicts over abortion or sexual practices are examples of the many difficult life issues therapists and clients may discuss during this process. Therapist experience and conviction can be helpful, but wisdom and self-restraint are equally relevant. Some therapists successfully collaborate with clergy or other respected counselors within the client's cultural tradition in such matters.

The therapy process can best be compared with that of good parenting: Trust is established; guided growth is stimulated; values are conveyed in a respectful way; the person being influenced becomes stronger, more assertive, and independent; the person learns ways of clarifying and testing value choices; the influencer decreases dependency nurturance and external advice; and the person experiments with new behaviors and ideas until he or she becomes more mature and autonomous. Therapists should therefore help clients form new cognitive controls that activate their agency and develop it to an optimal level (Bandura, 1986; Rogers, 1961). The therapists's ascendancy is thus temporary and serves the client's growth toward autonomy and full functioning (Bergin, 1985a, pp. 108–109).

Universals versus relativism. As value orientations are incorporated into therapeutic approaches, it is necessary to balance the notions of universalism and relativism. It is honest and fair for therapists to communicate to clients where their judgments lie on this continuum with respect to given values that they think are mentally healthy. It is easy for therapists to be tentative and relative because their scientific education has trained them in such an orientation. It is often harder to convey strong conviction, but often this may be essential to the change process. If a given value is not endorsed with strong conviction, then the client may lose moral courage in the face of crisis situations requiring persistence. Strupp's comment that "major values . . . seem to be universally true regardless of what a therapist's attitude toward a supreme being might be" (cited in Bergin, 1985a, p. 101) makes the point well. Superordinate values, such as a belief that human life is sacred, are like an umbrella over specific cultural traditions. In addition, commitments also must be made to specific, instrumental values to make the practices of life purposeful.

Kitchener (1980) and Maslow (see Goble, 1971) have argued that ethical relativism is inconsistent with the notion that laws regulate human behavior. Campbell (1975) has also suggested that human growth and cultural evolution may be regulated in part by moral principles comparable in exactness with physical or biological laws.

Some writers object to these views because they consider a preoccupation with universals or absolutes to be authoritarian and incompatible with personal freedom.

> This dichotomizing of lawfulness and freedom is, however, oversimplified. Obedience to moral law is, in principle, no different from obedience to physical laws. We are free to launch a space shuttle into orbit only as we precisely obey the natural principles that make it possible. It may be that behavioral laws are just as precise and obedience to them just as essential to obtaining desirable and predictable consequences. The freedom to self-actualize, for example, is predicated on obedience to the laws by which self-actualization is possible. Thus, the thinking that pits conformity to moral law against individual freedom, and then repudiates all favorable references to ethical universals, is inconsistent and misleading. (Bergin, 1985a, p. 111; cf. Bergin, 1980b)

Assuming that ethical universals undergird many of the consensus mental health values identified in our values survey, they can become guiding constructs for clients to use in orienting choices and goals. Cognitive therapists,

in particular, consider goal-oriented constructs to be important ingredients in the way clients construe the world, activate their agentive capacities, and take responsibility for the consequences of their conduct. A belief that lawful principles underlie disturbance and improvement anchors therapeutic techniques in a sense of educated conviction.

For instance, if one attempts to enhance self-control over impulses or addictions, the concept of universals enhances those efforts because one elaborates the idea that self-regulation is valuable and that it will lead to consequences beneficial to the client and others. Endorsing such values and making them explicit helps clients have the courage to face their weaknesses in a more profound way. As Alcoholics Anonymous has shown, commitment can be stronger and more lasting if people feel they are committing to something that is lawful, moral, and transcendent.

Training and education. Although it is not common to train new therapists in value intervention, it would be a useful for them to know how to show their clients the connections between values and mental health consequences. Taking a values orientation also will lead to construing treatment outcomes in the broader sense of modification of a life-style rather than the usual immediate and narrow criterion of symptom relief. For instance, treating eating disorders may be reconstrued in terms of a new way of eating, or a new life-style. Values guide life-styles and life-styles have mental health consequences, just as they have physical health consequences. As clients progress from the immediate need to be relieved of distress, these value and life-style issues can be discussed more freely because the client becomes more capable of making independent judgments. In the later phases of therapy, ego processes become more dominant and clients begin to adapt their behavior to anticipated long-term consequences. Therapy then becomes more educational than clinical and one begins to see how a change in life-style may maintain symptom improvements and prevent future problems.

