Religious Orientation in Marriage and Family Therapy

by

William Keene Carruthers III

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APPROVED:

Joseph W. Maxwell, Ph.D., Chair

Marilyn V. Lichtman, Ed.D.

Howard O. Protinsky, Ph.D.

Laurie Shea, Ph. D.

Michael J. Sporakowski, Ph.D.

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ABSTRACT

The stated purpose of this research project was:

1. to provide a consensus definition of "religious orientation" as the term is currently being used by Marriage and Family therapists familiar with religious families.
2. to identify and prioritize clinicians' perceptions regarding the effects of religious orientation on "Well Family" functioning, both positively and negatively.
3. to develop descriptions of clinicians' perceptions of dimensions of behavior which can be employed beneficially in marriage and family therapy with religiously-oriented families.

In order to address those areas of inquiry, a Delphi methodology was employed, polling marriage and family therapists familiar with Religious Orientation in clinical practice, research and supervisory contexts. This research design is one which is useful in exploratory studies, following the data rather than attempting evaluate a pre-conceived hypothesis. Open-ended questions generated the initial data base which was subsequently refined and clarified through recursive re-evaluation of each suggested characteristic by the participant-panelists. The final profiles included only those characteristics identified as important or very important by at least 80% of the participants when describing the attributes under consideration. This study suggests that Religious Orientation can be a healthy, stabilizing, life-enhancing perspective about which many individuals and families organize their lives and experience. This study has identified and distinguished between many specific characteristics of both healthy and unhealthy Religious Orientation for individuals and families. Assets of Religious Orientation to the therapeutic process and well-family functioning were also specifically identified. The general omission of Religious Orientation from marriage and family therapy training, supervision and research was addressed from historical and epistemological perspectives. Recommendations for inclusion of Religious Orientation as a significant paradigm were offered, as were recommendations for further research.

ACKNOWLEDGEMENTS

Following the ordeal of Comprehensive Exams, an acquaintance asked how I felt. I told him that I was thankful that it was over, and that I did well. He asked, "Thankful to whom?" "God," I replied. He had absolutely no comprehension of the potential of an individual's relationship to God. My relationship to God is truly "the central organizing paradigm" of my life, and I am thankful that it is.

I am also thankful for my wife Jan, who has endured much, with good humor (mostly), and has provided invaluable help and encouragement throughout the project. I love you.

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CHAPTER I

INTRODUCTION: RELIGIOUS ORIENTATION IN MARRIAGE AND FAMILY THERAPY

Purpose of the Study

The purpose of this study was to discover and specify a set of indicators regarding "Religious Orientation" which would be helpful in developing theoretical constructs and practical clinical applications in the field of marriage and family therapy. Specifically, the purpose was:

1. to provide a consensus definition of "religious orientation" as the term is currently being used by Marriage and Family therapists familiar with religious families;
2. to identify and prioritize clinicians' perceptions regarding the effects of religious orientation on "Well Family" functioning, both positively and negatively; and
3. to develop descriptions of clinicians' perceptions of dimensions of behavior which can be employed beneficially in marriage and family therapy with religiously-oriented families.

The Importance of the Study

This study helps to fill a void in the existing literature. Many "well family" studies refer to "spirituality or religious orientation" as an important element for well family functioning, yet researchers have been unable to develop consensus about either definitions or specific aspects of religious orientation that are important to well family functioning. This study specifically addresses the development of a consensus definition and the description of those aspects of religious orientation that are important to well family functioning.

Spirituality or religious orientation are terms that are widely used, rarely defined and generally have been a source of confusion and misunderstanding. This study provides a specific consensually derived definition of religious orientation and descriptions of associated beliefs and behaviors from Clinical members of the American Association for Marriage and Family Therapy (AAMFT). This information will help to clarify the terms employed for further research as the clinical and theoretical domains of marriage and family therapy expand.

There are two other compelling reasons to go forward with the investigation of Religious Orientation in marriage and family therapy: they are intimately related. The first may be described as the ethical imperative of providing the best possible care for the clientele; the second is related to demographics.

Family therapists are mandated by the profession to maintain "high standards of professional competence and integrity" and "to remain abreast of new developments in family therapy knowledge and practice...."(Section 3, Introduction, and 3.4, AAMFT, 1987). These sections of the AAMFT code are cited to support this investigation in light of the demographic data regarding the pervasiveness of a religious orientation on the part of the American population.

The studies cited in the literature review below indicate more than just a "high level of interest" in spirituality or religious orientation by the majority of the U. S. population; they indicate that spirituality/religious orientation is a major organizing paradigm for the lives of those interviewed and for their families. The data of the demographic studies indicate that the pervasiveness of religious orientation crosses ethnic, socioeconomic and geographic markers. To understand the society, the families, or the individuals that compose it, one must be aware of this huge contextual variable. Spirituality and religious orientation are terms almost unknown in the field of marriage and family therapy, but central concepts to millions of American families. The literature review indicates significant inattention toward and general disregard of the area of religious orientation by the field of marriage and family therapy. It is conspicuous in its absence.

Theoretical Framework

This study extends the ongoing expansion of marriage and family therapy research into wider systems and multi-systemic study and will provide a rich source of material for further theory construction and integration. General Systems theory stresses context, constructs, and interrelationship. One of the major tenets of marriage and family therapy is that the "patterns which connect" form the structures of mind and of meaning with which therapists work. These ecologies of mind focus on "fit" and "coherence", terms popularized within marriage and family therapy in the works of Bateson (1979, 1988), Dell (1982), Maturana (1980), and Tomm (1984, 1987).

Cybernetics Theory (Bateson, 1988, and Keeney, 1986) posits that personal beliefs are socially constructed through language and social interactions which are then internalized, through processes of reciprocal interaction between the various elements (both intra-personally and interpersonally.)

These social interactions may be either "real" or imagined, without practical consequence, the result being the reification of a mental construct within an individual or group. That construct becomes part of the mental structure reciprocally refining and redefining views of reality. One of the strongest patterns which connects to define reality in Western Civilization is, and has historically been, the practice of relationship with the divine, regardless of the specific conception of the divine.

Perceptions about and conceptions of human nature are no longer limited to reductionistic mechanistic determinism. Discussions of meta-processes (Bateson, 1988; Wilber, 1982) and values (Bergin, 1988; Herr & Niles, 1988) have entered (re-entered) the domain of therapeutic investigation.

While theorizing remained within the parameters established by Newtonian constraints, investigation into meta-physical topics were, by definition, excluded and therefore deemed irrelevant. Bergin (1988) described a paradigmatic crisis resulting from the human potentials movement and the awareness of the centrality of values in challenging and expanding the theoretical presuppositions of therapy. The logic of Third Force psychology (the centrality of the "Between" and the assumption that the whole may exceed the sum of the parts) can be extended to include larger systems, inter-behavioral dimensions, and meta-physical aspects of human behavior.

As to the clinical utility and the theoretical appropriateness of investigating spirituality in the therapeutic process, Bergin (1988) cited Marks' (1978) study of dramatic behavior change following "religious" experiences:

> When it works, faith healing has a power for surpassing the existing psychotherapy technology. The order of magnitude of this difference is that between nuclear and more conventional explosives. But we have not yet harnessed

> nuclear power satisfactorily and our understanding of faith and religious process is far more primitive than our knowledge of sub-atomic particles. Given a prepared mind, however, some paths into this labyrinth might be laid down
>
> (Marks, 1978, p. 530).

This study will assist those in the field of marriage and family therapy to explore with greater confidence a territory which is currently unmapped by marriage and family therapists by developing parameters and language for the study of Religious Orientation within the context of marriage and family therapy. The task of this study is to begin to lay down some paths into the labyrinth.

In keeping with the research philosophy of "following the data" in order to identify emerging themes rather than pursue a specific hypothesis (Glaser & Strauss, 1967; Glaser, 1978), a more general problem statement or goal for the study has been developed. This study has focused on developing a consensual definition of religious orientation in marriage and family therapy and the description of associated factors regarded as important to individual and family functioning by clinical members of the AAMFT.

The Delphi method itself may be regarded as a method isomorphic with the guiding constructs of General Systems Theory and of Cybernetic systems.

Information was gathered from diverse sources, each of which provided a unique perspective and unique input. The large volume of data was evaluated and re-evaluated by the collective mind, clarifying the proposed constructs though recursive consensual analysis and agreement. The resulting information was then catalogued, classified, and made available to the participants for further consideration.

While the research process itself represents "first order" change, (change within the existing system-framework, that is, the addition of information,) the information generated by this study may affect the theory-building and research process if the system is capable of receiving that input, in order to access a larger-systems perspective.

A "second order" change would involve the re-organization of perception about how the material itself is perceived. If this area of inquiry is pursued and expanded by AAMFT researchers, an awareness of the nature of these patterns which connect meaning, relational structure, purpose, epistemology, and world-view could yield integrative theory construction and powerful intervention strategies.

CHAPTER II

LITERATURE REVIEW

Overview

The review of the literature which follows details several aspects of the current state of the literature regarding religious orientation. The first section describes the nature and extent of religious practice in the U. S. as seen through several statistical surveys. The well-families literature is then reviewed, focusing on the "religious orientation" dimension. Philosophical and historical barriers to the investigation of spiritual matters are then proposed as part of the review. Finally, literature indicating movement toward theoretical and clinical integration is presented.

Demographics and Spirituality

Information relevant to spirituality and religious practice in the U.S., published by the U.S. Bureau of the Census (1991) highlighted several important descriptions. As a percentage of the total population, membership in religious organizations has remained fairly stable over the past decade--68.5 % of the population or 59.3 % of the population depending on type of data reported. The significant fact is that such a large percentage of the U.S. population is involved with religious organizations. Because questions dealing with religious issues are not part of the official U.S. Census questionnaire due to potential conflict in the area of church and state

separation, this information is a composite of a series of private studies for the period described.

A more focused and comprehensive study of religious demographics in the U.S. was commissioned by the Graduate School of the City University of New York. Nationwide telephone interviews were conducted over a 13-month period with 113,000 randomly-selected adults between April 1989 and April 1990. Sampling error was claimed to be less than one percent. The findings have been described as both surprising and valuable (New York Times, 1991). Results of this study indicate that 90.2 % of the U.S. population describes itself as religious. Of that 90.2 %, 7.5 % said that they had no specified religion, 3.7 % described themselves as holding a non-Christian belief, while 86.4 % indicated a Christian affiliation. Twenty-six percent of the latter group were Catholics, and 60.2 % were self-described as affiliated with other Christian groups. Only 2.3 % said that they had no religion at all. The survey demonstrated both the pervasiveness and diversity of American religious experience.

Commenting on the results of the study, Dr. Martin Marty of the University of Chicago said that he considered it "astounding that in a high-tech, highly affluent nation, we have 90 % who identify" themselves as being religious. The study focused on how people identified themselves, not on organizational memberships, attendance patterns or financial contributions (N. Y. Times, April 10, 1991).

The Connecticut Mutual Life report on American values in the 1980's offered interesting parallel data to the CUNY study cited above. Connecticut Mutual conducted an extensive nationwide study to develop information regarding which factors Americans believe "contribute to their feelings about their personal relationships, their work, their religious commitment, life in their communities, and participation or lack of participation in our political system" (Connecticut Mutual Life, 1981). This study investigated a broad range of variables including age, gender, race, educational level, income, occupation, and political orientation.

> In investigating major aspects of American life--community involvement, political and moral beliefs, personal relationships, and work--time and again, systematic analysis led to one factor that consistently and dramatically affects the values and behavior of Americans. This factor is the level of religious commitment. The initial intent of this study was not to prepare a report on the impact of religion on American life, but the pattern of responses was compelling (Connecticut Mutual, 1981, p. 6).

To the original title of the Connecticut Mutual Life report was appended the sub-title The Impact of Belief, due to the pervasive pattern of the impact of religious involvement on all other aspects of American life. In what is a truly astonishing summary statement of their 337-page report, the authors concluded that their study "goes

far beyond finding a simple increase in the influence of organized religion. Rather, it demonstrates that the level of religious commitment of Americans provides the key to understanding their values and behavior" (Connecticut Mutual, 1981, p. 40).

Survey data from Gallup and others confirm these patterns and shed further light on the importance and impact of religious belief in the U. S. In 1980, over 95 % of respondents indicated a belief in God, 89 % prayed, and 59 % attached a high level of importance to religious belief (Gallup & Poling, 1980). Pattison (1982) asserted that "religion is not merely an epiphenomenon of family belief, but is an intrinsic part of the structure, order, and dynamic of family life and function" (Pattison, 1982, p. 158). Despite the prevalence of the belief that personal spirituality is of great importance, research into this area by marriage and family therapists is only beginning.

In the realm of theorizing, marriage and family therapy as a discipline may have been guilty of what Bateson termed "chopping up the ecology", in setting aside a significant dimension of understanding by discounting that which is called "spiritual," (Bateson, 1979, 1988) due to an inherited epistemological hubris. (Why this may be so is presented in a later section.) For many individuals and families it is precisely the dimension of spirituality which is employed to make sense of the world, and from which they derive a sense of meaning in their lives. This dimension may have as great an impact on an individual or family as any other demographic or descriptive factor.

Religious Orientation and Well Families

A review of the "well families" literature reveals some interesting patterns. In the field of marriage and family therapy, research into well families is conspicuously under-represented. While research in this area has been slow, several key elements and themes have emerged.

Results of much early work were summarized as lists of well family characteristics. Herbert Otto's work (1962, 1963) presented 14 characteristics which focused on relationships, roles and role performance, life cycle stages and transitions, and family relationships in the larger community. In the context of this investigation, it should be noted that healthy families were able to "provide for the physical, emotional and spiritual needs of their members" (Ponzetti & Long. 1989).

Many researchers (Lewis & Looney, 1983; Otto, 1962, 1963; Stinnett & Sauer, 1977) have followed primarily the Parsonian structural or structural-functionalist models in their exploration of family strengths:

> A family ought to raise children who become autonomous, and it should provide sufficient emotional support for stabilizing the parents' personalities and continuing their emotional maturation. To the extent that it accomplishes these tasks, it can be considered competent; to the extent it fails at one or

both tasks, it can be considered less competent or dysfunctional (Lewis & Looney, 1983).

The early family strengths studies, exemplified by Stinnett and associates (Stinnett, 1979; Stinnett & Sauer, 1977, and Stinnett, Sanders, DeFrain & Parkhurst, 1982) brought forth basic theoretical constructs and characteristics. Despite being methodologically flawed through sampling problems due to cultural homogeneity, limited size and limited geography, these studies provided a starting point for further research. Characteristics of clear communication, mutual appreciation, time spent together, problem-solving ability, mutual commitment and a shared religious orientation were proposed as central to well family functioning. A nationwide study of strong families (Stinnett, et. al., 1982), supported previous results. The four most important characteristics of family strengths were reported as love, religion, respect, and communication.

Studies of successful black families have yielded results which closely parallel those cited above. Central to the well-being of the successful black families studied were characteristics of "strong religious convictions and behaviors" (Billingsley, 1968), strong religious orientation (Hill, 1972), and stability resulting from religious involvement (Scanzoni, 1971). While acknowledging small sample size, Lewis and Looney reported: "a striking difference between the most and least competent families is the role that religion plays in family life....Religious beliefs and activities were at the core of family life for the most competent families and appeared

less important to the least competent families" (Lewis & Looney, 1983, p. 107).

Other well family researchers generally confirm and complement this list of characteristics. The following briefly notes researchers referencing the positive impact of spirituality/religious orientation as severally described. Beavers' (1977) and Billingsleys' (1968) focus in this area describes a set of transcendent values with accompanying behaviors which are consistent with those values. Specifically, "religious" convictions or a "shared religious core" or a "strong religious orientation" are identified as important by Billingsley, (1968) Curran, (1986) and Hill, (1971).

An intrinsic religious faith (Allport, 1950) is described by Schuum (1986), and others (Otto, 1975; Scanzoni, 1971) as being important in the promotion of other positive aspects of family functioning. Family togetherness, communication, appreciation, shared goals, purpose and perspective, flexibility and adaptability in crisis and life transitions are seen to be enhanced through this dimension. Community involvement of the family (and the individuals within that unit) is also enhanced through the presence of positive role models, informal support groups and shared values.

In his discussion of family structure and stress, Lewis (1986) described the reciprocal nature of beliefs about the environment's characteristics and the capacity of families to positively interact with the larger environment. Perceptions of experience over time are reciprocally refined, precipitating beliefs about the environment,

human nature and our place in the universe. Is the world a safe place? Are people essentially good? To what extent is interpersonal disclosure to be preferred over privacy? Why? Reiss (1981), Lewis (1986) and associates (Lewis, Beavers & Gossett, 1976) suggested that perceptions arising from questions such as these influence the development of family norms and the transgenerational transmission of those norms. While these structures of beliefs and values are pervasive and generally shared through processes outside the individual's awareness, they provide a key axis about which life experience is organized.

Walter Schumm (1985), lamenting the relative inattention to theoretical development in the well families literature, proposed a "mid-range" theory, a starting point for discussion, suggesting relationships between several identified key well family factors. This theory posits religious orientation as central to the well being of the families studied. Schumm acknowledges that this framework, being based on analysis of previous studies, may reflect artifacts of sampling deficiencies of the constituent studies.

Worthington's (1989) extensive discussion of faith across the life span describes the parallels of religious orientation with the cognitive, psychosocial and moral developmental theories of Piaget, Erickson and Kohlberg. Throughout the life cycle people engage issues which have great existential importance. Object permanence, identity formation, sexuality, gender issues, mate selection, marriage, child rearing, personal productivity, power and worth, aging, death

and subjective life-meaning all can have profoundly religious and spiritual dimensions which are shared in the family context.

Not only are beliefs and values important, but the focus of those shared values and beliefs are transcendental in nature, exemplified in healthy families by a "sense of relatedness in time and space with their past and future family history and the larger world. They are not in conflict with their external environs but feel a kinship to the rhythm of the cosmic universe They believe they matter and have a deep and abiding sense of meaning and purpose in their lives" (Kaslow, 1982). Individuals and families who view themselves in this context of relationships to a larger reality employ this perspective in the service of making sense of events in both personal and family history (Beavers, 1981; Stinnett & DeFrain, 1989).

One of the most surprising findings of a literature review in the area of well families is the realization that this is an area which has been largely overlooked. The primary research focus has been on pathology and theoretical functionalism in its various forms. A review of available well families literature suggest that, concepts and discussions relating to spirituality, while not prominent, were often present and held by many to be important, even crucial.

Barriers to the Investigation of Religious Orientation

Given the strength of the preceding, one must ask why marriage and family therapy, as a field, has not investigated this area more thoroughly. No studies have been located which

specifically address philosophical or epistemological questions regarding the investigation of religious orientation in marriage and family therapy, though some allude to difficulties in terminology or interpretation. There are, no doubt, many possible explanations, some of which are suggested here. The following brief discussion suggests several factors which may have combined to form an effective barrier against the investigation of spirituality/religious orientation by those interested in psychology generally and marriage and family therapy specifically.

Freud

One of the primary elements of the historical animosity between psychology and religion is the life-long atheism of Sigmund Freud. His principal writings on the topic of religion focused on the origins of religion as psychological phenomena viewed through his own psychoanalytic lens.

Totem and Taboo (1913), Freud's psychoanalytical fantasy of psycho-archaeology, is set in the realm of historical anthropology. It is a collection of four essays in which Freud imaginatively explores possible origins of primitive religion. Wish fulfillment and desires for omnipotence were themes commonly addressed, as were those of sexual taboo and intra-personal ambivalence. It was the linkage of totem-clan religion and sexual taboo/ambivalence which Freud proposed as the origin of modern religious thought.

Through what is admittedly a fanciful reasoning process, Freud arrived at the conclusion that the societally and individually inflicted

Oedipal guilt enables the development of civilization and the creation of a god from a father. It is this father-god which was passed from generation to generation and against which Freud so vehemently fought.

In The Future of an Illusion, Freud placed religion in the context of the broader cultures which, he asserted, existed to counter the hostile environment. The inevitability of death, suffering and disease was the backdrop of his treatise: "Religious conceptions originated in the same need as all other achievements of culture, from the necessity of defending oneself against the crushing superiority of nature" (Gay, 1988, p. 530). Religion, asserted Freud, is the neurosis of humanity, both corporately and individually. Like neurosis, religion is a human attempt to solve difficult problems, though in a way which is, itself, problematic. Guilt and fear are assuaged, but at what cost? Insight, he believed, would cure neurosis and science would eliminate the need for religion (Gay, 1988; Humphries, 1982; Westendorp, 1975).

