“Bias in the Counseling Session: Are Religious Individuals Pathologized?”

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Acknowledgment

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Abstract

This article investigates the comfort level of mental health providers when servicing religious individuals. The current literature suggests that mental health providers (such as counselors and psychologists) are uncomfortable servicing religious persons and fail to embrace religion within the treatment plan due to value-laden biases.

Inherently, failure to embrace religion within the treatment setting can possibly lead to religious persons being pathologized and misdiagnosed by professional counselors. To adequately service the mental health needs of religious persons (and in response to the highly significant beneficial effects of religiosity/spirituality), clinicians should begin to incorporate a patient’s religious and spiritual beliefs into mental health assessments and treatment plans.

General Review

This article was planted as a seed within me on a cold spring night in 1992. I had transported a guest minister of our church to his hotel room. Just prior to getting out of the vehicle after a silent 10-minute ride across town, he turned to me and said, “You will bridge the gap between religion and psychology.” Of course I had no idea what he meant by this, but nevertheless I hung on his words.

While researching another topic in the spring of 2006, I stumbled upon articles related to religious persons being pathologized and misdiagnosed by religious and non-religious counseling professionals. In my years of counseling, I’m sure that subconsciously I have pathologized and misdiagnosed religious persons.

Upon further investigation, I found that religious persons reported that a desire to experience peace, a need to resolve their hurts, legal problems, family issues and personal problems are reasons why they sought out mental health treatment. However, what they were not aware of was the stunning realization that professional mental health counselors
are usually not comfortable discussing religious persons’ symptoms and problems within the framework of religion.

Counselor’s lack of comfort discussing religion within the service plan is a critical clinical treatment issue in that more than over 60 percent of Americans report believing in God, being religious or having religious values. Counselor’s comfort is important to the mental health field to ensure accurate diagnosis, sound treatment planning, fresh research data and professional responsibility. Counselor’s comfort with religious topics is also important because religious themes and ideas help religious persons achieve balance, remain optimistic, persevere through difficult times, hope, remain connected to the larger society, receive support and move forward emotionally (Hintikka, 2001).

**Clinical Values & Treatment Theory**

Clinical values and treatment is a well-documented topic in the current body of literature. Pargament (2002) theorized that from a distance, psychologists have tended to view religion as a global, undifferentiated, stable process that has both positive and negative benefits. The positive benefits of religion are thought to be the ability to promote balance, harmony, wholesomeness, relationship healing and maturity. The negatives associated with religion include its ability to be irrational, illusory, punitive and exploitative. The negative associations regarding religion can encourage mental health practitioners to fail to be value-free. The relationship between religion and counseling has frequently featured antagonism and conflict due to practitioners’ failure to perform value-free therapy.

Religious and non-religious counselors can struggle with remaining value-free and performing quality psychotherapy. Part of the struggle can be attributed to a lack of consensus on values or how they are implemented in treatment (Bergin, 1991). The lack of consensus is a result of psychotherapy not being a technical procedure. Psychotherapy is a value-filled process that helps to enhance the client’s functioning and understanding of the underlying treatment issues. The lack of consensus is also due to religious values in mental health services being difficult to determine due varying moral frames of reference.

On a personal level, Pargament’s theory and Bergin’s assessment resounds within my heart. I (like other counselors) often made it a point to put distance between the counseling process and religious themes and thoughts. Years ago, even as a staff pastor performing counseling within the local church setting, I steered clear of religious themes and ideas. I guess within myself I held to there being a “separation of church and counseling” just as there is a “separation of church and state.” In the last several years, I have corrected my error.

**Counselors’ Treatment Approach**

The literature documents that most counselors have not been trained to recognize and manage value differences in counseling and they fail to recognize the potential impact of their own religious beliefs on the process of counseling (Zinnbauer &
Failure to recognize and manage value differences can lead to counselors acting unethical and as subversive moral agents.