Religious Values

Although there are difficulties in directly addressing general mental health values in therapy, addressing religious values is even more difficult. An orienting framework for such considerations may be provided by examining three major contributions that a spiritual perspective can make to the therapeutic enterprise. These are a conception of human nature, a moral frame of reference, and specific techniques.

Conception of human nature. Conceptually, the most significant contribution of a spiritual perspective is the view that there is a spiritual reality and that spiritual experiences make a difference in behavior. The spirit of God or divine intelligence can influence the identity, agency, and life-style of human beings. This idea was expressed by Rogers in his statement that "there is some kind of transcendent organizing influence in the universe which operates in man as well" (cited in Bergin, 1985a, p. 102). The Book of Job (32:8) states it as "There is a spirit in man and the inspiration of the almighty giveth them understanding."

This view can be subjected to tests, just as the invisible processes of biology and physics have been subjected to tests. An example of this would be to correlate verbal reports of religious experience with mental health criterion variables. The self-reports gathered in such studies do not provide conclusive evidence, but they do provide a basis for inferring phenomena that are unlikely to be inferred by other theories. The process is not different in principle from that which guided the discovery of genes in biology or atomic particles in physics.

It may be that what is referred to as *spiritual* is related to matter in unexpected ways. Studies of spiritual experiences indicate relations between them and observable behaviors that reflect mental status and life-style (Bergin, Masters, & Richards, 1987; Bergin, Stinchfield, Gaskin, Masters, & Sullivan, 1988). There is also some evidence that spiritual conviction, as manifested in coherent meaning and personal control in one's life, is related to physical health (Antonovsky, 1979; McIntosh & Spilka, 1990). Although we cannot prove that a spiritual theoretical structure is needed to explain the phenomena discovered in various studies, it does address the experiences that many human beings report, and it facilitates the study of related psychologically significant phenomena.

Moral frame of reference. Another contribution of a spiritual perspective is that it provides a moral frame of reference and underscores the notion that therapy is not value free. Professional and personal ethics that guide change are always grounded in ontology, or a way of looking at human nature. Our national survey showed that professionals do seek to orient their work in terms of value judgments about the mental health implications of various behaviors and attitudes. Spiritual values help to root mental health values in terms of universals, and the spiritual perspective makes it easier to establish a moral frame of reference because it views the world in value-laden terms. It also helps therapists feel more confident about helping people activate values that can be used as cognitive guides in their life-styles. At the same time, specific implementation of values needs to be constrained by clinical experience and empirical data wherever possible, to avoid turning the clinical setting into a values free-for-all.

Techniques. Another contribution of a spiritual perspective is a set of techniques (e.g., Collins, 1980). These range from intrapsychic methods such as prayer to family and social system methods. In addition, spiritual factors may be considered in the context of nonspiritual therapies (Lovinger, 1984; Spero, 1985; Stern, 1985).

One illustration of a technique is the *transitional figure* method, the description of which is paraphrased here from a previous article (Bergin, 1988b). In this technique the client is taught to become a transitional person in the history of the family by adopting a redemptive role. First, clients assess their emotional genealogy. They are then encouraged to consider themselves at the crossroads of their family history and to realize that forgiveness rather

than retribution is more likely to engender health than is dwelling on having been the victim of pathologizing events. Although anger toward perpetrators may have a temporary therapeutic role, the notion is that anger is not sufficient. It is emphasized that someone sometime in the history of a pathological family must stop transmitting pain from generation to generation. Instead of seeking retribution, the transitional person absorbs the pain of past conflicts and tries to be forgiving and reconciling with forebears. The therapeutically changed individual thereby becomes transitional by resisting the disordered patterns of the past, exercising an interpersonally healing impact, and transmitting to the new generation a healthier mode of functioning. A number of cases have improved substantially as a result of reconciliation experiences facilitated by adoption of the transitional figure role.

Criticisms

Many criticisms have been addressed to the themes I have outlined here (Seligman, 1988), which I have responded to elsewhere (Bergin, 1988a); but I should reemphasize certain points lest this spiritual orientation be dismissed as a regression to religious dogmatism or primitive supernaturalism. As I view it, the spiritual orientation is empirical, eclectic, and ecumenical. It complements other approaches and does not displace the accumulated empirical knowledge of mental functioning and mental health treatment. It requires an eclectic viewpoint because it endorses the value of various approaches that rest on a substantive base. This view is ecumenical in the sense that it does not dictate theory or practice according to the tenets of any particular denomination or homogeneous philosophy.