Moses and Monotheism, a collection of four essays written between 1934 and 1938, traces Freud's fascination with the person of Moses and his significance to the people of Judaism, and by extension, to other religious groups as well. Drawing from Voltaire, historians Edward Meyer and Max Weber, in addition to German radical criticism theologians, Freud developed a theory that Moses was not a Jew, but an Egyptian noble. Briefly, it was this Moses who led the Israelites into a monotheistic belief, but during the Exodus,

rebellion re-instituted polytheism and Moses was murdered. A second Moses attained leadership due to the guilt of the people for the murder of their primal father figure and Yahweh worship was institutionalized and later extended into Christianity (Gay, 1988; Philip, 1974).

This radical re-construction of the Biblical narrative allowed Freud to superimpose his own framework from Totem and Taboo upon the account, and by so doing, place Judaism and its descendants within the realm of psychoanalytic explanation. It was this, the subjugation of religion to science, which was his goal.

It was Freud's desire to free humanity of the "universal obsessional neurosis" of religious belief through the advancement of scientific secularism:

> The scientific spirit generates a certain posture toward matters of this world; before matters of religion it stops for a while, hesitates, at last there too crosses the threshold. In this process there is no stopping; the more the treasures of our knowledge become accessible to people the more defection from religious belief will spread, at first only from its obsolete offensive vestments, but then from its fundamental presuppositions as well.
>
> (Freud, The Future of Illusion, 1927, p.38)

Interestingly, Freud may have seen himself as another Moses of sorts, leading the people to the frontiers of the new Promised Land.

The new religion is science, and psychoanalysis, its chief priest. As prophet, Freud claimed objectivity for psychoanalysis and defined it as science.

Freud believed that unless his work was regarded as scientific it would be undervalued. While consciously clinging to orthodox science, his own methods and theories did not accord well with its spirit: "Science became Freud's faith and psychoanalysis his sect. Whatever illusion other men might or might not possess, his illusion was science" (Philp, 1974, p. 129). Not surprisingly, psychoanalytic theory was employed as a framework for criticism of Freud's discussions of religion. Biographers point to Freud's life-long fascination with religion and his own determined atheism as the source of his desire to supplant religious faith with faith in science.

The neurotic illusion has its origins in human wish-fulfillment. Thomas Szasz (1978) boldly asserted that there is nothing scientific about Freud's hostility toward, and opposition to, religion, but that it is a manifestation of the analyst's own wish-fulfillment fantasies.

Cartesian Dualisms

Perhaps the most celebrated of Freud's contributions to our understanding of human psychology was the fundamental recognition of unconscious processes. Through his emphasis on the power of the non-conscious, Freud's theory paralleled one of the basic historical scientific paradigms of his day, that of dualistic description.

The seventeenth century French philosopher Rene Descartes offered the formulation of an influential perspective employed by "science" to order and interpret the cosmos. He suggested that the essential unity of the human being could be divided into "mind" and "matter", into transcendent and material.

Science, generally, and medicine, specifically, embraced this philosophy which promoted an atomistic approach to knowledge. The inevitable result was a mechanistic science which succeeded very well in its description of physical phenomena in a linear, causal modality. Thomas Silber (1983) noted that this perceptual orientation brought with it the inevitable consequence of medical specialization focusing only on the body, its parts, its defense mechanisms and medical interventions, while excluding other factors important to health. Dissatisfaction with this perspective of medical practice has given rise to a different, holistic approach to healing. This ecological medicine will be discussed in a later section of this review.

Gregory Bateson (1987) described the impact of the Cartesian mind/matter split as providing the basis for a host of modern superstitions as "monstrous as itself." Dichotomies of mind/body, intellect/affect, will/temptation, object/subject, fact/value, and knower/known are all the direct descendants of Descartes' dualisms. Once separated, the dissociated part, or parts, could be effectively ignored or dismissed as irrelevant or impossible to quantify, (given the current state of technology in "science.") The materialistic,

empirical emphasis excluded pattern, contrast and gestalt as the focus of interest or investigation.

> The world of Cartesian coordinates relies on continuously varying quantities, and while such analogic concepts have their place in descriptions of mental process, the emphasis on quantity distracted men's minds from the perception that contrast and ratio and shape are the base of mentality. Pythagoras and Plato knew that pattern was fundamental to all mind and ideation. But this wisdom was thrust away and lost in the mists of the supposedly indescribable mystery called "mind" (Bateson, 1987, p. 60).

This division of mind and brain was the focus of conflict and evolution in the study of human nature.

Lucas (1985) chronicled the philosophic evolution of science during this period as a clash of titans. Mechanists sought the extension of the ideas and methods of Newtonian physics (and other hard science) into the realm of psychology. From this perspective, humans were nothing other than one of many creatures, which had emerged from the primordial ooze, and gone its own peculiar way. As such, any human process, including self-reflexive sentience, was reducible to basic physiological/chemical processes. These basic processes were believed to be the exclusive domain of reductionistic science.

Integration

Philosophical/Theoretical Integration

Philosophical problems with scientific mechanical reductionism began to surface as the new physics emerged. The basic assumptions of an external, knowable, self-existent reality came into question with the rise of assertions by eminent physicists (Bohr, Heisenberg, Einstein) that matter was essentially not physical but a set of relationships governed by probability, not linearity (Hawking, 1988; Lucas, 1985). The change from Newtonian predictability and certainty to the Uncertainty Principle of the new physics, where direct observation and observation without influence were impossible, brought forth a diametrically new perspective. This change was characterized by an awareness of the validity of subjective experience in scientific inquiry, in fact, an awareness that all experience or observation is observer-dependent (Hawking, 1988; Lucas, 1985). The strict mechanistic behaviorism of Pavlov and Skinner which centered in physiological/physiochemical processes with only minimal reference to subjective, conscious input, grudgingly gave way to Popper's mind-body interactionism in the mid-1960's (Ackerman, 1976). Freudian determinism was also supplanted by the "Third Force" psychology of Allport, Maslow, and Rogers (Bergin, 1988; Goble, 1970).

The "Mentalist" perspective emerged from the perception that there was an agency of mind which not only interacted with the body but actually dominated brain physiology in many instances.

This change in perspective radically re-oriented the study of human nature and action, overthrowing behaviorism and elevating the cognitive-mentalist paradigm to ascendency and acceptability. Sperry (1988) noted that this change brought with it an opening up of psychological investigation "in which the traditionally rejected subjective mental qualities of inner experience were conceived to play an active, causal role in conscious behavior and evolution" (Sperry, 1988, p. 607).

Part of this reappraisal of the domain of science includes a reappraisal of the conceptualization of human nature and experience. One of the central theoretical premises of this reappraisal is the assumption that psycho-behavioral processes are multi-systemic in nature. The human body is a unified whole, whose various sub-systems obey discrete sets of physical laws, be they chemical, structural, hydraulic or electrical. While no single part fully represents a human being, the sum of the parts allows the human to be, and the total is greater than the sum of the parts. It is precisely this "greater than" aspect of humanity that is to be addressed here. This is part of the theoretical and clinical expansion of marriage and family therapy in the consideration of larger systems with a view toward better and more comprehensive therapy.

Clinical Integration

Attitudes toward spirituality by those in the psychotherapeutic community have ranged from broad acceptance to absolute dismissal. Several attempts have been made toward the integration of

perspectives termed sacred and secular (Gordon, 1990; Percy, 1989). Others have offered alternative explanations for what has been described as spiritual, either through linguistic expansion of the domain of the definition of "spiritual" (Elkins, Hedstrom, Hughes, Leaf & Sanders, 1988) or through theorizing at the macro consciousness level (Bateson, 1987; Wilber, 1982).

Impetus toward integration has come from the arenas of the theoretical and of the pragmatic. Clinically, support for including a spiritual focus comes from many sources. The integrational character of holistic medicine offers a powerful model. Physicians operating from this perspective differ radically from the strict mechanistic approach that has characterized much of modern medicine.

James Gordon, MD (1990) well summarized this perspective on medical practice:

> Holistic medicine is concerned with the economic, social and ecological context in which health is promoted or illness precipitated and with the environment in which therapeutic interaction takes place....It includes an altered view of the meaning of each person's illness, a change in the structure of the physician-patient relationship, a wider conception of what might be potentially therapeutic, and a faith dimension, the spiritual, which enlarges and encompasses the domain of the biopsychosocial and redefines the nature and purpose of treatment (Gordon, 1990, p.358).

This ecological perspective both requires and allows the therapist to respectfully explore even previously excluded dimensions of spirituality with the people with whom they work. What information can be gathered from clinical reports?

Perhaps the most widely known clinical resources focusing on spirituality are the many 12-step programs based on the Alcoholics Anonymous model. Acknowledging personal helplessness and developing faith in a "higher power" than one's self are the cornerstones of the 12-step process of recovery (Alcoholics Anonymous, 1974). The framework of such programs involves a "spiritual" perspective toward oneself, toward relationships with others and toward the universe. Recovery is viewed primarily as a spiritual process (Corrington, 1989; Prezioso, 1987), and exploration of spirituality can be an effective diagnostic tool (Knox, 1986).

Not surprisingly, strong support for the importance of a spiritual dimension of treatment comes from Geriatric and Hospice literature. The essential questions of life-meaning, purpose, satisfaction, harmony, contentment and peace are brought into sharp focus as one faces the imminence of death. In confronting these issues, Brooke (1987) asserted that the spiritual dimension of a person allows for the integration of all aspects of being into a unified whole. This essential harmony grounded in spirituality was confirmed by Hungelmann (Hungelmann, Kenkel-Rossi, Klassen & Stollenwerk, 1985) in a study of 65-85 year old persons.

A National Hospice study of 1745 individuals was conducted in 1983 to determine which factors most strongly influenced the well-being of terminally ill patients. The most commonly mentioned source of support was the presence of friends; the second factor was religion (Greer & Mor, 1983).

Some therapists and researchers (Anderson, 1987; Griffith, 1986; Nunn, 1964; Pollner, 1989) have asserted that the person of God is, for many families, a central and crucial family member whose influence in the family is far reaching. From birth to death, across multiple generations, through life cycle tribulations and personal and familial tragedies and triumphs, God is there. The Person of God, not only a set of shared beliefs about transcendent experience, is often the focus of family norms, values, traditions, beliefs and meaning in life.

To ignore the impact of such a powerful family member for whatever reason parallels the alcoholic families' denial of the elephant in the living room. To ignore the Presence is to deny a central fact and focus of many families' world views, and excludes a huge range of therapeutic metaphors and interventions (Prest & Keller, 1990).

James Griffith (1986) suggested the exploration of relationships with God and various family members as both a diagnostic and therapeutic tool. He asserted that God, as family member, offers many positive attributes to the family system and many opportunities to the therapist in the process of change. In this frame,

Griffith placed God in the role of a wise elder in the family system, one who is individually accessible to each member and about whom a family myth and history is established and celebrated (Griffith, 1986). Melvin Pollaner (1989) concluded that there are significant positive effects of relationships (real or imagined) with a divine other. These benefits include: an increased sense of order and coherence in the universe, an increased capacity for and frequency of introspection, a positive mechanism for coping with guilt, and a sense of personal empowerment.

Pastoral Counseling as Integration

Any review of literature exploring the relationship of mental and spiritual processes should include an overview of the area of Pastoral Counseling. First, it should be noted that Pastoral counseling has its roots in the Judaeo-Christian tradition of the care of souls. It has been, until this century, primarily concerned with the spiritual direction of individuals in their pursuit of the sacred. This enterprise has been carried out historically by pastors and rabbis whose task it was to guide those in their care according to scriptural principles of spiritual health and psychological well-being (Clinebell, 1984).

Within the pastoral context, many have pursued specific training in counseling and/or psychotherapy as an expression of call, ministry or service. These persons received training from virtually every type or school of psychotherapeutic enterprise. Rather than attempt a full description of the various schools by sub-phylum and species, a brief discussion of some of the major schools is here

presented, followed by a discussion of pastoral counseling distinctives.

Clinical Pastoral Education, (C. P. E.), provides an internship-based chaplaincy program at selected, accredited sites, through which the participant experiences intense group interaction and opportunity for introspection. These sites are often affiliated with medical or psychiatric hospitals. Each group is independent and develops its own character and close supervision is maintained (Meier, et. al., 1982). CPE is an educational process which introduces the developing minister to the interactional spheres of theological, psychological and medical models of healing.

A second approach is characterized by generally Conservative Evangelical pastors and teachers. Focusing on the application of Biblical principles for daily living, Charles Swindoll and James Dobson have become widely known through daily or weekly radio broadcasts and book publications. Bill Gothard has developed the "Institute of Basic Youth Conflicts" as regional, annual events nationwide, filling large auditoriums and civic centers for 5-day intensive workshops, stressing conservative Biblical solutions to developmental, relationship and family problems.

The third major grouping of pastoral counselors advocates an integration of spiritual and psychological principles. Jay Adams (1970, 1983), Gary Collins (1986), Larry Crabb (1977), Clyde Narramore (1960), and Henri Nouwen (1979) offer several

perspectives for the integration of Biblical and psychological principles under the aegis that "all truth is God's truth."

Pastoral counseling is in a state of flux, and is in the midst of an identity crisis of sorts. Bergin (1990) suggested that as the lines between secular and sacred blur, in the area of mental health there is the tendency for both the psychotherapist and the pastoral counselor to become what he calls "secular priests." Bergin followed Power (1990) who asserted that the focus of pastoral counseling should be on the spiritual, as that dimension affects all other areas of life. The field, he and others asserted (Bollinger, 1985; Clinebell, 1984), should be defined by problems that may be broadly described as religious. Power went on to say that

> like any kind of counseling, pastoral counseling is meant to help individuals to work through crises. Yet pastoral counseling, if it is to be distinctive, must focus on the ultimate questions that life crises raise. Pastoral counseling, in the strict sense, goes beyond concern for mental health to a concern for the Kingdom of God. (Power, 1990, p. 85).

The unique character of pastoral counseling is its specifically religious/spiritual focus. Religious resources such as scripture, prayer, ritual, ceremony, may all be appropriately employed, but the focus is generally on the meaning of life events in the context of the spiritual (Bollinger, 1985).

Summary

As outgoing editor of the Journal of Marital and Family Therapy (JMFT, Oct. 1990), Douglas Sprenkle reviewed the major trends of the 1980's and suggested future trends of the 1990's. Among those prognostications, Sprinkle put forth a call for studies in areas which he said are currently under-represented in the field. Included in that listing is the need for study in the area of the relationship of marriage and family therapy to religion.

In July of 1990 a conference focusing on "well family" functioning was conducted in Washington, DC by leading researchers in the field (Stephen Bayme, Robert Beavers, Urie Bronfenbrenner, John DeFrain, Lawrence Gary, Robert George, Harriet Pipes McAdoo, David Olson, Margaret Owen, Walter Schumm, Nick Stinnett, William Vega & Froma Walsh). Nine characteristics of healthy family functioning emerged, eight of which these experts were able to clearly define and describe. The ninth, "religious/spiritual orientation" was included because "many of the researchers describe religiosity or spirituality as a characteristic of healthy families", despite being unable to reach consensus regarding the functioning or definition of these terms in this context (Krystan, Moore & Zill, 1990, p. 9).

The growing interest and discussion within and across many disciplines in processes called "spiritual" suggest the possibility of an impending paradigm shift. While information is still scattered and

compartmentalized, there is a growing interest in multidisciplinary integration of all aspects of human systems.

No one discipline can claim absolute knowledge about the complexities of human behavior. Each provides a portal, a perspective, a philosophical orientation. Our most accurate information and our most complete conceptions arise from the integration of information from different perspectives, focusing on fit, coherence and consistency.

Human behavior is influenced by a huge number of factors, each being part of its own context. Physical, social, historical, ethnic background, gender, intelligence, education and spiritual orientation are a few of the contextual variables which have been identified by research in the field of marriage and family therapy or well family research. The adoption of a multi-systemic frame of reference has provided the field of marriage and family therapy the opportunity for expansion of description, theorizing and understanding concerning human psycho-behavioral life.

An extremely rich source of therapeutic metaphor and cultural support becomes available to those who are willing to explore spiritual orientation with their clients (Prest and Keller, 1991). Demographics, training, and ethical issues challenge the therapist to examine his/her own fundamental assumptions about the realm of the spiritual. In the Family Therapy Networker's special issue on Psychotherapy and spirituality, Butler cited data indicating that less than 5% of marriage and family therapists have formal training

regarding working with religious issues, while over 40% of the US population attend religious services regularly, and over 60% report that spirituality is important to them (Butler, 1990). Further, 68% of marriage and family therapists and other practitioners in the field of psychology express personal interest in spiritual context and pursuits.

An emerging interest in the field of marriage and family therapy involves the work of a variety of poets, philosophers and historians of whom Joseph Campbell and Robert Bly are examples. Their work is integrative in character and explores areas of Archetype, Deep Image, Myth and Parable in the context of what might be termed sociological psychology. Some have called this human spirituality, others religious orientation.

Multi-systemic or "Larger systems" thinking, demographics, ethics, professional responsibility and therapeutic curiosity, can each focus our attention toward the region of human experience known as religious orientation. Those in the field of marriage and family therapy are in a position to venture into this previously taboo region, to go exploring and to begin mapping the territory.

CHAPTER III

METHODOLOGY

Overview of Chapter Organization

The general description of the Delphi technique is developed in terms of a brief history and rationale for the application of the method, a critique of the method, a description of panelist criteria, sample selection, and a demographic profile. Descriptions of the adjustments which were made to the method as the study progressed are included.

The Appendices referenced in this section include: Goals for each sequential questionnaire round, cover letters, questionnaire forms, response tables, and a flow chart, which demonstrates the progression of the Delphi method over the course of this study.

General Description of the Method

The Delphi technique was developed by the RAND corporation as a systematic method for generating consensus perspectives from a group of experts on specific topics. The method has demonstrated its flexibility and utility, having been successfully employed across a broad spectrum of contexts. Business and defense forecasting (Dalkey, 1967), studies for defining research priorities in nursing (American Nurses' Association for Nursing Research, 1980), parameters of normal grief (Demi & Miles, 1987), best strategies for beginning and maintaining an independent practice in professional psychology (Walfish and Coovert, 1989), and defining distinctions between structural and strategic family therapies (Fish & Piercy,

1987) are among the hundreds of topics which have been investigated using the Delphi procedure.

The principle that "N heads are better than one" (Dalkey, 1972) lies at the heart of the Delphi technique. Norman Dalkey (1972) as primary developer of the method, investigated group decision-making and communication processes in order to refine a technique which would take advantage of the "N-heads" principle while eliminating some of the negative aspects of group decision-making processes. These negatives are described by Preble as being "slow, expensive, dominated by one or a few individuals, high on group pressure, lacking in accountability and overburdened with redundant or irrelevant information" (Preble, 1983, p. 76).

The Delphi method enables researchers to elicit and categorize information provided by a group of experts focusing on a specific area of inquiry. These experts are recruited to participate in a multiple wave questionnaire process over a specified time period, by which topics are explored, data are gathered and feedback provided to participants.

Rationale for Use of Delphi Technique

Linstone and Turoff (1975) suggested the following criteria as indicators that the Delphi is an appropriate technique for investigation when:

1. the topic is broad and complex, and the participants have had no history of significant communication about the problem to be addressed.

2. the collaborative judgments of experts would be beneficial to further exploration of the topic.

3. the problem at hand is not viewed as amenable to empirical analysis.

4. face to face meetings of participants are not feasible.

These reasons reflect the choice of the Delphi method for this study. The Delphi is well suited to the exploratory nature of this investigation.

Participants/Sample

General Description

Within the Delphi technique, participant/panelists are to be "experts" in their field as defined by the researcher's criteria. Education, clinical experience, publication history, teaching and, professional stature are considered when evaluating each candidate. A nomination procedure is also frequently employed to identify individuals as appropriate participants. Other desirable characteristics include strong participant motivation, personal involvement in the area under consideration and well developed skills in written communication.

No minimum number of participants was explicitly specified by Dalkey (1972) or Linstone and Turoff (1975). Dalkey's 1972 experimental data used in the development of the Delphi procedure ranged from n=3 to a maximum of n=29. A review of studies employing the Delphi suggested a broad range of applications with

initial samples ranging from 8 members (Lundberg &Glassman, 1983) to 334 members (Daniel and Weikel, 1983).

Samples of larger initial group size (Carpenter, 1985; Daniel & Weikel, 1983; Van deVen & Delbecq, 1974) tended to have lower response rates generally; some authors offered explanations of extenuating circumstances and/or poor initial questionnaire design (Daniel & Weikel, 1983) Many studies (Coovert & Walfish, 1989; Demi & Miles, 1987; Fish & Piercy, 1987; Jurth-Schai, 1988; Lechowicz & Gazda, 1975; Prochaska & Norcross, 1982; Spitzer, 1975) were conducted with between 25 and 50 participants. Some were conducted with fewer than 25 (Dalkey, 1972; Lundberg & Glassman, 1983; Spinelli, 1983). Sample size varies according to the goals of the study and specificity of the expertise desired. In exploratory studies, the "N-heads" rule suggests that larger samples are preferred over very small (5-10) ones, although even small samples can generate large amounts of high quality information.