For the most part, counselors do not remain value-free during sessions. A counselor’s values can determine therapeutic techniques, goals, measurement of success and the structure of therapeutic sessions (Zinnbauer & Pargament, 2000). The religious values of mental health practitioners not only affect their own lives, but their religious values also affect their definition of mental health and the role of values in the therapeutic process (Bergin, 1991). To offset the detriment of failing to remain value-free, the successful counselor must remain balanced, honest and fair toward the client (Bergin, 1991).

Remaining balanced, honest and fair toward clients is not an easy task for counselors. I have found that to do so requires me to not only have an open mind, but I must also quiet my own pet-peeves, embrace the experiences and expectations of the client and accept the fact that I do not hold the final authority in the client’s life. The stated revelations are humbling to say the least. As my grandmother often stated: “Humble pie will keep your own humanity in full view.”

Clients’ Conversion To Secular Values

Within American society, counselors are often less involved in traditional religious practices than their clients and they tend to view the inclusion of religious material in counseling as less important than do clients. These differences can cause counselors to attempt to knowingly and unknowingly convert clients to a more secular value system. This is not acceptable and to some degree may cause measures of harm to religious clients. To avoid harming religious clients and to adequately service their mental health needs (and in response to the highly significant beneficial effects of religiosity/spirituality), clinicians should begin to incorporate a client’s religious and spiritual beliefs into mental health assessments and treatment plans (Grabovac & Ganesan, 2003; Coyle, 2001).

My religious training and professional counseling ethics forbid me to proselytize clients. This fact has been hammered into my soul and my approach to treatment for years. However, I do not recall being trained or expected to avoid secularizing the values of clients. It stands to reason that efforts on the part of counselors to include religious and spiritual beliefs into the treatment plan and counseling sessions, helps to avoid secularizing the values of religious clients.

Pathologization of Religious Beliefs & Religious Persons

Many mental health practioners pathologize religious beliefs and practices when they arise during treatment sessions. This is due to their personal view that religious beliefs lack rationale, are not important and are not a necessary aspect of their client’s lives to address in therapy (Myers & Truluck, 1998). Ellis (1992) observed that religiousness is not irrational, nor does it create a disturbance in emotions. It is imperative
that psychologists and counselors do not pathologize or elevate a client’s religious and spiritual beliefs without clear empirical or clinical justification (Zinnbauer & Pargament, 2000). O’Connor and Vandenberg (2005) studied 110 mental health professionals. The participants completed the Pathological Beliefs Questionnaire. The results indicated that the mental health professionals made differential assessments of pathology for religious persons.

As I ponder the above stated theories and studies, it appears that pathologization is the by-product of mental health professionals not viewing religion and religious beliefs as appropriate and necessary during treatment. This leads me to at least consider that such derailment of religious topics can encourage counselors to view client’s religious beliefs and values as some sort of clinical symptoms (instead of as personal beliefs and values) that are then placed by the counselor into an inappropriate DSM-IV classification. In other words, the religious client stands to be misdiagnosed due to religious and non-religious counselor’s beliefs that the exploration of religiosity and a client’s religious life has no place or value in the clinical treatment setting.

What is the solution to pathologizing religious clients? The solution is rather simple. To avoid pathologizing religious clients, psychologists and counselors must respect the clients’ beliefs, learn to be tolerant and refrain from automatically interpreting religiosity as negative (Bergin et al., 1988). In addition, it would be beneficial for mental health counselors to be trained on how to respond to the unique spiritual and religious needs of clients.

**Closing Perspectives**

It is expected and important to religious persons and the mental health field for professional counselors to be value-free and to embrace religion within the treatment plan. We as mental health providers can meet the stated objective by:

1. Affirming that we do not have to pathologize religious persons.
2. Embracing religious beliefs and values in the treatment plan.
3. Remaining balanced and fair when setting goals, measuring treatment outcomes, etc.
4. Participating in focus groups, enrolling in coursework and facilitating training sessions that highlight the pathologization and misdiagnosing of religious persons.
5. Initiating dialogue with our peers and clinical director regarding religious person’s treatment needs.
6. Exploring religious themes when instructing college level students in their coursework, supervising field placements and supervising limited licensure mental health providers.
References


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