Although religious therapists often have a strong interest in value discussions, this can be problematic if it is overemphasized. It would be unethical to trample on the values of clients, and it would be unwise to focus on value issues when other issues may be at the nucleus of the disorder, which is frequently the case in the early stages of treatment. It is vital to be open about values but not coercive, to be a competent professional and not a missionary for a particular belief, and at the same time to be honest enough to recognize how one's value commitments may or may not promote health. It is vital for professionals who approach their work this way to recognize that their own beliefs can distort their perceptions and that immersion in values can sometimes be an escape from the intensity of the therapeutic process. Managing therapist dysfunctions and countertransferences is as important with respect to values as with other content. However, treatment approaches may be enhanced by discerning the real values issues that may underlie disorders but that appear to be simply psychopathological matters (Bergin, 1985b, pp. 1193–1194).

It is important to recognize that many clients are not treated within a congenial values framework because so many clinicians do not understand or sympathize with the cultural content of their clients' religious world views but instead deny their importance and coerce clients into alien values and conceptual frameworks (Bergin, 1983, Lovinger, 1984). Psychologists' understanding and support of cultural diversity has been exemplary with respect to race, gender, and ethnicity, but the profession's tolerance and empathy has not adequately reached the religious client. As the helping professions change to better meet the needs of the public, more tolerance will allow clients and counselors to freely pursue their spiritual values (Bergin, 1988a, 1988b).

Religion and Mental Health

A fundamental issue that has kept religion and the clinical fields in relatively separate compartments is the legitimate concern among clinicians that religiosity can be associated with a variety of mental disorders. Some have argued that religiousness is irrational and equivalent to emotional disturbance (Ellis, 1980; Freud, 1927), whereas others have been more cautious (Argyle & Beit-Hallahmi, 1975; Spilka, Hood, & Gorsuch, 1985) and still others have been more positive (Stark, 1971).

The empirical literature contains numerous conflicting results, so persons with differing biases can select the evidence they prefer. Because of the ambiguities and biases in the extant literature, I did a meta-analysis across 14 studies consisting of 20 data sets that contained both pathology and religiosity measures (Bergin, 1983). Transforming the 20 reported sets of data into correlations, I found a mean Pearson correlation of +.09 between religiosity and better mental health. I also examined 10 additional studies that did not provide enough quantitative detail to be included in the statistical meta-analysis. These showed 2 positive results favoring religion, 8 null results, and no negative results. The ambiguity of previous narrative reviews was confirmed. Overall, there was no correlation between religion and mental illness. This provided little support for those holding to divergent views, but embedded in the findings were some clarifying threads of evidence.

Factoring the Religious Dimension

One finding that most scholars in this area agree on is that religious phenomena are multidimensional. King and Hunt (1975) identified a large number of factors in religiosity. Other analyses of typologies show fewer factors and some focus on only two, essentially "good" and "bad" religiousness. Allport (Allport & Ross, 1967) called them *intrinsic* (good) versus *extrinsic* (bad). William James (1902) referred to the religion of "healthy-mindedness" versus the religion of the "sick soul." These attempts provide a good starting point toward specificity as opposed to global and misleading evaluation of a complex phenomenon. Spilka and Werme (1971) argued that religion may serve as a means of expressing emotional disturbance, as a haven from stress, as a source of stress, as a means of social acceptance and conformity, or as a means of growth and fulfillment.

Healthy and Unhealthy Religion

Results using Allport and Ross's (1967) intrinsic (I) and extrinsic (E) dimensions suggest that there are indeed different kinds of religiosity and that their correlations with independent criteria differ. The extrinsically religious person uses religion as a means of obtaining security or status, whereas the intrinsically religious person internalizes beliefs and lives by them regardless of social pressure. Kahoe (1974) studied college students and found divergent patterns of correlations with the two orientations. Intrinsic scores correlated positively with responsibility, internal locus of control, intrinsic motivational traits, and grade-point average, whereas extrinsic scores correlated positively with dogmatism and authoritarianism but negatively with responsibility, internal control, intrinsic motives, and grade-point average. Such differing findings are typical when religion is thus subdivided, which suggests that conflicting results in many studies may be due to the failure to distinguish discrete subgroups whose scores correlate divergently with the same criterion (Bergin, 1983, p. 179). New refinements in measurement may facilitate making such distinctions (Kirkpatrick, 1989).