Selection of Participants for this study

Participants for the present study were selected on the basis of their AAMFT credentials and familiarity with the subject area. "Expert" status is evidenced by the participant's AAMFT Clinical membership, professional position, conference presentations, authorship of articles in professional journals, and/or nomination by those who fit the criteria for this study.

The Washington headquarters of the American Association for Marriage and Family Therapy was contacted but was unable to

provide a method of identifying members who deal specifically with families of religious orientation or of members who have specific interest in religious matters.

The following procedure for identifying and recruiting panelists was employed:

1. Several authors who were identified in the literature review process as appropriate panelists were contacted directly by telephone, recruited for the study and asked to nominate other potential participants.

2. Some of this author's personal acquaintances who fit the study criteria were also contacted, invited to participate and asked for nominations.

3. Nominees were then contacted, the study explained, credentials confirmed and questions answered. They were also asked to nominate additional potentially appropriate panelists.

Potential panelists were contacted by telephone and the outlines of the study presented. Any questions they had at that time were answered. Participants were given approximations of the requirements for their time and of the mailing schedule. Participants were asked for a firm commitment both to participate throughout the entire study and to agree to a rapid turn-around schedule when they received questionnaires. Finally, participants were asked to nominate others who fit the study criteria. A return call for those nominations and confirmation of participation was made, as needed.

This procedure was employed to successfully recruit appropriate panelists.

Levels of commitment toward the project and expressed enthusiasm by the participants were high. All persons contacted agreed to the terms of participation in the study, that is, they committed to a multi-wave process over a period of several months, and a rapid ten-day to two-week turn-around time for processing the questionnaires when received.

Clinical membership in AAMFT was the primary sample selection criterion. This allowed for controls regarding completion of specific and recognized educational and clinical requirements.

Description of the Delphi Process For This Study

The first questionnaire (DQI) invited wide-ranging and creative commentary on several broad questions germane to the study. Upon receipt of the responses, the researcher identified emerging themes and from them developed more specific questions and statements about the topic, which formed the core of the second-wave questionnaire.

In addition to the DQII questions, respondents received a summary of the first-wave results which enabled them to respond to the responses of other members of the group. This interactive aspect provided for a richness which would be unlikely apart from this feature. The intra-study anonymity of the respondents minimized the possibility of undue influence by strong personalities or persons of professional reputation (Dalkey, 1972).

Results of the second round generally indicated emerging trends, areas of consensus and definition. Responses were evaluated and the process was repeated until general consensus was reached, response ranges stabilized, and sufficient information was obtained to satisfactorily complete the study.

Data Analysis--General Approach

1. Responses to the initial questionnaire (DQI) items were categorized by theme, description and frequency of response.

2. The responses were then developed as statements to which the participants were asked to respond in terms of levels of agreement/disagreement, importance, or priority on Likert-type scales in DQII.

3. Results of DQII. The DQII responses were processed through the use of percentages as descriptors of levels of agreement and/or priority with regard to a specific statement/category. The information generated was arranged in tables for both description and distribution to the study participants. This information formed the core of the next wave of the questionnaire (DQIII).

4. DQIII --The statements generated from DQII, with the appropriate description, were then mailed to participants who were asked to reconsider and adjust their statement score responses. This phase was designed to evaluate the level of consensus generated in the previous round. This second round reconsideration typically clarified the parameters of consensus definition and description.

Critique of the Delphi Method

Positive Qualities of Delphi include these features:

- Written responses generally require respondents to think carefully and critically.
- Isolation of respondents results in a high quality of ideas.
- Anonymity allows freedom to explore what may be unconventional avenues/ ideas without negative peer pressure.
- Method tends toward minimizing researcher bias.
- Efficient in terms of time and expense when compared to other methods of gathering similar information.
- Method allows for a broad range of ideas and opinion to be expressed.
- Useful for exploratory studies (Dalkey, 1969, 1972; Linstone & Turoff, 1975).

Negative Qualities of the Delphi include these features:

- Absence of direct, immediate verbal feedback can create difficulties in interpretation by respondents.
- There is no opportunity for the social-emotional rewards of problem-solving, i.e., affective isolation.
- There is no opportunity for resolution of directly contradictory ideas/ opinions.
- Low response rates have been reported by several authors as have high attrition rates (Kurth-Schai, 1988; Linstone & Turoff, 1975; Sackman, 1975).

Mixed Evaluations of Delphi Method

- There is some criticism on the basis of "encouraging conformity", but findings indicate that the convergence is usually in the direction of greater accuracy (Spitzer,1975).

- Time--this method can take several months. Delphi is not time efficient if speed is necessary, although its use may be superior to other methods, given potential scheduling and transportation problems inherent in gathering a group of experts to one place (Sackman, 1975).

Evaluation of Delphi by Participants

- Efficient

--time and effort expended by panelists is appropriate to the task; it is not deemed excessive or burdensome.

--time and money expended by researchers is minimized while still accessing expert data from geographically diverse sources.

- Effective

--generates high quality data

--anonymity: allows for personal, controversial and/or imaginative responses from participants

--Researcher bias is minimized by the self-adjusting nature of the process. The panelists' responses, not the researchers' hypothesis, guide the research process.

--Creativity is also encouraged through synergy with other panelists responses. This interactive aspect is identified by many panelists as the most motivating dimension of the process, thus

generating higher levels of enthusiasm and interest than might otherwise be present.

- Empowering

--greater than 80% of the participants who were asked evaluated the experience as educational. Comments about the Delphi process include statements regarding positive impact on the participants' creativity and clarity of thought, as well as surprise at their own capacity for contribution to the enterprise (Kurth-Schai 1988, Weingand 1980,1981).

Rationale for Using AAMFT Therapists to Study Characteristics of Healthy Families and Religious Orientation

1. marriage and family therapists are specifically trained to focus on and explore areas important to family functioning.

2. AAMFT Clinical members generally share a certain commonality of language and conceptual base upon which description and discussion can be built. The people at this level of training and education generally have well developed skills in verbal and written communication.

3. This panel is made up of people who have expertise in working with families that exhibit religious orientations.

4. Stinnett and DeFrain (1989, p. 67) noted that "members of strong families are often seen at counseling centers or talking with a priest or rabbi or dropping by a social agency for ideas. Many of them do not know how to fix the transmission of a car so they take it

to a specialist. Likewise, they also recognize the fact that they often do not know how to 'fix' a marriage problem, a dispute with in-laws, or a teenager who is depressed. In short, they are smart enough to know not only what they do know, but also what they do not know."

Modifications to the Process

Rather than opening this exploratory study with a limited number of pre-existing statements, this study began with open-ended questions in order to generate maximum input from the cadre of experts. While not unknown to conventional Delphi processes, this extra step provided maximum opportunity for creative individual responses.

Questions for the initial round probed the broad areas of inquiry suggested by the literature review and the pilot study. The initial questionnaire (DQI) invited panelists to explore freely each of the suggested questions, in order to gain maximum breadth of information. The wide-ranging responses created both depth and breadth in the development of large response sets which could later be evaluated and refined by the entire group.

Conventional Delphi process feeds back to each participant their own specific scores for each of the items of the previous questionnaire-response rounds. This information, in conjunction with the group scores for each item, form the baseline for the recursive reconsideration of item scores.

For this study, information regarding specific scores per response was not returned to participants. Instead, a general

statement indicating that the listing of characteristics returned to them were evaluated by at least 75% of the group was deemed sufficient.

The decision to feed back information to participants in this way was made on the basis of two factors. First, participant fatigue needed to be taken into account. The DQII was a very long document; even after paring down, there were still 317 items to be evaluated. Second, consultation with a statistical and research consultant indicated that specific information regarding specific individual responses did not significantly affect the participants' overall perceptions or evaluations of the material under consideration.

DQII

The extraction of short statements from prose/paragraph responses required significant editing. The possibility of introducing error at this point was addressed through comparison of the DQI responses and the proposed DQII statements/questionnaire.

Twenty-five percent (25%) of the DQI response questionnaires were randomly chosen to be evaluated with the corresponding DQII statements. Each DQII statement chosen was evaluated by two independent raters to assess the sufficiency of representation vis-a-vis DQI. DQII statements were said to be in agreement with DQI if DQII "substantially represented the idea, concept, behavior, or attitude" presented in DQI. One statement per question was randomly chosen for comparison.

Inter-rater reliability was computed by dividing the total number of agreements noted (between DQI and DQII) by both raters, by the total number of agreements plus disagreements. The inter-rater reliability score was computed to be 0.96.

DQIII

The DQIII followed directly from DQII, employing a listing of those statements to which 80% or more of respondents agreed. These listings were spot checked for accuracy of representation.

Author's Evaluation

The author's experience with this study generally supports the evaluations cited above.

Philosophically, the expanded Delphi approach of initially asking participants to respond to open-ended questions did generate high-quality data and a broad range of responses. The volume of information was a mixed blessing. Positively, the range of ideas and nuance provided a substantial basis for the development and refining of those ideas.

Negatively, the volume posed some editing and logistical difficulties. Significant financial expenditures were required for printing and mailing costs incurred through the necessity of multiple mailings and return postage. The emotional costs of multiple mailings provided many anxiety-provoking opportunities as the several due dates came and went.

The editing and logistical difficulties were addressed primarily through a decision to feed back a larger volume of material to the

second round participants than had originally been anticipated. This approach was in keeping with the general commitment to follow the data in allowing the participants to edit and focus the material through recursive responses to the information presented to them. Though somewhat cumbersome, the method's veracity was upheld, in that the levels of agreement between rounds two and three were high, that is, few items identified in round two as important or very important for inclusion were rejected upon reconsideration.

Some participants commented that the large volume of material made their continued participation difficult, even burdensome. Studies employing this expanded approach, steps should be taken to insure participant commitment to the entire process.

In an effort to ward off attrition due to participant fatigue, telephone calls were placed, letters written and encouraging reminders sent. The instruction packet for round three participants included an "Ed McMahon-style" Super Sweepstakes announcement notifying the recipient that they would qualify for a $75.00000000 Grand Prize if they completed and returned their DQIII and DQIV on time. Total average response rate over all four rounds was calculated to be 73.5%.

Chapter IV

RESULTS AND DISCUSSION

Description of the Participants

Demographic information concerning the description of the participant panelists for this study was requested in order to confirm "expert" status and to give readers of this study a profile of the participants involved.

The profile consisted of predominantly mature (a mean age of 53.5 years) white male practitioners with Protestant affiliation (see Appendix 5). Of the initial group of qualified candidates who agreed to participate, four were women, three of whom withdrew from the study, citing time constraints.

While clinical membership in AAMFT was an important criterion for panel selection, it was not the sole criterion. Three individuals were nominated to participate by clinical members and were accepted on the basis of those recommendations, their expertise, experience and familiarity with the issues involved.

Participants were well educated, all but three holding earned Doctorates in marriage and family therapy or related fields. Of the three Masters' level participants, one had earned two Master's degrees. The Masters' level group had a combined 51 years of clinical experience, averaging 17 years clinical and 11.3 years supervisory experience. The participant group as a whole averaged 18.6 years of clinical experience and have spent significant time integrating religious orientation into their clinical practice of

marriage and family therapy (18 years). Furthermore, of those who were engaged in supervision and education, all had specifically included religious orientation in those processes. Supervisory integration of Religious Orientation and marriage and family therapy averaged 13 years, and accounted for 96% of their supervisory experience.

Of the twenty-nine persons who met the study's criteria and had agreed to participate, three dropped out following DQI due to time constraints, one dropped out due to illness and one did not respond to repeated attempted contacts regarding participation in the study; these were considered to have withdrawn themselves from the process. Participation rates are therefore represented as follows:

DQI	20/29	or 69%
DQII	17/24	or 71%
DQIII	20/24	or 83%
DQIV	17/24	or 71%

DQI

The first questionnaire, DQI, consisted of 14 open-ended questions to which the participants were invited to respond. Questions were directed by the goals of the study into the specified regions of defining Religious Orientation, characteristics of religious orientation for individuals and families, and therapeutic aspects of religious orientation in the practice of marriage and family therapy.

DQI Results

Responses to each DQI question were generally in the format of either a paragraph or a short sentence description of specific characteristics. The received information was then examined and the characteristics identified by the participants were listed in alphabetical order. All characteristics identified were included in DQII for response and evaluation by the panel. Although inclusion of the complete listing of identified characteristics made the second-round questionnaire large and somewhat cumbersome, it was judged to be the best method of accurately representing the information received.

DQII

Participants identified a total of 598 items in response to the 13 focal questions of the study's first round. Redundant items were represented by a single entry. The derived item lists for each question formed the basis for the Second Questionnaire, DQII, shown in Appendix B.

The 598-item inventory was presented to the participants in DQII. Panelists were instructed to indicate their estimate of the relative importance of an item or their estimate of their level of agreement/disagreement as to whether or not each specific listed item should be included in a description of the attribute or statement under consideration.

DQII Results

Panelists indicated strong support for many of the characteristics identified. In assessing the degree of agreement among participants it was determined that 53% of the 598 characteristics identified by DQI were items with which 80% or more of the panelists either "Agreed" or "Strongly Agreed" to be descriptors of the specified characteristic. The 80% cut-off point was chosen in order to assure that those items included represented a true majority of opinion of the participants regarding any specific item.

DQIII

The Tables which follow represent those characteristics identified in DQI and which were agreed to by at least 80% of the respondents in DQII (for a full listing of all items see Appendix B.) The item lists presented here form the basis for DQIII, which was employed to more clearly focus the final results.

Explanation of Format and Weighted Scores

Weighted Scores for each item were calculated from the DQIII responses in which participants indicated their level of agreement with the statements presented from the DQII listing. Weighted Scores are presented in the left margin of the following Tables and indicate the average score per item recorded by the DQIII participants (N=20). Weighted Scores are based on the following Likert scale which was used in the DQIII questionnaire:

Strongly Agree				Strongly Disagree
1	2	3	4	5

Weighted Scores were computed as follows:

$$\text{Weighted Score (W.S.)} = \frac{1(A) + 2(B) + 3(C) + 4(D) + 5(E)}{N}$$

where A, B, C, D, and E each represent the number of participants who whose the corresponding numerical score for the item under consideration, and N = the number of participants. For DQIII, N = 20.

Thematic organization (Cognitive, Relational, Theoretical, etc.) represents the researcher's assessment for appropriate categorization of the information.

Terminology for each of the specific items is presented in the original working form. For purposes of authenticity, no effort has been made to achieve similarity in form.

Discussion of Findings

Overview

Findings will be discussed within the general framework of the Delphi questions. Statements have been thematically grouped, then sub-grouped by weighted score. Thematic groupings represent the choices of the investigator for focusing the participants' reponses into useful general categories, based on the statements' central emphasis as perceived by the investigator. These groupings may be viewed as having to do with the assets and liabilities of Religious Orientation with respect to the cognitive, relational, ethical and theological

aspects of individual and family functioning. In addition, information presented regarding the practice of therapy includes assumptions, beliefs, resources, problems and therapeutic practice.

The presentation format of the various identified characteristics is generally in accordance with the rank ordering of weighted scores within the topical groupings. The characteristics of greatest agreement are presented first. For specific weighted scores, see accompanying Tables.

Definition of the term "Religious Orientation"

"Religious Orientation is a set of beliefs about life, the world and its structure that posits an external guiding force, separate from, yet encompassing the natural world, which provides values, direction, and purpose for individuals, families and societies." Seventy percent of the respondents either agreed or strongly agreed with the proposed definition. Some participants who indicated a disagreement with the proposed definition focused on the perceived lack of behavioral aspects for the proposed definition of Religious Orientation. These aspects of Religious Orientation tend to focus on how one relates beliefs to behaviors in context.

Several participants, while agreeing with the general sense of the proposed definition, would adjust it by focusing on the centrality of the presence of God in all creation. One participant suggested that an awareness of the "Eternal Internal" could be considered in the context of the entire universe as well as that abiding sense of connectedness with the individual.

In and of itself, the availability of a clear and concise definition of Religious Orientation is an important contribution of this study to the field. Despite the mercurial nature of the subject matter, which has long been an impediment to the exploration of the concepts and power of the paradigm, the Delphi group was able to clearly define a difficult and multifaceted concept.

This constructed definition of Religious Orientation may not satisfy the perceptions or beliefs of other groups who may similarly attempt definition in the future. It does, however, merit serious attention by theologians and therapists because of the scientific method by which it was derived. It is not arbitrary, it represents independent thoughts and consultations, permitted reflection over time, and allowed revisions until a high level of agreement was reached. It can, therefore, provide a defensible statement for others who wish to investigate the concept in future research.

Discussion of Religious Orientation as an organizing construct or a component of a construct requires the identification of general parameters which this definition can provide. The concepts contained in the definition can establish a starting point for discussion and some common ground of meaning for inter-disciplinary dialogue and future exploration within the field of family therapy.

Table 1

Definitions of the Term "Religious Orientation" (N = 20)

Definition statements identified by DQI participants numbered 16. DQII participants' responses indicated agreement by 80% or more that the following seven items, or 44%, were deemed "Important" or "Very Important" and should therefore be included in defining religious orientation.

Weighted Scores (W.S.) are presented in left column and represent the mean scores of respondents' evaluations based on the 1 through 5 Likert scale of the DQIII, where 1 = very important and 5 = irrelevant for consideration. Thematic groupings were made at the investigator's discretion.

STATEMENTS DEFINING RELIGIOUS ORIENTATION:

W.S.	
1.55	A belief system which spells out what that person values most in life, believes about life, death, meaning and eternity
1.55	R.O. is organized system of belief
1.60	Beliefs and behaviors based on the individuals understanding of meaning and truth
1.70	R.O. is generated by a community of faith and is grounded in an historical process
1.70	R.O. is strongly influenced by family of origin, denominational heritage and interaction with other R.O.s
1.70	R.O. has both intra-personal component (belief system) and an inter-personal component (relationships)
1.85	R.O. is the core of beliefs and object relations in relationship to that which one perceives as the Ultimate Reality (or God)
1.95	R.O. describes the individual's beliefs

(table continues)

Table 1, continued

1.95	R.O. is the container for spiritual expression, development and maturation
2.05	Sense of meaning/purpose derived from religious experience
2.60	Broadly, an R.O. is any belief system pertaining to the Transcendent Being

Attributes of Healthy Religious Orientation

The characteristics of a healthy Religious Orientation identified by the Delphi group may be classified into four primary areas described as: cognitive, relational, ethical and theological.

In the cognitive domain, a healthy Religious Orientation may be described as a belief system which is congruent with the general demands of life, developmental tasks and world view. One of its primary features is that of love and acceptance of self and others. One's actions are motivated by love, not driven by guilt. A healthy Religious Orientation promotes a positive self-concept, a positive sense of full humanity, and a sense of self-love as a reflection of an awareness of God's love.

A healthy Religious Orientation is essentially life-enhancing, supporting mature decision-making based on values and spiritual principles. Life is viewed as purposeful, and the individual as being free to explore new ideas with an acceptance of what is, of others and of difference. A healthy Religious Orientation provides a framework within which experiences make sense, where the individual experiences the integration of thought, feeling and behavior, and an expanded world view which is empowering for growth. This cognitive framework enables the individual to work out life's struggles; it is holistic in scope, flexible, and enhances general well-being.

Relationally, a healthy Religious Orientation is manifested in a lifestyle characterized by love, forgiveness and reconciliation, the

perceived love of God modeling the individual's love for others. The individual is engaged with others and lives in a sense of relatedness to the community. There is a balance in life and relationship, a balance of law and grace, a capacity for compassion and a capacity for intimacy. The individual has a commitment to a community of faith, to a religious community which provides mutual support, challenge for growth, honest reflection and opportunity for service.

Ethically, a healthy Religious Orientation is seen to be characterized as one in which there is a respect for life, a concern for justice and peace and for the personal care of others. Personal integrity headed the listing of character traits which included fidelity, honesty, trustworthiness and tolerance. Behavior was characterized by the Golden Rule--treating others as you would have them treat you, with the individual exercising freedom responsibly. There was also the assumption that moral absolutes exist and that in a healthy Religious Orientation there is a clear sense of right and wrong.

Theological statements by the Delphi participants described attributes of God and relationship to God. The participants agreed that a healthy Religious Orientation viewed God as transcendent, trustworthy, just, and fundamentally about unconditional love. Relationships to God in a heathy Religious Orientation were characterized by a sensitivity to the presence and grace of God and an awareness of personal acceptance. Law and grace were perceived to be in balance and full humanity promoted.

While the Delphi group agreed that there are many paths to God, the priority of the divine in one's life was viewed as consistent with a healthy Religious Orientation, as was the regular practice of spiritual discipline. The relationship with God was viewed as personal, uniquely one's own.

Table 2

Attributes or Characteristics of a Healthy Religious Orientation

(N =20)

The participant panelists identified 93 attributes of a healthy religious orientation in DQI. The 50 item list presented represents attributes or characteristics identified by 80% or more of the participants as being "Important" or "Very Important" to be included in a description of a healthy religious orientation.

Weighted Scores (W.S.) are presented in left column and represent the mean scores of respondents' evaluations based on the 1 through 5 Likert scale of the DQIII, where 1 = very important and 5 = irrelevant for consideration. Thematic groupings were made at the investigator's discretion.

COGNITIVE

W.S.	
1.25	Love and acceptance for self and others
1.30	Love motivated, not guilt driven
1.50	Belief system congruent with the general demands of life, developmental tasks and world view
1.55	Positive self-image, self love because of God's love for me
1.65	Positive sense of full humanity; positive self concept
1.60	Mature decision-making based on values/spiritual principles
1.60	Acceptance of what is, of others and of difference
1.65	Essentially life-enhancing
1.70	Life is purposeful
1.70	Free to explore new ideas

(table continues)

Table 2, continued

1.75	Integrated thought, feeling and behavior
1.80	Expanded world view
1.80	Provides a framework within which experiences make sense
1.80	Empowering for growth
1.85	Mature differentiation, clear self-developed boundaries coupled with flexibility and adaptability
1.90	Self-discipline results in freedom
2.05	Enhances general well-being
2.05	Internally motivated
2.10	Holistic scope
2.10	Centrality of meaning
2.10	Cognitive framework within which the individual can work out life's struggles
2.10	Flexible
2.75	Family of origin strongly influences the individual's view of God

RELATIONAL

W.S.	
1.10	Lifestyle characterized by love, forgiveness, reconciliation
1.20	God's love for me is a model for my love toward others
1.25	Forgiveness
1.40	Capacity for compassion
1.45	Compassion
1.60	Balance of grace and law
1.60	Capacity for intimacy
1.60	Balance in life and relationship
1.85	Engaged with others
1.90	Relatedness to community
1.90	Responsible use of freedom
1.90	Religious community to provide support, challenge for growth, honest reflection and opportunity for service
1.90	Willing to sacrifice for others' well being
2.00	Commitment to a community of faith
2.40	Coherent with beliefs

(table continues)

Table 2, continued

ETHICAL

W.S.	
1.50	Respect for life
1.60	Concern for justice and peace
1.60	Personal care of others
1.60	Personal integrity is very important
1.70	Fidelity
1.70	Honest
1.70	Trustworthy
1.75	Tolerant
1.90	Golden rule
2.10	Moral absolutes exist
2.20	Clear sense of right and wrong

THEOLOGICAL

W.S.	
1.50	Sensitive to presence and grace of God
1.55	Belief in transcendent God
1.55	Personal acceptance by God

ATTRIBUTES OF GOD

W.S.	
1.50	God is trustworthy
1.50	God is fundamentally about unconditional love
1.70	God is just

RELATIONSHIP TO GOD

W.S.	
1.55	Balance of Law and Grace
1.70	Promotes full humanity
1.75	Priority of the divine

(table continues)

Table 2, continued

1.90 There are many paths to God
2.05 Regular practice of spiritual discipline
2.20 Relationship with God is personal, uniquely one's own
3.75 God is only within one's self

Attributes of Unhealthy Religious Orientation

Participants' perceptions of unhealthy Religious Orientation were classified by cognitive attributes, relational attributes and theological perceptions.

Much of the description of unhealthy Religious Orientation is summarized by the statement of highest agreement in this category: "Mine is the only correct interpretation." Difference is equated with "wrongness" and there is an attitude of dogmatic exclusivity providing a definite division between who is acceptable and who is not. There is a closed-minded, closed-awareness, black or white character to the thought process.

In addition, there is the perception that an unhealthy Religious Orientation is characterized by fear as a primary motivation, a driven, paranoid approach to life, requiring absolute conformity to group standards, a perspective that rules are absolute and must be obeyed absolutely. The individual abdicates personal responsibility in order to conform to the group. There is a strict, rigid suppression of growth or change.

It is not surprising that the Delphi group also characterized unhealthy Religious Orientation as one in which there is significant resentment, self-deception, and repression of "negative" emotions and thoughts. They describe adherents to an unhealthy Religious Orientation as blaming, hostile and perfectionistic, engaging in self-punitive or self-destructive behaviors. The other side of that coin describes people who maintain an unhealthy Religious Orientation as

narcissistic, self-serving and desiring to avoid difficulty, pain or suffering at all costs. The central characteristic of unhealthy Religious Orientation is a fear of exploring other ideas or approaches.

Relationally, difference is equated with "wrongness". Adherents to an unhealthy Religious Orientation characteristically are rigidly non-responsive to the needs of others. There is an attitude of spiritual superiority which manifests in judgmental, autocratic interaction.

The Delphi group identified several perceptions of God as characteristics of an unhealthy Religious Orientation. These attributions regarding God are predominantly negative. God is perceived to be punitive, non-accepting, dangerous, and judgmental. At best, God is envisioned as detached. In practical terms, there is a fear of punishment if performance is not perfect, and a fear of God (in the sense of terror) without an understanding of the nature of love and acceptance.

Table 3

Characteristics of Unhealthy Religious Orientation (N = 20)

DQI participants identified 105 attributes or characteristics of unhealthy religious orientation. Of those 105 items, 34, or 32% of those initial statements, were considered "Important" or "Very Important" to be included in a description of unhealthy religious orientation by 80% or more of the participants in DQII.

Weighted Scores (W.S.) are presented in left column and represent the mean scores of respondents' evaluations based on the 1 through 5 Likert scale of the DQIII, where 1 = very important and 5 = irrelevant for consideration. Thematic groupings were made at the investigator's discretion.

COGNITIVE

W.S.

1.35 Mine is the only correct interpretation
1.40 Abdication of responsibility
1.45 Difference is equated with "wrongness"
1.45 Dogmatically exclusive
1.45 Fear driven
1.45 Strict, rigid suppression of growth
1.50 Fear-focused: paranoid us/them approach to life
1.55 Closed-mindedness
1.65 Closed awareness
1.65 Black or white thinking
1.65 Self-punitive, self-destructive behaviors
1.65 Confusing my will with God's will
1.70 Blaming
1.70 Definite division between who is acceptable and who is not

(table continues)

Table 3, continued

1.70	Hostile
1.70	Narcissistic
1.75	Self-serving
1.75	Rules must be obeyed absolutely
1.80	Afraid to explore other ideas/approaches to an issue
1.80	Self-deception
1.85	Absolute conformity to group standards
1.85	Resentful
1.95	Avoidance of difficulty, pain or suffering at all costs
2.10	Perfectionistic
2.00	Repression of "negative" emotions/thoughts

THEOLOGICAL

W.S.	
1.55	God is punitive
1.60	God is non-accepting
1.85	God is detached
1.95	God is dangerous
1.95	God is judgmental
1.60	Fear of punishment if performance is not perfect
1.65	Fear of a transcendent Being without an understanding of the nature of love and acceptance
3.40	Belief in an entity outside of one's self that one must worship

RELATIONAL

W.S.	
1.45	Difference is equated with "wrongness"
1.55	Rigidly non-responsive to needs of others
1.60	Spiritually superior
1.75	Judgmental
1.95	Autocratic

Participants' Assumptions regarding Religious Orientation

Theological Statements--Perspectives toward God

The strongest levels of agreement across the entire study were reflected in the participant's theological assumptions. The statement that "A Creator exists" coupled with the strong assertion that the human being is a spiritual being, defines the essential parameters of the basic assumptions of this group of therapists. These are their foundational assertions regarding the nature of humanity and its place in the universe. Those general, cosmic assertions take on a distinctly personal dimension with the statement that God not only creates but calls individuals into partnership in that creation. Further, each individual is seen as having the specific power to choose to what extent he or she will relate to God.

Religious Involvement

Religious involvement, per se, was regarded as essentially neutral; that is to say, affiliation with a religious group can be either healthy or unhealthy. Participants noted that affiliation with an organized religious group can provide emotional support, social awareness, awareness of community, improved self-esteem and a sense of security.

A religiously-oriented individual generally participates in a religious community of like-minded people. While religions tend to formalize the relationships of persons and God, pursuing integration and integrity is seen to result in heightened spirituality and wellness.

There was also strong agreement among the participants that Religious Orientation generally gives greater depth to human relationships, and that Religious Orientation is manifest in our relationships with others.

Regarding the cognitive domain, participants agreed that a healthy Religious Orientation can be a wonderful resource, providing stability during crisis and reinforcement of positive values. They further asserted that a scripturally based Religious Orientation can be a healthy one.

Individual Psychological Characteristics

Participants' assumptions included some general statements regarding psychological characteristics of the individual. Perhaps the most sweeping statement, that Religious Orientation is the basic context for all else, goes to the core of the assumptions presented by the participants. Religious Orientation may be described as the central organizing paradigm for all life experience. An interesting parallel assumption, that one's Religious Orientation is subject to change over time, suggests the awareness of developmental processes, learning and re-organization of beliefs in the context of experience.

Participants also identified two broad assumptions impacting their perspective on Religious Orientation in the practice of therapy. First is the assertion that personality dynamics and the nature of

Religious Orientation are closely related. Second is that unhealthy forms of Religious Orientation are similar to other unhealthy mental structures and must be clarified and worked through.

Table 4

Participants' Basic Assumptions about Religious Orientation (N = 20)

DQI participants identified 40 of their collective assumptions about religious orientation. Of those, 50%, or 20 assumptions, were agreed upon by at least 80% of the participants in DQII. Those statements are presented below.

Weighted Scores (W.S.) are presented in left column and represent the mean scores of respondents' evaluations based on the 1 through 5 Likert scale of the DQIII, where 1 = very important and 5 = irrelevant for consideration. Thematic groupings were made at the investigator's discretion.

THEOLOGICAL STATEMENTS--Perspectives toward God

W.S.	
1.10	A creator exists
1.10	A human being is a spiritual being
1.65	God creates and calls individuals into partnership in that creation
1.75	People have the power to choose to what extent they will relate to God

STATEMENTS REGARDING RELIGIOUS INVOLVEMENT

W.S.	
1.40	Affiliation with a religious group can be healthy or unhealthy
1.50	Affiliation with an organized religious group can provide emotional support, social awareness, awareness of community, improved self-esteem and a sense of security
1.85	Religions tend to formalize the relationships of persons and God

(table continues)

Table 4, continued

1.85 A religiously oriented individual generally participates in a religious community of like-minded people
2.00 Pursuing integration and integrity will result in heightened spirituality and wellness

STATEMENTS REGARDING RELATIONSHIPS

W.S.

1.40 Gives greater depth to human relationships
1.60 Living one's faith, exposing others to it without imposing it is optimal
1.90 R.O. is manifest in our relationships with others

STATEMENTS REGARDING COGNITIVE FRAMEWORK

W.S.

1.45 A Healthy R.O. can be a wonderful resource
1.55 Scripturally based R.O. can be healthy
1.55 Faith provides stability during crisis
1.70 Unhealthy forms of R.O. are similar to other unhealthy mental structures and must be clarified and worked through
1.80 Faith provides reinforcement of values
1.85 R.O. is the basic context for all else
2.15 Personality dynamics and the nature of R.O. are closely related

Religious Orientation in the Practice of Therapy

Assumptions regarding Therapy

Participants identified several elements of Religious Orientation which can be assets to the therapeutic process. Among these elements was also the disclaimer that although a valuable resource, a healthy Religious Orientation does not guarantee specific resolutions and outcomes of therapy.

A central assertion was that the core meanings and beliefs of clients, and client systems, are crucial to the therapy process. Concepts of love, acceptance and forgiveness, which are central to many religions, can be very helpful in the healing of relationships. The therapeutic process is viewed as being a co-creative partnership of individuals, the family, the therapist and God. The panel also asserted that when issues of Religious Orientation are introduced into the therapeutic process, deeper levels of significance are opened to exploration than would otherwise be the case.

Assumptions Regarding Family Functioning

Assumptions regarding family functioning were classified with and accompanied by the general acknowledgement that the operative belief system is more important than the professed. The participants also agreed that a healthy Religious Orientation promotes healthy family functioning.

Although the level of agreement was not as strong as many other statements, participants acknowledged the power of the parents' Religious Orientation as a central organizing factor in the

family, through not the most important organizing factor. While agreement was lower on this item than some others, the power of competing factors should be noted, for instance, socioeconomic status, education, ethnicity, and all the factors which are specifically not religious in nature but powerfully influence the development and organization of the family. There were higher levels of agreement among the panelists concerning their assumptions regarding the impact of parental Religious Orientation on children, exemplified by the statement:

> "When parents have a clear and congruent Religious Orientation it provides the children with a means to express and explore their own spirituality."

In the therapeutic context, many participants asserted that Religious Orientation should be actively explored by the therapist because of its importance to family dynamics. Addressing issues emanating from Religious Orientation was also viewed as important to well family functioning. Finally, a strong level of agreement indicated the participants' perception that the process of Individuation includes the Religious Orientation dimension, that is, each individual making adult choices regarding beliefs and practices.

Therapist's Stance

An interesting array of information may be classified under the heading of Therapist's Stance. Regarding the therapeutic context, there was almost universal agreement that the therapist is not the healer, but one who provides an atmosphere where healing can begin

or take place. The stance of the therapist is to be characterized by love, acceptance, compassion and truthfulness. The therapist can be a messenger of hope, but should not proselytize regarding specific beliefs, Religious Orientation, or related concepts.

The panel demonstrated general agreement that the therapist operates from a "value informed" position, acknowledging that the therapist is never neutral in terms of values, beliefs and meaning systems. They also asserted that understanding something of the client's religious culture is important to the therapeutic process. Discussion of Religious Orientation issues were viewed as increasingly acceptable in the practice of marriage and family therapy.

The Delphi group strongly agreed that the essential perspective characterizing the therapist's stance is that it be respectful of the client's Religious Orientation.

Table 5

Religious Orientation in the Practice of Therapy (N =20)

DQI participants identified 42 assumptions, 28, or 66%, of which 80% or more of the DQII respondents deemed "Important" or "Very Important" in a description of their assumptions regarding religious orientation in the practice of therapy. Those statements are reproduced below.

Weighted Scores (W.S.) are presented in left column and represent the mean scores of respondents' evaluations based on the 1 through 5 Likert scale of the DQIII, where 1 = very important and 5 = irrelevant for consideration. Thematic groupings were made at the investigator's discretion.

PSYCHOLOGICAL CHARACTERISTICS

W.S.	
1.50	R.O. is subject to change over time
1.55	Healthy R.O. promotes healthy family functioning
1.80	Some R.O.s undermine emotional development

ASSUMPTIONS--ASSETS TO THE THERAPEUTIC PROCESS

W.S.	
1.30	Concepts of love, acceptance and forgiveness (which are central to many religions) can be very helpful in healing relationships
1.35	The operative belief system is more important than the professed

(table continues)

Table 5, continued

1.40 The core meanings and beliefs of clients and client systems are crucial to the therapy process
1.40 Though a valuable resource, a healthy R.O. does not guarantee specific resolutions or outcomes of therapy
1.50 Therapy is part of the co-creative partnership of individuals, the family, the therapist and God
1.50 Religious organizations can provide a support system during crisis
1.60 When issues of R.O. are introduced into the therapeutic process, deeper levels of significance are opened to exploration
1.70 Individuation includes the R.O. dimension (ie, each individual making adult choices regarding beliefs and practices)

THERAPIST'S STANCE

W.S.

1.15 The therapist is not the healer, but provides the atmosphere where healing can begin or take place
1.25 The therapist's stance must be respectful of the client's R.O.
1.35 The therapist's stance is that of love, acceptance, compassion and truthfulness
1.35 Proselytizing is unethical (specific beliefs, R.O. or concepts)
1.35 Therapists can be messengers of hope
1.50 The therapist operates from a "value informed" position
1.50 It is important to understand something of the client's religious culture
1.50 R.O. issues are increasingly acceptable in MFT practice
1.60 The therapist, in directing the therapy, must allow for grace
1.65 The therapist is never neutral in terms of values, belief and meaning systems
1.65 Issues of R.O. should be integrated into the training and supervision process
1.90 The therapist must seek to not manipulate, convert, control or be intrusive into clients' values, beliefs and meaning systems

(table continues)

Table 5, continued

STATEMENTS REGARDING FAMILY FUNCTIONING

W.S.	
1.70	When parents have a clear and congruent R.O., it provides the children with a means to express and explore their own spirituality
2.05	R.O. should be actively explored by the therapist because its so important to family dynamics
2.10	Addressing issues emanating from R.O. is central to well family functioning
2.35	The R.O. of the parents is probably the most important organizing factor in the family

Aspects of Religious Orientation Psychologically Valuable to Individuals

Descriptions of aspects of Religious Orientation which can be psychologically valuable for individuals were organized into four categories. A healthy Religious Orientation provides opportunity to become more aware of positive perspectives of life and interaction, encourages certain behaviors and values, and provides a framework for life events.

There was strong agreement that a healthy Religious Orientation provides an awareness of love, grace and hope; it also offers a basis for love and trust in addition to an awareness of unconditional love from God. The awareness that the individual has access to great wisdom is related to the sense of empowerment perceived in being connected to a grace-filled and loving Higher Power.

A healthy Religious Orientation encourages a more meaningful connection to others, an increased sense of empathy, caring and charity. This orientation extends the individual's focus beyond self to a more loving approach to others and the larger world. The themes of self-actualization or growth orientation were strongly present in the characteristics identified by the Delphi group. This is not in contrast to the expanded world view but exists in conjunction with it.

A healthy Religious Orientation invites people into the loving freedom to be and to become themselves. The individual is

encouraged toward healthy reflection, introspection and self-awareness. People are encouraged to trust the inner voice, the spiritual intuition. Individual responsibility, a creative balanced lifestyle and positive self-image were also identified by the participants as characteristics encouraged by a healthy Religious Orientation.

The last element identified as psychologically valuable for individuals centers on the provision of a framework for constructing both identity and meaning. The stable value systems and world views inherent in healthy Religious Orientation provide a sense of confidence and relationship to the universe. A Biblically based model, for example, provides a rich source of affirmation, metaphor, symbol, meaning and sense of history.

A healthy religious orientation provides a safe context to work through psychological difficulties, in addition to the provision of an emotional, cognitive, interactional framework for healthy (some add optimal) personal growth and development.

Table 6

Aspects of a Religious Orientation which can be Psychologically Valuable for Individuals (N =20)

When asked, "What about religious orientation can be psychologically valuable for individuals?", DQI respondents produced a listing of 43 options. Forty-one of those 43 items, or 95%, were agreed to by 80% or more of the respondents in DQII.

Weighted Scores (W.S.) are presented in left column and represent the mean scores of respondents' evaluations based on the 1 through 5 Likert scale of the DQIII, where 1 = very important and 5 = irrelevant for consideration. Thematic groupings were made at the investigator's discretion.

A HEALTHY R. O. PROVIDES AWARENESS OF

W.S.	
1.20	love
1.20	grace
1.25	hope
1.30	a framework to deal with the guilt and forgiveness
1.40	a basis for love
1.40	a sense of meaning for life and events
1.42	unconditional love from God
1.45	a basis for trust
1.45	empowerment by connection to a grace-filled and loving Higher Power
1.50	a framework for moral justice
1.55	access to great wisdom
1.60	Biblical model as rich source of affirmation, metaphor, symbol, meaning and sense of history

(table continues)

Table 6, continued

1.60 greater self-awareness and emotional freedom
1.75 Amelioration of existential sense of aloneness
1.75 that God, not the individual, is the central fact of life

HEALTHY R. O. ENCOURAGES:

W.S.

1.33 meaningful connection to others
1.35 empathy, caring
1.35 world-view/focus beyond ourselves
1.45 a more loving approach to others and the larger world
1.50 charity
1.50 individual responsibility
1.60 positive self-image
1.60 fearless moral inventory
1.65 creativity
1.65 balanced life style
1.65 stable value system
1.70 active membership in a supportive, challenging, validating community of faith
1.70 Invites people into the loving freedom to be and to become themselves
1.75 growth orientation
1.75 healthy reflection, introspection, self-awareness
1.80 people to trust the inner voice, spiritual intuition
1.95 self-actualization and self-transcendence

HEALTHY R. O. PROMOTES:

W.S.