To pursue this matter further, Bergin et al. (1987) studied several samples of Mormon students at Brigham Young University. The majority were from psychology classes, but they also studied one group of returned missionaries in a religion class. Thus, both the I and E dimensions and mental health could be examined in a relatively devout population that participated in a variety of religious activities and followed such strictures as chastity and abstinence from alcohol and drugs. Table 3 shows clearly that the intrinsic scores correlate negatively with pathology (manifest anxiety) and positively with a variety of positive traits. Extrinsic scores revealed exactly the opposite pattern, thus supporting the notion that I and E represent differing ways of being religious, and that I is healthier than E. Although individual correlations are modest, the pattern is striking and the differences between the I and E correlations is frequently in the vicinity of .50. It is thus feasible to assume that the overall null relationship between religion and mental illness observed in the earlier meta-analysis represents a sum of negative and positive correlates, thus obscuring the real and divergent nature of religiosity.

In addition to the correlational data, means and standard deviations on the personality measures showed the sample to be average or better compared with standardized norms. Higher than average levels of self-control (Rosenbaum, 1980) were also evident in this group, but this high degree of control was not related to anxiety or other evidence of emotional disturbance, thus contradicting the view that orthodox religiousness results in pathological overcontrol.

The missionary subgroup also showed positive results in a devout group who were living a very disciplined life. Bergin et al. (1987) measured them on the Irrational Beliefs Test (Jones, 1977) based on Ellis's (1989) theory of pathology, and on the Beck Depression Inventory (BDI). The mean BDI score was 3.75, compared with means from other colleges that ranged from 4.70 to 7.28. By comparison, mean scores of clinically depressed groups range from about 16 to 30. The mean scores on the 10 Irrational Beliefs subscales and the total score were generally lower (more rational) than for the normative sample. The Religious Orientation Scale (ROS) scores were high, and this restricted range may have caused a failure to find correlations between them and Irrational Beliefs and the BDI. Checks on social desirability revealed no evidence of "fake good" response sets in our samples. These results provide an acid test and refutation of the theory that devout religiousness is equivalent to emotional disturbance (Ellis, 1989), because this group was both orthodox and healthy.

Bergin et al. (1988) and Bergin et al. (in press) pursued these issues further with a longitudinal study of 60 Mormon college students and found religious and personality development to be intertwined. Different pathways to mental health and pathology occurred. The most common developmental pattern consisted of benevolent child rearing, smooth or continuous religious development, and mild religious experiences. These people were rated by interviewers as conforming to the parental faith without the common adolescent turbulence, and their re-

Table 3
Pearson Correlations of the Religious Orientation Scale With the Manifest Anxiety Scale, Self-Control Schedule, and California Psychological Inventory in Psychology Classes

Personality scale	Intrinsic	Extrinsic
Manifest Anxiety Scale (n = 61)	−.27*	.27*
Self-Control Schedule (n = 33)	.38**	−.19
California Psychological Inventory (n = 78)		
Dominance	.16	−.11
Capacity for status	.13	−.19*
Sociability	.30***	−.21*
Social presence	.07	−.21*
Self-acceptance	.03	−.03
Sense of well-being	.34***	−.24**
Responsibility	.44***	−.23*
Socialization	.24*	−.08
Self-control	.32***	−.13
Tolerance	.35***	−.24*
Good impression	.34***	−.26**
Communality	.03	.04
Achievement by conformance	.34***	−.22*
Achievement by independence	.17	−.23*
Intellectual efficiency	.29***	−.38***
Psychological-mindedness	.17	−.17
Flexibility	.06	−.14
Femininity	.08	.12

Note. From "Religiousness and Mental Health Reconsidered: A Study of an Intrinsically Religious Sample" by A. E. Bergin, K. S. Masters, and P. S. Richards, 1987, *Journal of Counseling Psychology, 34,* p. 18. Copyright 1987 by the American Psychological Association. Adapted by permission.
* $p < .05$. ** $p < .01$. *** $p < .005$.

ported religious feelings were real but not dramatic. Institutionalized religion provided for individuals with this pattern stimuli for growth that reinforced positive aspects of family life and helped them prevent pitfalls. These subjects became normal, resilient adults.

Those whose child rearing was more conflict-laden experienced diverse consequences from religious influence. They were also assessed by the same interviewer coding scheme. Several manifested discontinuities in religious commitment over time that were part of a troubled life in that they became nonpracticing or deviated from norms of the religious subculture. Troubled personal development and troubled religiosity seemed to go together, but a number of these people later found healing in intense religious experiences that compensated for deficiencies in their personalities. They showed significant improvement in mental health due to religious influences. In a few cases, the structure of religious belief and activity provided temporary relief from emotional conflict but did not resolve the deeper problems. The religious involvement seemed to strengthen unadaptive defenses that later gave way, yielding an increase of disturbance (e.g., translating high ideals into a rigid perfectionism that provided temporary relief from anxiety but that ultimately resulted in depression). It became clear that for many individuals religious influences were therapeutic, but for some the religious factor was part of a self-defeating pattern (summarized from Payne, Bergin, Bielema, & Jenkins, in press). These studies thus confirm the work of others in showing that religion is a multidimensional phenomenon with divergent qualities and consequences (Richards, Smith, & Davis, 1989).