1.40 the value of commitment
1.45 the value of humility
1.50 balanced individuated life

(table continues)

Table 6, continued

HEALTHY R. O. PROVIDES:

W.S.	
1.20	a basis for love, justice and hope
1.40	a basis for constructing both identity and meaning
1.45	a relationship to the universe
1.50	a basis for confidence
1.65	a safe context to work through psychological difficulties
1.75	emotional, cognitive, interactional framework for healthy and optimal growth and development
1.85	an optimal vehicle for personal growth

Aspects of a Religious Orientation which may be Psychologically Detrimental for Individuals

Generally, the aspects of Religious Orientation which the participants identified as potentially detrimental were permutations of the theme of closed-mindedness. Absolute refusal to change, calcified guidelines, rigid intolerance and mindless acceptance of statements, dictates, and policies were strongly agreed upon as detrimental factors.

Identity formation was regarded as retarded or restricted through enmeshment with rigid structures of dogma. These enmeshments may be characterized by: habitual submission to autocratic control, acceptance of institutional biases, and a commitment to principles not one's own.

Several statements focused on guilt and fear. The respondents agreed than an inordinate stress on God as punitive judge had detrimental effects. These could include all the aforementioned in addition to the development of unrealistic expectations for self or others, motivation by fear of punishment, a "works-based" generalized anxiety, even a form of intellectual isolationism--an unwillingness to engage new ideas or of a denial of reality.

Relationships can also be adversely affected by some aspects of Religious Orientation which may be psychologically detrimental for individuals. The participants identified several broad characteristics. Some people use "God" to perpetuate or excuse dysfunction: structured gender inequalities and unrealistic role expectations are

among the most blatant examples. Excessive dependence or co-dependence were noted as characteristics of a detrimental Religious Orientation, as were tendencies to withdraw from the larger society or refusal to engage those who differ from the particular group.

Table 7

Aspects of a Religious Orientation which may be Psychologically Detrimental for Individuals (N = 20)

DQI respondents identified 43 aspects of religious orientation which they deemed potentially detrimental to individuals. Eighty percent or more of DQII respondents agreed that 25 of those statements (58%) should be included.

Weighted Scores (W.S.) are presented in left column and represent the mean scores of respondents' evaluations based on the 1 through 5 Likert scale of the DQIII, where 1 = very important and 5 = irrelevant for consideration. Thematic groupings were made at the investigator's discretion.

STATEMENTS REGARDING THE INDIVIDUAL

W.S	
1.25	Rigid refusal to change
1.40	Authoritarian R.O. can lead to false guilt and inhibited emotional development
1.50	Using God to excuse/perpetuate dysfunction
1.50	Closed-mindedness
1.55	Unrealistic expectations of self and/or others (perfectionistic)
1.55	Acceptance of institutionalized biases
1.55	Autocratic control
1.55	Rigid/intolerant
1.55	Inordinate stress on God as punitive judge
1.53	Calcified guidelines
1.60	Motivation by fear of punishment
1.65	Denial of reality
1.75	Isolationism--unwilligness to engage new ideas
1.80	Mindless acceptance of statements, dictates, policies, etc.

(table continues)

Table 7, continued

1.85 "Works-based" generalized anxiety
1.90 Commitment to principles not your own
1.95 Identity formation is retarded/restricted through enmeshment with rigid structures of dogma

STATEMENTS REGARDING RELATIONSHIPS

W.S.

1.55 Unrealistic role expectations (for/of family members)
1.65 Guilt/shame based motivation
1.70 Excessive dependence/co-dependence
1.70 Gender inequalities
1.70 Refusal to engage those who differ with us
1.95 Withdrawal from society other than those of one particular group
2.10 Infantile dependency

Aspects of a Religious Orientation which can be Assets to Healthy Family Functioning

Twenty-one aspects of Religious Orientation were identified by the DQIII participants as characteristics which can be assets to healthy family functioning. For the individual the most common citations related to the area of values: that Religious Orientation provides the basis for values, that those were values which the family has in common, and that it was these values which formed the central focus or core of the family which is probably linked to a common perspective or meaning.

Personal responsibility and improved self-concept (the belief that I am created by God and I am unique) were also cited by participants as assets to healthy family functioning.

Relationally, it was noted that Religious Orientation can encourage loving connection or intimacy, mutual respect of husband and wife, and encourages meaningful relationships. In promoting ethical responsibility, healthy Religious Orientations generally teach the value of commitment or covenant. Healthy Religious Orientations also provide a framework for coping with the stresses of life, are a source of support, and encourage nurturance of and by the community.

Transgenerationally, the family's mutual love and commitment is perceived as including God, the individuals in the marriage and their offspring. Parent-child bonding and mutual understanding is promoted through activities associated with religious practice,

specifically: prayer together, hymns sung together, attending worship services as a family and recreation in the context of Religious Orientation.

The characteristic most frequently acknowledged by the participants as being "very important" when considering aspects of Religious Orientation which can be assets to healthy family functioning was forgiveness.

Table 8

Aspects of a Religious Orientation which can be Assets to Healthy Family Functioning (N = 20)

Eighty percent or more of DQII participants indicated that 20, (63%), of the 32 items identified in DQI were "Important" or "Very Important" to be included when considering this topic.

Weighted Scores (W.S.) are presented in left column and represent the mean scores of respondents' evaluations based on the 1 through 5 Likert scale of the DQIII, where 1 = very important and 5 = irrelevant for consideration. Thematic groupings were made at the investigator's discretion.

COGNITIVE

W.S.	
1.35	Forgiveness
1.40	Basis of values
1.40	Values give family a central focus or core
1.60	Common values
1.45	Provides framework for coping with stresses of life
1.55	Encourages personal responsibility
1.60	Improved self-concept (I am created by God and I am unique)
1.70	Common perspective on "meaning"
2.00	Validation

RELATIONAL

W.S.	
1.40	Encourages loving connection/intimacy
1.40	Encourages mutual respect of husband/wife
1.45	R.O. teaches the value of commitment/covenant
1.45	Encourages meaningful relationships

(table continues)

Table 8, continued

1.60 R.O. promotes ethical responsibility
1.60 Nurture by/of community
1.65 Source of support
1.70 The family's mutual commitment and love include the Transcendent Being, the individuals in the marriage and their offspring
1.75 Loving, honoring and forgiving parents when an adult
1.80 Parent/child bonding and mutual understanding through activities associated with religious practice
1.80 Shared activities (prayer together, hymns sung together, attending worship as a family, recreation in the context of R.O.)

Aspects of a Religious Orientation which may be Detrimental to Healthy Family Functioning

While several of the characteristics parallel those cited as detrimental to individual functioning (specifically elements clustered around the themes of judgmental attitudes and closed-mindedness), participants identified aspects detrimental to family functioning somewhat differently.

Panelists showed strong agreement regarding the impact of a closed-minded perspective of a rigid, judgmental, intolerant world-view, of which cult brainwashing is the extreme example. Participants frequently cited a high pressure to conform to rigid rules and a repression of freedom to explore. Intolerance and denial of ambiguity coupled with the idea that "right belief" means that all think alike, and a fear of autocratic rules may result in a style of living which draws artificial distinctions between the "real" self from the "religious" self.

An under-developed capacity for ethical decision-making due to strict adherence to dictates or laws was identified as being detrimental to healthy family functioning. In this context, religion might be used in the service of keeping unhealthy secrets, equating parents' words with God's law, or inspiring absolute obedience to persons in higher positions of hierarchical structures. Some Religious Orientations may be used to perpetuate dysfunctional family-of-origin rules, roles and hierarchy. Shame- or guilt-based motivations were commonly cited as detrimental.

Relationally, participants noted that conflicting Religious Orientations, when rigidly held by individual family members, can produce a variety of problems. Specifically, doctrinal differences can be barriers to communication. Some sexual problems may be rooted in the precepts of particular Religious Orientations. Differences in values, differences in commitment to religion and differences in the degree of commitment to a Religious Orientation can cause tension and block intimacy. Some Religious Orientations promote a stern and severe concept of God which translates to a stern and severe "discipline" of children. Finally, participants noted that unhealthy religious lifestyles can become characterized by excessive neediness, enmeshment and fusion. One of the central themes emerging here is that an unhealthy Religious Orientation can inhibit personal development and exploration. It can also slow the process of individuation by encouraging or requiring legalistic adherence to hierarchically imposed rules.

Table 9

Aspects of a Religious Orientation which may be Detrimental to Healthy Family Functioning (N =20)

In DQI, panelists identified 36 aspects of religious orientation which may be detrimental to healthy family functioning. Responses of participants in DQII indicated that 80% of them agreed that 25 items listed, or 69% of the DQI list, were "Important" or "Very Important" as descriptors.

Weighted Scores (W.S.) are presented in left column and represent the mean scores of respondents' evaluations based on the 1 through 5 Likert scale of the DQIII, where 1 = very important and 5 = irrelevant for consideration. Thematic groupings were made at the investigator's discretion.

STATEMENTS REGARDING COGNITIVE ASPECTS

W.S.

1.40 Rigid, judgmental world-view
1.40 Cult brainwashing
1.45 Intolerance
1.45 High pressure to conform to rigid rules
1.50 Right belief means all think alike
1.55 Religion used as reason for keeping unhealthy secrets
1.65 Repression of freedom to explore
1.65 Schizophrenic living (real self/religious self)
1.85 Denial of ambiguity
1.80 Fear of autocratic rules
1.80 Equating parents' words with God's law

(table continues)

Table 9, continued

1.90 Undeveloped capacity for ethical decision-making due to strict adherence to dictates/laws
1.95 Split loyalties
2.00 Absolute obedience to person in higher positions in hierarchical structures

STATEMENTS REGARDING RELATIONAL ASPECTS

W.S.

1.50 Some R.O.s may be used to perpetuate dysfunctional family of origin rules, roles, hierarchy, etc.
1.55 Shame/guilt-based interaction
1.65 Conflicting R.O.s, when rigidly held by family members can produce a variety of family problems
1.65 Promotion of stern and severe concept of God
1.70 Promotion of stern and severe "discipline" of kids
1.75 Lifestyles characterized by excessive neediness, enmeshment/fusion
1.80 Sexual problems rooted in precepts of a particular R.O.
1.85 Negative labeling with religious vocabulary
2.00 Doctrinal differences can be barriers to communication
2.00 Painful differences in values
2.10 Differences in degree of commitment to religion can cause tension
2.15 Can block intimacy

Beliefs about Religious Orientation most commonly held by families seen in therapy

Families seen in the context of therapy were described by the participants as having some of the following characteristic beliefs. The most frequently cited belief was that a personal relationship with God is essential to wellness. This group was also reported to commonly hold the belief that "Secular counselors would not be as effective as counselors with Religious Orientations." Love and forgiveness are understood to be central concepts by these families. Religious Orientation is regarded as both important and helpful, and should be an important part of family life. People should live according to the precepts of Religious Orientation; its beliefs, rules and moral codes are a guide to conduct. Association with others of similar Religious Orientation is also viewed as important.

For those seen in the therapeutic context, the summary statement that "there must be a purpose in this" was a commonly held reported belief. The idea that "a Biblical basis for living was optimal" was not as strongly supported as other statements in this group, but was still representative of the beliefs of many of the families.

Table 10

Beliefs about R.O. most commonly held by families seen in therapy

(N = 20)

DQI participants identified 33 assumptions, 11 of which, or 33%, were deemed "Important" or "Very Important" by 80% or more of the DQII respondents in a description of their assumptions regarding religious orientation in the practice of therapy. Those statements are reproduced below.

Weighted Scores (W.S.) are presented in left column and represent the mean scores of respondents' evaluations based on .the 1 through 5 Likert scale of the DQIII, where 1 = very important and 5 = irrelevant for consideration. Thematic groupings were made at the investigator's discretion.

CLIENTS' BELIEFS

W.S.	
1.55	Personal relationship with God is essential to wellness
1.65	Love and forgiveness are central concepts
1.70	R.O. is important and helpful
1.75	R.O. should be an important part of family life
1.80	We ought to live according to the precepts of R.O.
1.85	Beliefs, rules, moral codes are a guide to conduct
1.90	There must be a purpose in this
1.95	Association with others of similar R.O. is important
2.00	"Secular" counselors will not be as effective as ones with R.O.
2.15	R.O. is basis for respect
2.25	Biblical basis for living is optimal

How Religious Orientation Can be an Asset to Therapy

Participants' responses have been categorized into three areas detailing how Religious Orientation can be an asset to therapy: statements regarding access to resources, inherent advantages of including Religious Orientation in the therapeutic process, and elements associated with Religious Orientation which support the therapeutic process.

Resources accessible to the clients and therapists are perceived to be broadened when Religious Orientation is included in the process. First, participants cited access to God as a resource, coupled with the idea that this includes access to power, healing and insight beyond client or therapist. Many noted that there are "great support systems" available including access to client-friendly resources like a pastor, marriage enrichment, church activities and groups.

Participants also noted several inherent advantages of including Religious Orientation in the therapeutic process. If the therapist understands the language of the Religious Orientation, it can be a bridge to enter the system and frees the therapist to honor the religious dimension.

Working with Religious Orientation opens a significant pathway to therapeutic creativity. The therapist and client family can explore the connections between individuals, the family, larger systems and God, allowing investigation of much broader and often neglected spiritual resources for change. If the therapist is aware of the in-breaking grace of God, in the context of the client's Religious

Orientation, he or she is free to comment upon that grace and build upon it, joining the family in witnessing the transforming Presence.

Respect and understanding by the therapist for the Religious Orientation of the family is perceived to reduce defensiveness and resistance. Religious Orientation can also provide specific content, beliefs, values, language, stories and metaphors that can be built upon or discussed in the context of therapy. Exploration of specific beliefs can open avenues to behavioral and attitudinal changes, possibly guided by principles inherent in the Religious Orientation being explored. The process of therapy also may provide an opportunity to re-evaluate Religious Orientation and make adjustments if the client should so choose.

Participants also identified elements associated with Religious Orientation which support the therapeutic process. Religious Orientation supports forgiveness and reconciliation, strengthening the sense of forgiven-ness and acceptance. Positive Religious Orientation shares many of the goals of therapy: personal affirmation, improved interpersonal relationships, and healthy honest introspection; it is perceived as being a freedom-honoring and life-enhancing process. Religious Orientation generally supports the required courage and risk associated with change. It also assumes grace and hope. Inclusion of Religious Orientation introduces a very large system into the therapeutic process.

Table 11

How Religious Orientation can be an Asset to Therapy (N =20)

DQI participants identified 34 descriptions of ways in which religious orientation can be an asset to therapy. Eighty percent or more of participants in DQII agreed that 26 of those (or 77%) were appropriate to be included.

Weighted Scores (W.S.) are presented in left column and represent the mean scores of respondents' evaluations based on the 1 through 5 Likert scale of the DQIII, where 1 = very important and 5 = irrelevant for consideration. Thematic groupings were made at the investigator's discretion.

STATEMENTS REGARDING ACCESS TO RESOURCES

W.S.	
1.40	Allows therapy to access God as a resource
1.45	Access to power, healing and insight beyond client or therapist
1.60	Access to client-friendly resources (pastor, marriage enrichment, church activities, groups, etc.)
2.05	Great support systems available

INHERENT ADVANTAGES OF INCLUSION OF R.O. IN THERAPEUTIC PROCESS

W.S.	
1.45	If therapist understands the language of R.O. it can be a bridge to enter system
1.55	Allows the therapist to investigate much broader and often neglected spiritual resources for change
1.60	If therapist is aware of the in-breaking grace of God, he/she is free to comment/build upon that grace

(table continues)

Table 11, continued

1.60 R.O. makes connection between self, family, larger systems and God
1.60 Therapist can join with the family in witnessing the transforming Presence rather than attempting to engineer change
1.65 Working with R.O. opens a significant pathway to therapeutic creativity
1.70 Exploration of beliefs can open avenues to behavioral and attitudinal change
1.70 Respect and understanding by therapist for R.O. of family reduces defensiveness and resistance
1.75 Provides specific content beliefs, values, stories, metaphor that can be built upon or discussed in the context of therapy
1.90 Common language, metaphor and stories from Scripture can be helpful
1.95 Frees the therapist to honor the religious dimension
1.95 Family history may have significant events which are best explored through R.O. context
2.00 R.O. can provide guidelines for behavior and change
2.05 Can provide basis for accountability
2.05 Therapy provides opportunity to re-evaluate R.O. and make adjustments if they so choose

ELEMENTS ASSOCIATED WITH R.O. WHICH SUPPORT THE THERAPEUTIC PROCESS

W.S.

1.35 Supports forgiveness and reconciliation
1.45 Strengthens the sense of acceptance and forgiven-ness
1.50 Support for courage and risk associated with change
1.60 Positive R.O. shares goals of therapy (personal affirmation, improved interpersonal relationships, healthy honest introspection, freedom-honoring and life-enhancing process)
1.60 R.O. assumes grace and hope

(table continues)

Table 11, continued

1.80 Allows therapy to be truly "systemic" by including the Transcendent level of systems
1.85 Values understanding and reconciliation
2.00 R.O. assumes truth effects change

Problems Associated with Religious Orientation

In describing specific problems associated with Religious Orientation, the Delphi participants' responses can be identified as issues which are primarily identified with the individual or with relational difficulties.

The most strongly supported problem statement was that of a shame orientation. "Black and White thinking" patterns and guilt about one's own needs were the two other most frequent 'internal' difficulties identified by the panel. Misapplication of Biblical passages was also frequently cited as problematic. Associated with these were several statements which might be described as religious rationalization, a process through which an individual exhibits an over-dependence on spiritual explanations for all events. Another permutation of that idea results in an individual's or group's viewing religious platitudes as solutions. These problems may be related to others cited, such as denial of emotional or physical problems, and confusion of genuine mental illness or addiction with a "weak will." Perfectionism and negative self-image were cited as common problem areas for individuals, as were strong desire for control and repressed sexuality.

Relational difficulties also covered a broad spectrum. Rigid hierarchical structures and sex role stereotyping and gender issues were common. Lack of tolerance from persons associated with extremely "conservative" Religious Orientation became problematic as did inappropriate child-rearing practices (either too strict or too

tolerant.) The problem of widely divergent views of Religious Orientation by spouses was another problem brought forward by the Delphi group. Also identified were families with low spiritual self-esteem, that is, families who thought that their spirituality was not good enough.

Table 12

Problems Associated with Religious Orientation (N =20)

Participants were asked to identify specific problems associated with Religious Orientation. DQI described 48 specific problems; 21, or 44%, were identified by 80% or more of DQII respondents as "Important" or "Very Important."

Weighted Scores (W.S.) are presented in left column and represent the mean scores of respondents' evaluations based on the 1 through 5 Likert scale of the DQIII, where 1 = very important and 5 = irrelevant for consideration. Thematic groupings were made at the investigator's discretion.

STATEMENTS REGARDING THE INDIVIDUAL

W.S.	
1.50	Shame orientation
1.55	Biblical passages often taken out of context or misapplied
1.55	Black and white thinking
1.70	Guilt about own needs
1.75	Religious platitudes viewed as solutions
1.75	Perfectionism
1.75	Negative self-image
1.80	Over-dependence on spiritual explanation of all events
1.90	Religious rationalization
1.85	Strong desire for control
1.90	Repressed sexuality
1.90	Denial of emotional or physical problems
2.00	Confusion of genuine mental illness or addiction with a "weak will"

(table continues)

Table 12, continued

STATEMENTS REGARDING RELATIONAL DIFFICULTIES

W.S.	
1.75	Rigid sex roles and stereotyping
1.75	Inappropriate child-rearing problems (either too rigid or too tolerant)
1.85	Gender issues
1.90	Rigid hierarchical structures
1.90	Lack of tolerance from persons associated with extremely "conservative" R.O.
2.15	Widely divergent views of R.O by spouses
2.35	Families who think that their spirituality is not good enough.

DQIV

The scope of this study was broadened somewhat in the fourth questionnaire (DQIV), in which participants were asked to place information generated by this study in various contexts. Specifically:

1. Agreement or disagreement response to a proposed definition of Religious Orientation was solicited, on a Likert scale (1-5) with invitations to indicate how participants would modify the proposed definition;

2. Participants were asked to cross-reference and record their evaluation of possible interactions between characteristics of Healthy Family functioning identified in a 1990 Washington DC study conference with Religious Orientation assets to family functioning;

3. Specific therapeutic strategies regarding identified common problems were solicited.

Cross-Impact Analysis: Well Families and Religious Orientation

This element of the Delphi exploration of Religious Orientation in marriage and family therapy asked the participants to record their perceptions regarding possible relationships between eight previously identified characteristics of Healthy Family Functioning and seven characteristics identified by this study as attributes of Religious Orientation which could be considered as assets to well family functioning.

Discussion of Cross Impact Findings

The participants were asked to record their assessment of the strength of a possible relationship between eight previously identified characteristics of Well-Family functioning and seven characteristics of Healthy Religious Orientation identified in the present study. These relationships will be discussed under the headings of the eight characteristics of Well-Family functioning and are displayed in Table 13. Mean weighted scores of 1.75 or less, indicating the panel's consensus estimate of a Strong to Very Strong relationship, will be the focus of discussion here. (The panelists were not asked to suggest causality.)

Adaptive Ability

Adaptive Ability refers to the family's capacity to adjust to predictable events and life-cycle changes, as well as the capacity to handle the unexpected stressors of life.

Participants in this study indicated a very strong perceived relationship between adaptive ability and the framework for coping with stress that a healthy Religious Orientation can provide. This framework may consist of several stable and predictable relationships and assumptions which were also identified by this study as being associated with adaptive ability. Specifically, mutual respect between husband and wife, relationships characterized by intimacy, and forgiveness cultivated in the context of a healthy Religious Orientation were associated with adaptive ability. Personal

responsibility was also identified, linking adaptive ability and Religious Orientation.

A healthy Religious Orientation provides a framework within which experiences make sense, where the individual experiences the integration of thought, feeling and behavior, an expanded world view which is empowering for growth. This cognitive framework enables the individual to work out life's struggles; it is holistic in scope, flexible, and enhances general well-being.

Clear Roles

This construct refers to a clear and flexible role structure in which family members know their roles and responsibilities and thus are able to function effectively in times of crisis as well as during normal times.

The Delphi group indicated that family members' perceptions of family roles as both clear and flexible were very strongly associated with the levels of mutual respect within the family.

The improved self-concept and emphasis on personal responsibility associated with healthy Religious Orientation were also identified as correlates to the concept of clear role definition in the healthy family. Identified aspects of healthy Religious Orientation contributing to a positive self-concept included an awareness of relationship to God and others: integrated thought, feeling and behavior in the context of a belief system congruent with the general demands of life, developmental tasks, and world view. Personal responsibility is encouraged by healthy Religious

Orientation through the individual's responsible use of freedom and self-discipline as tools to achieve mature differentiation--clear self-developed boundaries coupled with flexibility and adaptability.

Commitment to Family

This involves both the recognition of individual worth and acceptance of the value of the family as a unity.

The strongest relationship among Religious Orientation characteristics of "Commitment to family" was that of intimacy. This characteristic of loving connection was identified by the panel as central to commitment and was coupled with mutual respect and personal responsibility. In addition, the values which the family shares as its central focus or core were cited as an important component of commitment. The reciprocal relationship may also be considered; that the commitment to the family strongly influences the values of the individual and the family they represent.

Another relationship suggested by the participants linked commitment to the family with the characteristic of the framework which Religious Orientation provides. The reciprocal interaction of commitment and structure presents a comforting and stabilizing influence during stressful episodes. The relationship suggests the development of a secure cognitive/emotional context within which life events seem more manageable.

Communication

That patterns of clear, open and frequent communication among family members should be regarded as indispensable to well

family functioning is generally assumed. Specific relationships to Religious Orientation characteristics identified as assets to family functioning, while fairly predictable, do indicate the mutually supportive context of Religious Orientation and well family functioning.

Not surprisingly, the strongest perceived relationship was between the characteristic of mutual respect and communication. The Delphi group was in almost absolute agreement at the Very Strong level (1.06 where 1.00 is perfect agreement of all participants.) Intimacy and forgiveness were also strongly associated with clear, open and frequent communication among family members. This process would foster an awareness of human frailty, engendering compassion and capacity for forgiveness.

Participants identified perceived linkages of the communication characteristic with that of improved self-concept. Communication was also associated with the Religious Orientation based asset of a framework for coping with stress.

Encouragement of Individuals

This construct refers to the family's ability to encourage a sense of belonging at the same time as individual development is encouraged.

The encouragement of individuals within the family encompasses a variety of attitudes and behaviors which assist in the development of individual strengths and interests while cultivating the awareness of family cohesion and acceptance. Family members

benefit from a structure which encourages but does not confine (Krystan, Moore and Zill, 1990.)

Characteristics identified by the Delphi group fit this description well. In their description of the characteristics of a healthy Religious Orientation which can be assets to healthy family functioning, the asset most strongly identified with individual encouragement was mutual respect. When respect is coupled with intimacy, as it is here, in relation to individual encouragement, it is not surprising to find that improved self-concept is part of the package. The encouragement of individuals would also include appropriate individuation at various life-cycle stages, bringing both personal responsibility and forgiveness into focus.

Expression of appreciation

Walter Schumm described the well family characteristic of appreciation as one which delivers "a high level of positive reinforcement to family members, day in and day out, doing things that are positive from the other person's perspective, just for their sake" (Schumm, 1986).

The two healthy Religious Orientation characteristics identified by the Delphi participants as being very strongly related to the expression of appreciation were intimacy and mutual respect. Improved self-concept was also strongly related to appreciation as was personal responsibility.

Shared Time

This refers to the sharing of both quality and quantity of time by family members and the degree to which this is enjoyable for family members. Shared time was identified as an important relationship to two characteristics of healthy Religious Orientation--mutual respect and intimacy.

Social Connectedness

The connection between the family or family members and the larger society, including extended family, friends, neighbors, and the general community was linked to only one aspect of the identified healthy Religious Orientation assets to family functioning. The Delphi panel did consensually assert that social connectedness was associated with the framework for coping with stress that a healthy Religious Orientation can provide. This framework would include mutual commitments by and to the chosen community of faith and the many resources which it could provide.

Summary Observations regarding Healthy Religious Orientation Assets and Family Functioning

Mutual respect between family members, and particularly between husband and wife, was the characteristic most frequently cited by the Delphi participants in their assessment of positive relationships between assets to family functioning associated with a healthy Religious Orientation and other identified characteristics of well family functioning. Mutual respect was identified as having a

strong or very strong association with seven of the eight well family attributes.

The associated characteristic of intimacy linked with a healthy Religious Orientation was strongly or very strongly identified with six of the eight well family characteristics.

Personal responsibility, as a characteristic encouraged by a healthy Religious Orientation was strongly associated with five of the eight well family attributes.

While "values as a central focus or core" was identified by the Delphi panel as being an important characteristic or an asset to family functioning, that same group strongly associated this particular characteristic with only one of the well family attributes--that of commitment to family.

Table 13

Cross-Impact Analysis (N =16)

Characteristics of Healthy R. O.	Characteristics of Well-Family Functioning: Adaptive Ability	Clear Roles	Commitment to Family	Communication	Encouragement of Individuals	Expression of Appreciation	Shared Time	Social Connectedness
Forgiveness	1.63	2.69	1.94	1.44	1.69	2.17	2.75	2.38
Framework for coping with stress	1.13	1.88	1.75	1.38	2.06	2.31	2.25	1.69
Improved self-concept	2.06	1.56	2.06	1.75	1.31	1.44	2.38	2.00
Intimacy, loving connection	1.56	1.81	1.31	1.25	1.38	1.13	1.38	2.06
Mutual respect (husband/wife)	1.50	1.19	1.50	1.06	1.13	1.13	1.38	2.00
Personal responsibility	1.69	1.44	1.50	1.81	1.69	1.75	2.13	1.94
Values are central focus/ core	2.06	1.93	1.69	1.93	1.81	2.25	2.38	1.88

(table continues)

Table 13, continued

Explanatory Notes for Table 13

The results of the participants' evaluations of possible relationships are displayed in Table 13. A one-through-five Likert numeral scale was employed where 1 = Strong Relationship and 5 = No Relationship. The table records mean weighted scores for participant responses.

Weighted Scores are based on the following Likert scale which was used in the DQIV questionnaire:

Strongly Agree				Strongly Disagree
1	2	3	4	5

Weighted Scores were computed as follows:

$$\text{Weighted Score (W.S.)} = \frac{1(A) + 2(B) + 3(C) + 4(D) + 5(E)}{N}$$

where A, B, C, D, and E each represent the number of participants who whose the corresponding numerical score for the item under consideration, and N = the number of participants. For DQIV, N = 16.

Problem Area Interventions

In addition to the cross-impact evaluations, participants were also asked to consider and record specific therapeutic approaches to the identified problem areas recorded in Table 12. Through the Delphi process, participants identified seven specific problem areas sometimes associated with Religious Orientation. In the final round (DQIV) they were asked to briefly indicate the kind of therapeutic approach they might take for each identified problem. In this section the identified problem statement is followed by a listed compilation of participant responses.

Many of the responses indicate "generic" approaches which could be employed usefully in any context. Other responses focus specifically on aspects of Religious Orientation in order to work with the clients' world view.

Biblical Passages taken out of context or misapplied

- Loosening moves to help people view the material with greater flexibility;
- encourage awareness of context;
- affirm the Biblical concept and offer information to clarify context. This is not confrontational, but exploratory;
- education;
- read parallel passages and similar themes, looking for consistency across interpretations;
- explore the spirit of the law;
- explore the existing expressed meaning with the client;

• discussion of difficulties involved in change;

• adopt a position of curiosity, of intentionally "not knowing reality" in order to explore the importance of this context with the client;

• explore power issues; and

• consultation with expert sources, individuals, books, video and/or audio tape.

Black and White Thinking

• Provide a third alternative;

• Shift from an emotional to a cognitive frame;

• Explore the usefulness, both positively and negatively, of these thought patterns in family of origin and current circumstances;

• Cognitive reframing;

• Recognition that this type of cognitive pattern is not the only type available, e.g. metaphor of a dimmer switch as being as effective an instrument as an on/off switch, yet being more controllable;

• Use of multiple interpretation, paradox, strategic or straight cognitive approach;

• Encourage complete discussion of issues leveraging the value of ambiguity in exploration;

• Problem solving approaches;

• Explore exact meanings of terms in statements and alternatives; and

• Investigate the client's denial of gray areas in the context of the faith-doubt tension.

Guilt about One's Own Needs

• Look at transgenerational patterns;

• Emphasize that self-love is appropriate in Religious Orientation context, e.g. Love your neighbor as yourself;

• Group;

• Be playful, funny, encourage taking good care of self; self is a gift from God;

• Explore needs and consequences of having needs;

• Probe family of origin, especially relating to self-esteem;

• Reframe superego voice as something other than God;

• Suggest the voice of love as counterpoint to the guilt-inducing voice;

• Discuss being created in the image of God;

• Differentiate between "real" and "false" guilt;

• Gestalt approach--discover who they are protecting through their self-sacrifice and stay with the anxiety without taking care of them; and

• Engage the individual's Religious Orientation and reframe focus on loving neighbor as you love yourself.

Perfectionism

• Examine the lives of Biblical "greats" like Peter, David, etc. Notice "imperfections" in their character and conduct;

• RET; Cognitive restructuring, confrontation of irrational beliefs;

• Reframe as personal idolatry (only God is perfect);

• Encourage expression of fears which underlie symptoms;

• Go with feelings associated with feeling "imperfect";

• Monitor and modify self-talk and expectations;

• Discuss Genesis 1:26, 27. God places us here to "manage" our environment, not to make it perfect. God calls us to excellence, (doing the best we are capable of, not more);

• Focus on the theological issues of idolatry and justification by good works in order to counteract false authority;

• Focus on the accepting nature of love and grace (as contrasted with approval based on works and perfectionistic behavior);

• Use lots of negative metaphors (e.g. monkey on your back);

• Look for origins of insecurities;

• Paradoxical--amplify the symptom.

<u>Shame</u>

• Identify family patterns;

• Distinguish shame from guilt;

• Explore life experiences in family of origin;

• Work with forgiveness of self and others;

• Inner child approach;

• Reframe shaming voices as false gods;

• Explore religious teachings from "shaming perspective", especially early formative teaching;

• Work on building self-esteem. Emphasize differentiation and identity formation; and

• Examine source and current meaning of shame.

Strong Desire for Control

• In context of Religious Orientation, may reframe as desire to be God, or unwillingness to trust God;

• Examine family of origin;

• Identify defensive uses of control;

• Develop alternative ways to reach goal;

• Re-experience out-of-control feelings from family of origin, and stay with that experience until they know that they are safe;

• Discuss the role of God regarding the functioning of the universe;

• "The only thing we can control is ourselves and we need God's help to do that."

• Examine areas "under control" now'

• Examine worse case;

• Explore lack of trust issues;

• In the context of Religious Orientation, look at nature of God--is God strong enough to receive your cosmic trust?;

• Focus on anxiety issues and "letting go" techniques;

• Experiment with delegation of authority to others;

• Flooding--over-dose them with symptoms. Let them be in control of everything; and

• Twelve-step programs, modify as needed.

Widely Divergent Views of Religious Orientation by Spouses

• Discover common values;

• Solution focus;

• Different is not Bad, look for commonalities;

• Is this the "real problem" or is it a symptom?;

• Reframe differences as opportunity to learn about different perspectives and to better understand partner;

• Use material as focus for developing communication skills;

• Employ Religious Orientation in the service of tolerance, compromise and understanding;

• Focus on mutual respect and love;

• Investigate possible function of disagreement in this area, especially regarding differentiation and individuation;

• Explore the positive aspects of what each perspective offers to the relationship;

• Investigate complimentarity and support each feeling different from the other;

• Facilitate communication and exploration of origins and current manifestations of divergent views and gender/power implications;

- Evaluate importance of difference; triage and problem-solving; and
- Serenity Prayer

Chapter V

CONCLUSIONS AND RECOMMENDATIONS FROM THE STUDY

The stated purpose of this study was to discover and specify a set of indicators regarding "Religious Orientation" which would be helpful in developing theoretical constructs and practical clinical applications in the field of marriage and family therapy. Specifically, this included:

1. The provision of a consensus definition of "religious orientation" as the term is currently being used by an expert group of marriage and family therapists familiar with religious families;

2. The identification and prioritization of clinician's perceptions regarding the effects of religious orientation on "Well Family" functioning, both positively and negatively; and

3. The development of descriptions of clinician's perceptions of dimensions of behavior which can be employed beneficially in marriage and family therapy with religiously-oriented families.

The Delphi technique was employed in order to sample an expert panel familiar with Religious Orientation and family functioning. This four-wave Delphi was initiated with 14 open-ended questions which elicited a total of 598 specific items as descriptors for the various topics presented.

The Delphi process focused the initial responses at an 80% consensual agreement level for 317 item descriptors in Round Two (DQII). Those 317 items were re-submitted to the participants in Round Three (DQIII) and were generally strongly supported. Round

Four (DQIV) broadened the scope and integrated information generated in previous rounds into specific theoretical and clinical contexts.

Limitations of the study

In that this was an exploratory study, only broad outlines of topics under consideration were delineated. While this limitation was acknowledged at the outset, it engendered a certain level of frustration at not being able to provide more than a sketch of the subject. Still, a sketch is a good place to start.

The stated general goal of the study was "to go exploring and to begin mapping the territory." This initial venture, it is hoped, will be followed by more ambitious expeditions and many courageous explorers.

While the effects of Religious Orientation should not be under-emphasized, neither should they be over-emphasized. Acknowledging that it is important to recognize that one's conclusions must be limited and bounded by the data, the following limitations are noted. The participant sample was composed of family therapists with clinical, educational, and research experience focused specifically in the area of Religious Orientation. This was precisely the expertise that the design of this study sought.

Acknowledging the fact that this group does not represent the wide diversity that exists within the profession as a whole does not diminish the import of the information. The value of the study resides in the information developed by this group of experts and in

its availability to the field for further research, training, and clinical application.

The fact that most participants were white males undoubtedly colors the results. While religious affiliation was broadly distributed across the Protestant denominational spectrum, it was not exclusively limited to that domain, (For a full listing of participants' religious affiliations, see Appendix E.)

This study, exploratory in nature, does not attempt to generalize to AAMFT as a whole, but reports what these particular experienced clinicians, researchers and educators consider to be important aspects of Religious Orientation.

Summary and Implications

The field of marriage and family therapy has yet to seriously address the pervasiveness or the power of Religious Orientation as an important component of family functioning. The underlying assumption seems to be that Religious Orientation is irrelevant. The results of this study challenge that assumption.

As an overarching construct, as a starting point for further research and clinical intervention, it may be useful to view Religious Orientation as a culture. Preli and Bernard (1993) perceive "culture" as being a broad term encompassing not only ethnicity (the perception of group similarities deriving from common ancestry), but many broad and vital areas of human development. They quote Falicov (1988, p. 366), whose definition of culture was "those sets of

shared world views and adaptive behaviors derived from simultaneous membership in a variety of contexts."

In assessing the genesis of "those sets of shared world views and adaptive behaviors," the Religious Orientation of individuals and families cannot be ignored by the therapist, the training process, or the academic disciplines involved.

Whether to classify Religious Orientation as a culture in its own right, or as a component of culture, is not a central issue. The focus here is on the impact of Religious Orientation as an important variable in the lives of individuals and families.

While viewing Religious Orientation as a cultural phenomenon may be a useful approach in expediting further research, investigation into Religious Orientation should not be limited to the merely cultural domain. Research should also include the investigation of specific beliefs, their origins, and their many manifestations.

Qualitative methodologies seem particularly well suited to the in-depth exploration of the specific aspects of Religious Orientation which contribute to individual and family well-being. Following the data to its source, finding the origins of faith, is an enterprise worthy of investigation.

Summary of Results

Religious Orientation can be meaningfully defined and described. The consensual definition generated by this group of

experts suggests specific parameters. Descriptions of many facets of Religious Orientation are presented herein.

This study identified specific areas of Religious Orientation important to well family functioning. This movement toward a more detailed understanding of Religious Orientation will help guide future research into this region.

The central assertion of this study suggests that Religious Orientation can be a healthy, stabilizing, life-enhancing perspective about which individuals and families may organize their lives and experience. This assertion is in keeping with benefits earlier researchers have suggested.

Several family therapists and researchers have asserted that there are identifiable positive aspects of a spiritual-religious orientation for both the client and the therapist. Some of these benefits include: a sense of shared values (Bergin, Masters & Richards, 1987; Herr & Niles, 1988), awareness of the presence of the divine in a relational dimension (Griffith, 1986), opportunities for therapeutic alliance with the divine as well as discussion about the sacred as a significant diagnostic tool (Pattison, 1982). Pollner (1989) proposed that divine relations can function as do other positive social relations in terms of increased self-esteem and personal empowerment, providing a sense of order, coherence and meaning. Prest and Keller (1990) asserted that the linguistic nature of family therapy opens a treasure-house of previously ignored

resources of metaphor and specifically spiritual narrative for the therapeutic process.

Pattison (1982, p. 141) asserted that "religion is not merely an epiphenomenon of family belief, but is an intrinsic part of the structure, order, and dynamic of family life and function." This study supports that contention.

There are characteristics identifiable by experts in the field which are typical of a healthy Religious Orientation. Despite the anti-religious bias of much of the psychological literature, "Healthy Religious Orientation" is not a contradiction in terms. There are aspects of a healthy Religious Orientation which can be identified as assets to the individual, the family, and the therapeutic process.

Furthermore, these characteristics can be distinguished from the characteristics of an unhealthy Religious Orientation. Participants in this study were able to discriminate not only between the general characteristics but also between those characteristics which were perceived to be detrimental to individuals and families, and those which were perceived to be assets to healthy family functioning. Item lists exhibited no overlap between categories of healthy and unhealthy Religious Orientation, indicating that clear distinctions could be drawn.

Theoretical Implications: Reflections upon the Field

In the sense that "Mind is social", the collective mind of the field of marriage and family therapy may be described as having a set of operative beliefs and assumptions.

In the context of the marriage and family therapy literature including training, theory, and clinical practice, the operative assumption regarding Religious Orientation, seems overall to be that Religious Orientation is irrelevant. This may be a hidden assumption, a blind spot in the field of vision, of which the mind is unaware. A hidden assumption, blindly accepted, becomes incorporated into the structure of thought and as such operates outside the realm of awareness (Lewis, 1986.) As a discipline, the unwillingness or inability of marriage and family therapy to investigate Religious Orientation as an important factor in family functioning may be viewed as a characteristic of a system which has limited its ability for exploration through the acceptance of a paradigm-limiting assumption. Recursive interaction of new information with the internalized assumption results both in the reification of the construct and in the coloration of future thought.

As has been suggested, the assumption that Religious Orientation is irrelevant to marriage and family therapy may have its origins in Freud's militant atheism or in Descartes' approach to science. The important point at this juncture is to notice that because this assumption is hidden, it has gone largely unchallenged. There is a general acceptance of the Cartesian reductionistic and dis-integrative dualistic paradigm conceptualizing mind/body, material/immaterial, and objective/subjective splits in the punctuation of perception. The acceptance of both that paradigm and the assumption that Religious Orientation is irrelevant has excluded

the investigation by marriage and family therapy of a vast realm of human experience having to do with one of the most powerful organizing constructs of all human history.

It is precisely that assumption, which posits that Religious Orientation is irrelevant to MFT, that the results of this study directly challenge. Moving this assumption into the realm of the conscious (relative to the field of marriage and family therapy) offers the possibility of change through expanded awareness and re-evaluation of underlying assumptions and thought structures.