Social Psychological Studies

Social psychological studies often concern social conduct as opposed to intrapsychic functioning. Analyses of personality and social functioning separate from mental illness per se show considerable evidence that religious involvement is negatively correlated with problems of social conduct such as sexual permissiveness, teenage pregnancy, suicide, drug abuse, alcohol use, and to some extent, deviant or delinquent acts. There is also a positive association between religiosity and self-esteem, family cohesion, and perceived well-being (Burkett & White, 1974; Cardwell, 1969; Gorsuch & Butler, 1976; Payne et al., in press; Rohrbaugh & Jessor, 1975).

Another empirical trend shows that religious converts are as healthy, or more healthy, than are nonconverts, although the subgroup of sudden converts is often more disturbed than gradual converts or nonconverts (Parker, 1977/1978; Srole, Langer, Michael, Opler, & Rennie, 1962; Stanley, 1965; Williams & Cole, 1968). There are also several studies that indicate that conversion and intense religious experiences can be therapeutic with respect to a variety of symptoms (Bergin et al., in press; Galanter & Buckley, 1978; Galanter, Rabkin, Rabkin, & Deutsch, 1979; Ness & Wintrob, 1980; Womack, 1978).

Lindenthal, Myers, Pepper, and Stern (1970) studied 1,000 persons in the New Haven, Connecticut, area and found that psychiatric evaluations of mental impairment were negatively related to church affiliation and attendance. Similarly, Stark (1971) found that a sample of 100 mentally ill individuals were clearly less religious and less active in a denomination than were a matched group of control subjects who were not mentally ill.

The cumulating sociological studies imply a specific positive effect of religion. Of course, it also is possible that persons who are mentally ill are simply less active in any kind of social affiliation, including religion, and that religion has not affected the rate of disorder. The correlations between various mentally positive behaviors and religiosity could also be due to the fact that religious affiliation is an expression of the mainstream; to the extent that one is a participant in the mainstream culture, one is more likely to be a socialized, functional member of that culture.

Conclusion

In many ways, religion is surprisingly like psychotherapy and the studies thereof. The overall, average effects are generally positive, although not dramatic; harmful effects of some influences detract from the overall outcomes and counterbalance the positive effects of other influences; general positive effects are mediated by principles common to the different approaches, but specific effects of specific procedures produce enhanced outcomes not usually attainable by common factors alone; and, finally, it is often difficult to identify the positive ingredients and their efficacy because of poor measurement, design, sampling, definition, and specificity (Garfield & Bergin, 1986).

As in psychotherapy, some religious influences have a modest impact, whereas another portion seems like the mental equivalent of nuclear energy (Marks, 1978). The more powerful portion can provide transcendent conviction or commitment and is sometimes manifested in dramatic personal healing or transformation. When this kind of experience is also linked with social forces, its effect can be extraordinary. Harnessed for good, this can be constructive, as in the links between religiousness and civil rights; yet spiritual phenomena have an equal potential for destructiveness, as in fundamentalist hate groups. These divergent, yet linked, phenomena are not yet clearly understood.

Nevertheless, there is a spiritual dimension of human experience with which the field of psychology must come to terms more assiduously. If psychologists could understand it better than they do now, they might contribute toward improving both mental and social conditions. In the process, they will have to understand evil much better than they do, for this appears to be a spiritual force as well. Sometimes it appears that evil is clothed in religious language, which makes matters confusing. Religion is multidimensional, and some aspects of what is labeled religion are clearly not constructive.

Despite such difficulties, I am heartened by the existence of a growing clinical literature that provides descriptive evidence of the usefulness of spiritual dimensions in enhancing change (Bradford & Spero, 1990; Lovinger,

1984; Malony, 1988; Propst, 1990; Spero, 1985; Stern, 1985; Worthington, 1989), including a renewed positive interest in religion among psychoanalysts (J. H. Smith & Handelman, 1990). Morris Parloff (personal communication, May 14, 1990), in noting these trends placed them in historical perspective by the following citation:

A little philosophy inclineth men's minds to atheism, but depth in philosophy bringeth men's minds about to religion.

—Francis Bacon

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