Clinical Implications of the Study

Clinically, identification of these characteristics of Religious Orientation, and distinctions drawn between positive and detrimental aspects of Religious Orientation, could serve as a useful tool in assessment and intervention. Religious Orientation is, for many, the central organizing paradigm of their lives. Religious Orientation has characteristic structures of thought, relationship, ethics and world-view. Type of Religious Orientation can influence individual development, family structure and functioning.

In "larger systems" terms, there are characteristics of Religious Orientation which strongly influence regional cultures, nations and civilizations. Religious Orientation influences are felt in perceptions of national character and in relationships between cultures, nations and civilizations.

In terms of clinical utility, participants in this study have identified many characteristics which they have strongly,

consensually, asserted to be assets to the therapeutic process and to well family functioning. Supporting this perspective, Turner (1993, p. 14), in his work "Identifying African-American Family Strengths," warns that "the therapist should be careful not to underestimate the potency of the church and religion as integral components of intervention strategies."

Awareness of, and respect for, the Religious Orientation of both the client and the therapist was identified as a central concept by the participants. Respect for the context, world view, organizational characteristics and cultures of Religious Orientation will help to counteract the momentum of a mental health delivery system where "many programs and institutions force clients to accommodate to standard services rather than providing services that are culturally relevant to those clients" (Rodriguez-Nelson, 1991, p. 4).

The desirability of genuinely honoring the Religious Orientation of both the client and the therapist goes far beyond the elements of building rapport, mutual respect or joining, important as those are. Awareness of the Religious Orientation of the client offers an avenue for the respectful exploration of the world-views of all involved. When participants in a dialogue are mutually honoring the perspective of the others, the opportunity exists for the client-therapist system to enter what Anderson and Goolishian (1988) refer to as the Conversational Domain. Griffith cites Braten, who in this context suggests the importance of mutuality, understanding and

respect in order to facilitate the emergence of the Conversational Domain which

> arises only when the participants engage in dialogue that offers the perspective of each, while creating an opening for the perspective of the other. It cannot arise when participants offer monological perspectives that deny space for the other (Griffith, 1990, p. 22).

In this domain, participants engage in a genuine dialogue through which multiple perceptions and perspectives are entertained and explored. Entering this domain consists of recursive, reflexive, and inventive interchange and exchange of ideas, concepts, meanings and stories, through which perception is recursively transformed and change promoted.

The focal point here is that of therapeutic opportunity. If the therapist is to provide an atmosphere conducive to change, that atmosphere can be enriched through an awareness of and genuine respect for the Religious Orientation of the client.

The participants in the present study offered a catalogue of characteristics of an unhealthy Religious Orientation which would tend to inhibit the development of a Conversational Domain. The therapist who is aware of both his/her own Religious Orientation and that of the client would have greater opportunity to circumvent those potential barriers through a careful and respectful exploration of issues related to Religious Orientation.

Implications for Training, Education, and Supervision

One of the Delphi participants added the following astute comment reflecting upon this study and the educational process:

> I think that Rizzuto's statement in her book "The Birth of the Living God" that analysts suffer from the countertransference problem of never investigating their mental representations of God in their personal analysis; is relevant to marriage and family therapists also. Therapists are always intervening in the world-view and belief systems of their clients, and it would be helpful if the operative religious orientation of the therapist was brought more into consciousness as an important factor in the process of marital and family therapy. So while the study has its focus on the perceived religious orientation of the clients, it also is profoundly connected to the religious orientation of the therapist as well.

Training and supervision programs should openly address the presence or absence of an identifiable Religious Orientation and derived implications. Questions of therapist's stance, values, structure, and resulting perception of the family relative to the therapist's own Religious Orientation and its attendant attributes should be addressed. Relationships between the supervisor and supervisees should also be examined from this perspective.

If Religious Orientation is perceived to be an important influence in family functioning, the field of marriage and family therapy should investigate this area thoroughly. In the same way that the field has been enriched through the examination of ethnicity, gender issues, life-cycle perspectives, and multiple epistemological stances, the study of Religious Orientation by the profession should be enthusiastically undertaken in order to expand understanding in this area.

Religious Orientation is not a superstition to be feared or dismissed, but an important organizing paradigm to be explored.

Implications for Research

It might be useful to view Religious Orientation as a cultural phenomenon in order to bring established research methods, both qualitative and quantitative, quickly into the investigative process. Examining Religious Orientation from a cultural perspective might be less threatening to a discipline which has been historically ambivalent toward this region of human experience.

Further research might explore individual aspects of Religious Orientation in order to more closely analyze some of the characteristics identified in this study. The following list represents comments made by this panel regarding specific areas of Religious Orientation, in the context of marriage and family therapy, that they would be interested in exploring:

- Therapist/client matching and outcome;

• How levels of cohesion in family-of-origin correlate with religious affiliation;

• The level of impact Religious Orientation has in both mate-selection and the nature of the relationship developed;

• The extent to which insider/outsider perceptions and power differentials are exacerbated or minimized when Religious Orientation is introduced into the client/therapist system;

• The effect of Religious Orientation on everyday life;

• The effect of Religious Orientation on the nature of the relationships among family members and family groupings, from specific dyads to intra-familial perceptions of households;

• Investigation of "cross-cultural" similarities among groups with similar Religious Orientation; for instance, how an Hispanic family is similar to and dissimilar from an Appalachian fundamentalist family;

• Therapist counter-transference, specifically regarding level and direction of therapist bias toward religion;

• Distinctions between male and female perceptions of God and Religious Orientation; how have those perceptions affected development;

• Comparison of well families and healthy marriages to unhealthy ones in relation to type or presence of Religious Orientation;

• Ethical questions related to achieving a balance between exploring these issues and evangelizing, between being one's self as a therapist and imposing one's self as a person;

• How to integrate Religious Orientation issues into the practice of various marriage and family therapy models;

• Training issues regarding supervisory processes;

• The specific factors involved in making a decision based on Religious Orientation;

• The arts as a primary means of experiencing and expressing the spiritual;

• How religion provide a sacred space that facilitates marriage and family therapy;

• How rituals might help or hinder the therapeutic process;

• How families and therapists distinguish between the seal of the confessional and destructive secret-keeping;

• How cultic beliefs and practices impact marriage and family therapy;

• How Religious Orientations precipitate (or get blamed for) marriage and family problems;

• The relationship between Religious Orientation and physical health;

• How therapy influence Religious Orientation;

• Whether clients tend to develop a Religious Orientation similar to their therapists;

• How this study might affect the attitudes of MFT leaders toward religious leaders, given the fact that the AAMFT has generally distanced itself from many of the clergy who were so instrumental in the early growth and development of the MFT movement.

Conclusion

The Relativity of Einstein and the Uncertainty Principle of Heisenberg belong to the "Pleroma", a term Bateson (1987) borrowed from Jung to describe the physical realm and the relationships between elements within that realm. It may be an essential mistake to attempt to transfer the Relativistic paradigm (which offers a more comprehensive description of the physical realm than the Newtonian paradigm) to the ethical realm.

This would parallel the previously noted confusion brought about by the erroneous imposition of the Cartesian dualisms into the study of human relationships. Mind/Body, material/immaterial dichotomies parallel the assumption of mind/value dis-integration. A moral or ethical relativism, while potentially valid at the periphery of multi-cultural investigation, may not fit when applied to more essential propositions of human nature and human civilization.

While acknowledging that there are some societies which sacrifice their young on a wholesale basis, engage in slavery or cannibalism and see "ethnic cleansing" as an appropriate and worthy societal goal, the manifest general outrage at such behavior points to

some underlying commonalties of morality and ethics based on elemental values.

The apparent trend in academic and national circles is to pursue Multi-cultural appreciation and tolerance. This seems to focus first on the explicit and obvious cultures of ethnicity, race, gender and economics. Ironically, Religious Orientation is an obvious culture which is most frequently left off the agenda because it is not championed under a radical banner or political correctness. If the multi-cultural effort is to be pursued, then academic as well as national institutions would be well and better served to include Religious Orientation in its agenda of honor and acceptance, due to its breadth and depth and its ability to transcend and include other cultures in a wider world-view or orientation. If the multi-cultural agenda is to be promoted honorably, all cultures must be included, especially those which can serve to assist the unity and respect of all persons.

Insofar as Religious Orientation constitutes a broad and general culture in the United States, it can be said to influence families and individuals, even those who do not consider themselves "religious". Even if one does not personally ascribe to the specific tenets of a particular culture, its effects can be both widespread and influential in one's own development and thinking.

This study indicates that there is broad agreement by a group of experienced marriage and family therapists familiar with individuals from various religious traditions and diverse cultures,

who speak in a single and united voice toward respect for differences, commonalities and transcendent visions of the family. Could these ideas and impulses be applied as well to the struggles of the broader human family?

Marriage and family therapists, as well as the academy in which they are trained, would be well served to examine the assumptions which often exclude Religious Orientation from consideration as a viable and valuable culture or component of culture. These investigations might well yield a better understanding of the roots of Religious Orientation, the religious cultures which undergird families, as well as the associated problems. An improved understanding would offer accessible and valuable therapeutic information, which would certainly be assets to the therapists who work with religious and non-religious families alike.

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Appendix A--DQI

Dear _____,

Again, many thanks for agreeing to participate in this Delphi study of Religious Orientation in Family Therapy.

The initial questionaire is enclosed and consists of 14 open-ended questions. Please take time to consider each question, as your responses will form the basis for the rest of the study. This first round should take about one hour. Subsequent rounds will consist mainly of circling numbers and checking boxes, and will require considerably less time to complete.

The two week turn-around time is important so that we can process the data and get the next round to you. Please use the enclosed self-addressed, stamped envelope to be sure your response reaches me by November 30,1992.

If you have any questions, please call me at (703) 362-6650.

Sincere best wishes,

W. Keene Carruthers

enclosures: Delphi Questionaire #1,
SAS envelope
Informed Consent Form

November 2, 1992

Dear Participant,

This material has come to you through a nomination process by which I am enlisting AAMFT researchers, therapists and educators familiar with issues associated with religious orientation and family functioning.

Purpose: The purpose of this study is to define and investigate characteristics of Religious Orientation impacting family functioning, based on the perceptions of the study participants.

Time: This is a Delphi study which employs a multiple-wave questionaire series over a period of three months. The first questionaire consists of 14 open-ended questions and has taken pilot study participants about one hour to complete. The three subsequent questionaires are built around the results of the first, using Likert scale responses indicating your degree of agreement or disagreement for a given statement, but require considerably less time to complete (e.g. aproximately one half hour per questionaire.)

Commitment: If you wish to participate in this study we need from you a firm commitment to rapid turn-around times, in order to expedite the completion of the project (two weeks for the first questionaire, ten days for the three subsequent questionaires.)

Questions: If you have any questions about the study please call me at (703) 362-6650.

If you are able to participate in this project, please complete the enclosed questionaire (DQI), read and sign the Informed Consent Form. Please be sure the material reaches me by November 30, 1992. Also, please include your full name, address and telephone number so that we may contact you directly for subsequent mailings.

Thank you, in advance, for your contribution to this research.

Best wishes,

W. Keene Carruthers
P. O. Box 9711, Hollins College
Roanoke, VA 24020 (703) 362-6650

Informed Consent Form

In order to comply with the "Human Subjects" research safeguards at Virginia Polytechnic Institute and State University, the following information is presented for your consideration. If, having read the conditions described below, you agree to participate in the study in accordance with the cited provisions, then please sign at the bottom of the page and return with Delphi Questionaire #1.

1. All information which you provide is voluntary and confidential. This information will be protected by a numerical coding system to which only the primary researcher has access. This will insure that your responses are held in confidence.

2. The only exception to #1, above, regards the biographical information which will be requested of you. This information (Education, Professional Credentials, Publications, etc.,) will be published with the summaries of this study unless you object, in which case it will be withheld from publication.

3. The purpose of this study is to define and investigate characteristics of Religious Orientation impacting family functioning, based on the perceptions of the study participants.

4. The Virginia Polytechnic Institute and State University Human Subjects Review Process has labeled this project "minimal risk" to participants (Independent Review Board Approval Reference # 92-195.)

5. People who participate in Delphi studies consistently report having had very positive experiences in terms of personal and

professional growth and development. Your participation will involve mapping a territory which has at present few established landmarks. We expect that your participation will provide a significant contribution to the expansion of theoretical clarity and clinical utility in Marriage and Family Therapy.

6. Participants may withdraw from this study at any time without penalty of any sort.

7. Participants will receive a summary of study findings.

8. Questions or concerns regarding the nature of the study or the Human Subjects Review Process may be directed to

Dr. Janet Johnson
Acting Associate Provost for Research
306 Burruss Hall
Blacksburg, VA 24061-0244
(703) 231-6077

or to W. Keene Carruthers
(703) 362-6650

_____ Signature

Delphi Study Round 1: Religious Orientation and Family Therapy

Instructions: Please respond to the following questions/statements. If additional space is required, feel free to use the reverse side of the page.

1. Please identify the characteristics, attitudes, behaviors, thought structures, beliefs, etc. that you use to describe or define a healthy religious orientation.

2. Please identify the characteristics, attitudes, behaviors, thought structures, beliefs, etc. that you use to describe or define an unhealthy religious orientation.

3. What are your basic assumptions about religious orientation?

4. What are your basic assumptions about religious orientation in the practice of Marriage and Family Therapy?

5. What do you believe can be psychologically valuable about a religious orientation for individuals?

6. What aspects of religious orientation may be detrimental for individuals?

7. What aspects of religious orientation do you believe can be assets to healthy family functioning?

8. What aspects of religious orientation may be detrimental to healthy family functioning?

9. What do you think are the beliefs about religious orientation most commonly held by the families you have seen in the context of family therapy?

10. How can religious orientation be an asset to therapy?

11. What, if any, specific problems, or types of problems, in your experience are associated with religious orientation?

12. Do you distinguish between spirituality and religious orientation? If so, how?

13. After having thought about this topic for a while, how might you define religious orientation?

14. What other questions about religious orientation in the context of Marriage and Family Therapy would you like to explore?

Appendix B--DQII

December 16, 1992

Dear _____,

Don't panic! It's very bulky, but fairly simple and fast.

Many thanks for the time and effort that you invested in Round One of the study. Your responses have been processed with the responses of the other members of our expert panel and are presented in the lists which follow. If you are one of the participants who could not meet the first round deadline, your expertise is still needed and desired in the following rounds. I hope you will be able to join us for the completion of the project.

Enclosed is the Second Round of the study. This portion involves checking boxes which indicate your estimate of the relative importance, or your level of agreement/disagreement with statements presented.

The quick turn-around time is important in order that the study may proceed as scheduled. Please be sure that I receive your completed questionnaire by January 13, 1993. Feel free to call (collect) if there are any questions or problems meeting the schedule: (703) 362-6650.

Please accept my sincere thanks for your thoughtful responses and serious effort in the first round. I appreciate, in advance, your timely and generous participation in the next phases.

Best wishes,

W. Keene Carruthers

enclosures: Delphi Questionnaire 2
SASE

Explanatory Notes

1. Don't Panic!! It weighs a daunting ton, but it's not that bad! Most of your responses will be check marks. The goal of this round is to clarify,distill and reduce the information we've developed.

2. While many item-entries are direct quotations, the large quantity and high quality of information which the first questionnaire elicited required a certain amount of consolidation and editing. It is our hope that we have captured both the spirit and the letter of the responses which you gave.

--I have chosen to capitalize the word God to respectfully represent all of the various descriptions of the study participants. (Higher Power, Creator, Sustainer, Life Force, Transcendent Being, Spiritual Source, Ultimate being, etc.)

--Religious Orientation has been abbreviated "R.O."

3. When recording your evaluation of the statements, please note that the check mark columns may have multiple uses e.g. Column #1 is for Very Important and/or Strongly Agree, Column #4 is for Irrelevant/Strongly Disagree.

--Your responses are being temporarily identified by code numbers (upper corner) until the study is completed. <u>All responses are confidential</u>.

Thank you again for your contribution to this study. As you can see, it's pretty interesting stuff....

Instructions for DQII

For each question in the initial questionnaire, responses have been catalogued into alphabetized item lists.

Part I Please indicate, by placing a check mark in the boxes provided, your best estimate of:

a.) the level of relative importance or

b.) your level of agreement or disagreement for the listed items.

Only check one box per item.

Descriptors

Very Important = Items which are essential, central, focal, critical. Having direct bearing on the issue, must be included, high impact.

Important = Items which are important to be included, relevant, significant-to-moderate impact, should be considered.

Somewhat Important = Items probably having some relationship to the issue, but of secondary importance, not having a determining impact but may influence topic.

Little Importance = Approaching irrelevance.

In that we are attempting to discriminate the relative importance of the various factors, please try to balance the distribution of your responses.

Part II Please indicate your estimate of relative priority for the five most important of the items listed for each question or statement. Note their priority by placing a rank beside it in the left-hand margin (1 for highest priority, 5 for fifth highest priority.)

Thank you very much

DQII

DQII:1

Attributes or Characteristics of Healthy Religious Orientation (R.O.)

1	2	3	4	5
strongly agree				strongly disagree

Acceptance of what is, of others and of difference	1	2	3	4	5
Balance in life and relationship	1	2	3	4	5
Balance of grace and law	1	2	3	4	5
Belief in transcendent God	1	2	3	4	5
Belief system congruent with the general demands of life, developmental tasks and world view	1	2	3	4	5
Capacity for compassion	1	2	3	4	5
Capacity for intimacy	1	2	3	4	5
Centrality of meaning	1	2	3	4	5
Clear sense of right and wrong	1	2	3	4	5
Cognitive framework within which the individual can work out life's struggles	1	2	3	4	5
Coherent with beliefs	1	2	3	4	5
Commitment to a community of faith	1	2	3	4	5
Compassion	1	2	3	4	5
Concern for justice and peace	1	2	3	4	5
Empowering for growth	1	2	3	4	5
Engaged with others	1	2	3	4	5
Enhances general well-being	1	2	3	4	5
Essentially life-enhancing	1	2	3	4	5
Expanded world view	1	2	3	4	5
Family of origin strongly influences the individual's view of God	1	2	3	4	5
Fidelity	1	2	3	4	5
Flexible	1	2	3	4	5
Forgiveness	1	2	3	4	5
Free to explore new ideas	1	2	3	4	5
God is fundamentally about unconditional love	1	2	3	4	5
God is just	1	2	3	4	5
God is only within one's self	1	2	3	4	5

God is trustworthy	1	2	3	4	5
God's love for me is a model for my love toward others	1	2	3	4	5
Golden rule	1	2	3	4	5
Holistic scope	1	2	3	4	5
Honest	1	2	3	4	5
Integrated thought, feeling and behavior	1	2	3	4	5
Internally motivated	1	2	3	4	5
Life is purposeful	1	2	3	4	5
Lifestyle characterized by love, forgiveness, reconciliation	1	2	3	4	5
Love and acceptance for self and others	1	2	3	4	5
Love motivated, not guilt driven	1	2	3	4	5
Mature decision-making based on values/ spiritual principles	1	2	3	4	5
Mature differentiation, clear self-developed boundaries coupled with flexibility and adaptability	1	2	3	4	5
Moral absolutes exist	1	2	3	4	5
Personal acceptance by God	1	2	3	4	5
Personal care of others	1	2	3	4	5
Personal integrity is very important	1	2	3	4	5
Positive self-image, self love because of God's love for me	1	2	3	4	5
Positive sense of full humanity; positive self concept	1	2	3	4	5
Priority of the divine	1	2	3	4	5
Promotes full humanity	1	2	3	4	5
Provides a framework within which experiences make sense	1	2	3	4	5
Regular practice of spiritual discipline	1	2	3	4	5
Relatedness to community	1	2	3	4	5
Relationship with God is personal, uniquely one's own	1	2	3	4	5
Religious community to provide support, challenge for growth, honest reflection and opportunity for service	1	2	3	4	5
Respect for life	1	2	3	4	5
Responsible use of freedom	1	2	3	4	5
Self-discipline results in freedom	1	2	3	4	5

Sensitive to presence and grace of God	1	2	3	4	5
There are many paths to God	1	2	3	4	5
Tolerant	1	2	3	4	5
Trustworthy	1	2	3	4	5
Willing to sacrifice for others' well being	1	2	3	4	5

DQII:2 **Attributes of Unhealthy Religious Orientation**

Statements	Rating scale				
Abdication of responsibility	1	2	3	4	5
Absence of peace	1	2	3	4	5
Absolute conformity to group standards	1	2	3	4	5
Abusive	1	2	3	4	5
Afraid to explore other ideas/approaches to an issue	1	2	3	4	5
Autocratic	1	2	3	4	5
Avoidance of difficulty, pain or suffering at all costs	1	2	3	4	5
Bad behavior is equated with being a "bad" person	1	2	3	4	5
Behaviors isolated from expressed beliefs	1	2	3	4	5
Belief in an entity outside of one's self that one must worship	1	2	3	4	5
Bizarre rituals or practices	1	2	3	4	5
Black or white thinking	1	2	3	4	5
Blaming	1	2	3	4	5
Blaming God for poor personal choices	1	2	3	4	5
Bound in slavery, rather than growth	1	2	3	4	5
Closed-minded	1	2	3	4	5
Closed awareness	1	2	3	4	5
Compulsive or patterned behaviors	1	2	3	4	5
Confusing my will with God's will	1	2	3	4	5
Critical	1	2	3	4	5
Defensive	1	2	3	4	5
Definite division between who is acceptable and who is not	1	2	3	4	5
Demanding	1	2	3	4	5
Denial	1	2	3	4	5
Difference is equated with "wrongness"	1	2	3	4	5
Distorted view of God	1	2	3	4	5
Dogmatically exclusive	1	2	3	4	5
Driven by what others will think	1	2	3	4	5

Statements	Rating scale				
Envy	1	2	3	4	5
Excessive focus on religious/spiritual meaning of every event or thought in life	1	2	3	4	5
Externally motivated	1	2	3	4	5
Extreme fundamentalism or pluralism	1	2	3	4	5
Factious	1	2	3	4	5
Family isolates from people who believe differently	1	2	3	4	5
Fear driven	1	2	3	4	5
Fear-focused: paranoid us/them approach to life	1	2	3	4	5
Fear of a transcendent Being without an understanding of the nature of love and acceptance	1	2	3	4	5
Fear of God is closer to terror than awe	1	2	3	4	5
Fear of punishment if performance is not perfect	1	2	3	4	5
Fearful of change	1	2	3	4	5
Focus on extremes	1	2	3	4	5
Focus on only one aspect of God	1	2	3	4	5
Hostile	1	2	3	4	5
Goal is gaining approval of God and others	1	2	3	4	5
God is a non-personal higher power	1	2	3	4	5
God is authoritarian	1	2	3	4	5
God is dangerous	1	2	3	4	5
God is detached	1	2	3	4	5
God is distant	1	2	3	4	5
God is judgmental	1	2	3	4	5
God is non-accepting	1	2	3	4	5
God is punitive	1	2	3	4	5
God is not interested in me or involved in my life	1	2	3	4	5
God created in the image of man	1	2	3	4	5
God is punitive	1	2	3	4	5
Guilt or shame is primary motivation	1	2	3	4	5
Idolatry	1	2	3	4	5
Indifferent to others	1	2	3	4	5

Statements	Rating scale				
Individual is unaware of own assumptions or beliefs	1	2	3	4	5
Informationally closed system	1	2	3	4	5
Judgmental	1	2	3	4	5
Justification of "wrong" behaviors through manipulation of religious doctrine, symbol or ritual	1	2	3	4	5
Lack of balance or integration of beliefs with the rest of life	1	2	3	4	5
Lack of empathy	1	2	3	4	5
Lack of self-control	1	2	3	4	5
Little capacity for spirituality or intrinsic religiousness	1	2	3	4	5
Little concern for the planet or social justice	1	2	3	4	5
Little or no belief system	1	2	3	4	5
Little sense of interpersonal responsibility	1	2	3	4	5
Magical thinking, God will fix it without my involvement	1	2	3	4	5
Manipulative, to control others	1	2	3	4	5
Manipulative, to make others conform to your views	1	2	3	4	5
Means justify the end	1	2	3	4	5
Mine is the only correct interpretation	1	2	3	4	5
Narcissistic	1	2	3	4	5
Narrow-minded	1	2	3	4	5
Negative orientation	1	2	3	4	5
No sense of connectedness to community	1	2	3	4	5
Non-caring	1	2	3	4	5
Not congruent with demands of "normal" life, (thereby contributing to development or perpetuation of problems)	1	2	3	4	5
Nothing less than perfection is acceptable	1	2	3	4	5
Overly dependent	1	2	3	4	5

Statements	Rating scale				
Overly serious	1	2	3	4	5
Passivity	1	2	3	4	5
Perfectionistic	1	2	3	4	5
Person is unable to distinguish when religious behavior is appropriate and when it is not	1	2	3	4	5
Prefers distance to intimacy	1	2	3	4	5
Prejudiced	1	2	3	4	5
Pride	1	2	3	4	5
Repression of "negative" emotions/thoughts	1	2	3	4	5
Resentful	1	2	3	4	5
Rigid/absolute thinking	1	2	3	4	5
Rigid definitions regarding acceptable behavior	1	2	3	4	5
Rigidly non-responsive to needs of others	1	2	3	4	5
Rule driven	1	2	3	4	5
Rules must be obeyed absolutely	1	2	3	4	5
Selective literalism in application of scripture to life	1	2	3	4	5
Self-deception	1	2	3	4	5
Self-oriented	1	2	3	4	5
Self-punitive, self-destructive behaviors	1	2	3	4	5
Self-serving	1	2	3	4	5
Spirituality or Religion is irrelevant	1	2	3	4	5
Spiritually superior	1	2	3	4	5
Strict, rigid suppression of growth	1	2	3	4	5
Unwillingness to respect religious orientation of others	1	2	3	4	5
Uses God as means to an end	1	2	3	4	5

DQII:3

Basic Assumptions about R.O.

Statements	Rating scale				
A creator exists	1	2	3	4	5
A human being is a spiritual being	1	2	3	4	5
A religiously oriented individual generally participates in a religious community of like-minded people	1	2	3	4	5
Affiliation with a religious group can be healthy or unhealthy	1	2	3	4	5
Affiliation with an organized religious group can provide emotional support, social awareness, awareness of community, improved self-esteem and sense of security	1	2	3	4	5
Cultural and ethnic components of R.O. are important	1	2	3	4	5
Each person must deal with the issue of God at sometime	1	2	3	4	5
Faith provides:					
a framework for the modulation of anti-social impulses	1	2	3	4	5
focus, direction	1	2	3	4	5
protection from narcissism	1	2	3	4	5
reinforcement of values	1	2	3	4	5
stability during crisis	1	2	3	4	5
Gives greater depth to human relationships	1	2	3	4	5
God creates and calls individuals into partnership in that creation	1	2	3	4	5
God is known only through the person of Jesus Christ	1	2	3	4	5
Harmony with God is the key to happiness and fulfillment	1	2	3	4	5
Healthy R.O. can be a wonderful resource	1	2	3	4	5

Statements	Rating scale				
"Healthy" vs "Unhealthy" R.O. can be assessed in terms of "Life-Giving"	1	2	3	4	5
Heightened awareness of every aspect of human condition	1	2	3	4	5
Humans have an essential longing for connection with God	1	2	3	4	5
Living one's faith, exposing others to it without imposing it is optimal	1	2	3	4	5
One's faith is directly related to legacy	1	2	3	4	5
Our relationship with God preserves the unique identities of each of us	1	2	3	4	5
People have the power to choose to what extent they will relate to God	1	2	3	4	5
Personality dynamics and the nature of R.O. are closely related	1	2	3	4	5
Practice and belief are associated but not necessarily causal	1	2	3	4	5
Principles of love, grace and forgiveness govern all human interaction	1	2	3	4	5
Pursuing integration and integrity will result in heightened spirituality and wellness	1	2	3	4	5
Relationship to God and other people is vital to personal well-being	1	2	3	4	5
Religions provide a variety of spiritual pathways that are available to a wide variety of people	1	2	3	4	5
Religions tend to formalize the relationships of persons and God	1	2	3	4	5
R.O. is central to development of values, morality, self-esteem and world-view	1	2	3	4	5
R.O. is largely an unconscious process	1	2	3	4	5
R.O. is largely determined by family of origin patterns	1	2	3	4	5
R.O. is manifest in our relationships with others	1	2	3	4	5

Statements	Rating scale				
R.O. is the basic context for all else	1	2	3	4	5
R.O. is the center, the core of attitudes, beliefs and behavior	1	2	3	4	5
R.O. shapes and molds, enhances or defeats, the basic impetus of spirituality which seeks connectedness with God and others	1	2	3	4	5
Scripturally based R.O. can be healthy	1	2	3	4	5
Unhealthy forms of R.O. are similar to other unhealthy mental structures and must be clarified and worked through	1	2	3	4	5

DQII:4

Basic Assumptions about R.O. in the practice of therapy

Statements	Rating scale				
Addressing issues emanating from R.O. is central to well family functioning	1	2	3	4	5
All family relationships express basic religious themes and beliefs which are central to the understanding of family dynamics	1	2	3	4	5
All of religion is being, rather than doing	1	2	3	4	5
All R.O. is both individual and personal, and it affects every relationship (marriage, family, friends)	1	2	3	4	5
Concepts of love, acceptance and forgiveness (which are central to many religions) can be very helpful in healing relationships	1	2	3	4	5
Family systems theory is an embodiment of Biblical principles	1	2	3	4	5
God can be viewed as a family member in the context of therapy	1	2	3	4	5
Healthy R.O. promotes healthy family functioning	1	2	3	4	5
Important to focus on how institutional religious practices impact the individuals and the systems involved	1	2	3	4	5
Individuation includes the R.O. dimension (ie, each individual making adult choices regarding beliefs and practices)	1	2	3	4	5
Issues of R.O. should be integrated into the training and supervision process	1	2	3	4	5
It is a decided advantage to work with persons having a R.O.	1	2	3	4	5
It is important to understand something of the client's religious culture	1	2	3	4	5
Love, justice and hope are modeled in R.O. and are essential for functional families	1	2	3	4	5

Statements	Rating scale				
Most family dysfunction is reciprocally related to low self-esteem	1	2	3	4	5
Only spiritual aspects (belief in oneself) have a place in MFT	1	2	3	4	5
Proselytizing is unethical (re: specific beliefs, R.O. or concepts)	1	2	3	4	5
Religious organizations can provide a support system during crisis	1	2	3	4	5
R.O. and religious practice are often central issues in marital conflicts and parenting problems	1	2	3	4	5
R.O. is subject to change over time	1	2	3	4	5
R.O. issues are increasingly acceptable in MFT practice	1	2	3	4	5
R.O. issues are increasingly acceptable in MFT theorizing	1	2	3	4	5
R.O. should be actively explored by the therapist because it's so important to family dynamics	1	2	3	4	5
Scripture provides guidelines for marital and family well-being	1	2	3	4	5
The core meanings and beliefs of clients and client systems are crucial to the therapy process	1	2	3	4	5
The operative belief system is more important than the professed	1	2	3	4	5
The R.O. of the parents is probably the most important organizing factor in the family	1	2	3	4	5
The therapist, in directing the therapy, must allow for grace	1	2	3	4	5
The therapist is never neutral in terms of values, belief and meaning systems	1	2	3	4	5
The therapist is not the healer, but provides the atmosphere where healing can begin or take place	1	2	3	4	5

Statements	Rating scale				
The therapist must be aware and respectful of own R.O. and his/her attitudes toward R.O. of others	1	2	3	4	5
The therapist must seek to not manipulate, convert, control or be intrusive into clients' values, beliefs and meaning systems	1	2	3	4	5
The therapist operates from a "value informed" position	1	2	3	4	5
The therapist's stance is that of love, acceptance, compassion and truthfulness	1	2	3	4	5
The therapist's stance must be respectful of R.O.	1	2	3	4	5
Therapists can be messengers of hope	1	2	3	4	5
Therapy is part of the co-creative partnership of individuals, the family, the therapist and God	1	2	3	4	5
Therapy is to inform the client of his/her R.O.	1	2	3	4	5
Though a valuable resource, a health R.O. does not guarantee specific resolutions or outcomes of therapy	1	2	3	4	5
When issues of R.O. are introduced into the therapeutic process, deeper levels of significance are opened to exploration	1	2	3	4	5
When parents have a clear and congruent R.O., it provides the children with a means to express and explore their own spirituality	1	2	3	4	5
Which religion isn't as important as that there is a religious core that supports the development of a healthy family	1	2	3	4	5

DQII:5

What about R.O. can be psychologically valuable for individuals

Statements	Rating scale
A healthy R.O. provides awareness of:	
a basis for love	1 2 3 4 5
a basis for trust	1 2 3 4 5
a framework to deal the guilt and forgiveness	1 2 3 4 5
a framework for moral justice	1 2 3 4 5
access to great wisdom	1 2 3 4 5
empowerment by being connected to a grace-filled and loving Higher Power	1 2 3 4 5
grace	1 2 3 4 5
hope	1 2 3 4 5
love	1 2 3 4 5
that God, not the individual, is the central fact of life	1 2 3 4 5
unconditional love from God	1 2 3 4 5
Ameliorates existential sense of aloneness	1 2 3 4 5
Biblical narrative provides models for relationships	1 2 3 4 5
Biblical model provides rich source of affirmation, metaphor, symbol, meaning and sense of history	1 2 3 4 5
Can provide a sense of meaning for life and events	1 2 3 4 5
Can result in greater self-awareness and emotional freedom	1 2 3 4 5
Encourages:	
a more loving approach to others and the larger world	1 2 3 4 5
active membership in a supportive, challenging, validating community of faith	1 2 3 4 5
balanced life style	1 2 3 4 5
charity	1 2 3 4 5

Statements	Rating scale				
Encourages:					
creativity	1	2	3	4	5
empathy, caring	1	2	3	4	5
fearless moral inventory	1	2	3	4	5
growth orientation	1	2	3	4	5
healthy reflection, introspection, self-awareness	1	2	3	4	5
individual responsibility	1	2	3	4	5
meaningful connection to others	1	2	3	4	5
people to trust the inner voice, spiritual intuition	1	2	3	4	5
positive self-image	1	2	3	4	5
self-actualization and self-transcendence	1	2	3	4	5
stable value system	1	2	3	4	5
world-view/focus beyond ourselves	1	2	3	4	5
Invites people into the loving freedom to be and to become themselves	1	2	3	4	5
Promotes:					
balanced individuated life	1	2	3	4	5
the value of humility	1	2	3	4	5
the value of commitment	1	2	3	4	5
Provides:					
a basis for confidence	1	2	3	4	5
a basis for constructing both identity and meaning	1	2	3	4	5
a basis for love, justice and hope	1	2	3	4	5
a relationship to the universe	1	2	3	4	5
a safe context to work through psychological difficulties	1	2	3	4	5
an optimal vehicle for personal growth	1	2	3	4	5
emotional, cognitive, interactional framework for healthy and optimal growth and development	1	2	3	4	5

DQII:6

Aspects of R.O. which may be detrimental for individuals

Statements	Rating scale				
Acceptance of institutionalized biases	1	2	3	4	5
Authoritarian R.O. can lead to false guilt and inhibited emotional development	1	2	3	4	5
Autocratic control	1	2	3	4	5
Calcified guidelines	1	2	3	4	5
Closed-mindedness	1	2	3	4	5
Commitment to principles not your own	1	2	3	4	5
Control of individuals by those in leadership positions	1	2	3	4	5
Denial of reality	1	2	3	4	5
Excessive dependence/co-dependence	1	2	3	4	5
Exclusion of other interests	1	2	3	4	5
Extreme self-denial	1	2	3	4	5
Extreme self-sacrifice	1	2	3	4	5
Gender inequalities	1	2	3	4	5
Guilt/shame based motivation	1	2	3	4	5
Identity formation is retarded/restricted through enmeshment with rigid structures of dogma	1	2	3	4	5
Infantile dependency	1	2	3	4	5
Imbalance of intuitive/cognitive dimensions	1	2	3	4	5
Imbalance of the several aspects of life	1	2	3	4	5
Inordinate stress on God as punitive judge	1	2	3	4	5
Isolationism--unwilligness to engage new ideas	1	2	3	4	5
Lack of self-confidence	1	2	3	4	5
Limits placed on the interpretation of events or the nature of meaning	1	2	3	4	5
Loss of identity as an individual	1	2	3	4	5
Mindless acceptance of statements, dictates, policies, etc.	1	2	3	4	5
Motivation by fear of punishment	1	2	3	4	5

Statements	Rating scale				
Overemphasis on any one doctrine or practice, which distorts worldview	1	2	3	4	5
Overemphasis on cognitive blocks development of intuitive/spiritual	1	2	3	4	5
Overpowering "sin consciousness"	1	2	3	4	5
Paranoid "us/them" mentality	1	2	3	4	5
Pessimistic view of history	1	2	3	4	5
Refusal to accept God's acceptance	1	2	3	4	5
Refusal to engage those who differ with us	1	2	3	4	5
Reliance on "the church" for all Truth	1	2	3	4	5
Repression of emotions	1	2	3	4	5
Rigid/intolerant	1	2	3	4	5
Rigid refusal to change	1	2	3	4	5
Unrealistic expectations of self and/or others (perfectionistic)	1	2	3	4	5
Unrealistic role expectations (for/of family members)	1	2	3	4	5
Using God to excuse/perpetuate dysfunction	1	2	3	4	5
Willingness to be taken advantage of (for the glory of God)	1	2	3	4	5
Withdrawal from society other than those of one particular group	1	2	3	4	5
Withdrawal of self from growth enhancing environments	1	2	3	4	5
"Works" based generalized anxiety	1	2	3	4	5

DQII:7

Aspects of R.O. which can be assets to healthy family functioning

(Several participants made reference to their answers for question one. If responses from Question one fit best for you, please add those items at the end of the list, with your importance rating.)

Statements	Rating scale				
Awareness of salvation	1	2	3	4	5
Basis of respect	1	2	3	4	5
Common language (symbol, ritual, epistemology)	1	2	3	4	5
Common perspective on "meaning"	1	2	3	4	5
Common values	1	2	3	4	5
Community development	1	2	3	4	5
Encourages loving connection/intimacy	1	2	3	4	5
Encourages personal responsibility	1	2	3	4	5
Encourages self-care	1	2	3	4	5
Focus on others	1	2	3	4	5
Forgiveness	1	2	3	4	5
God is Ultimate authority	1	2	3	4	5
Improved self-concept (I am created by God and I am unique)	1	2	3	4	5
Loving, honoring and forgiving parents when an adult	1	2	3	4	5
Meaningful relationships	1	2	3	4	5
Model for family	1	2	3	4	5
Moral constraints provide limits for dysfunctional behavior	1	2	3	4	5
Mutual respect	1	2	3	4	5
Mutual respect of husband/wife	1	2	3	4	5
Nurture by/of community	1	2	3	4	5
Parent/child bonding and mutual understanding through activities associated with religious practice	1	2	3	4	5

Statements	Rating scale				
Proactive	1	2	3	4	5
Provides framework for coping with stresses of life	1	2	3	4	5
Raising children in the nurture and admonition of God	1	2	3	4	5
R.O. defeats excessive ego-centrism/narcissism	1	2	3	4	5
R.O. promotes ethical responsibility	1	2	3	4	5
R.O. teaches the value of commitment/covenant	1	2	3	4	5
Shared religious activities (prayer together, hymns sung together, attending worship as a family, recreation in the context of R.O.)	1	2	3	4	5
Source of support	1	2	3	4	5
The family's mutual commitment and love include the Transcendent Being, the individuals in the marriage and their offspring	1	2	3	4	5
Validation	1	2	3	4	5
Values give family a central focus or core	1	2	3	4	5
Others:	1	2	3	4	5

DQII:8

Aspects of R.O. which may be detrimental to healthy family functioning

Statements	Rating scale				
Absolute obedience to person in higher positions in hierarchical structures	1	2	3	4	5
Can block intimacy	1	2	3	4	5
Conflicting R.O.s, when rigidly held by family members can produce a variety of family problems	1	2	3	4	5
Cult brainwashing	1	2	3	4	5
Denial of ambiguity	1	2	3	4	5
Differences in degree of commitment to religion can cause tension	1	2	3	4	5
Diminished sense of belonging	1	2	3	4	5
Doctrinal differences can be barriers to communication	1	2	3	4	5
Emotions are often rejected or neglected, thereby generating dysfunction	1	2	3	4	5
Equating parents' words with God's law	1	2	3	4	5
Family is property of husband	1	2	3	4	5
Fear of autocratic rules	1	2	3	4	5
Fear of rejection if authentic emotions are expressed	1	2	3	4	5
High pressure to conform to rigid rules	1	2	3	4	5
Intolerance	1	2	3	4	5
Lifestyles characterized by excessive neediness, enmeshment/fusion	1	2	3	4	5
Negative labeling with religious vocabulary	1	2	3	4	5
Overprotection of family members	1	2	3	4	5
Painful differences in values	1	2	3	4	5
Pressure to remain dependent	1	2	3	4	5
Promotion of a R.O. which is extremely exclusive in character	1	2	3	4	5

Statements	Rating scale				
Promotion of stern and severe concept of God	1	2	3	4	5
Promotion of stern and severe "discipline" of children	1	2	3	4	5
Religion used as reason for keeping unhealthy secrets	1	2	3	4	5
Repression of freedom to explore	1	2	3	4	5
Right belief means all think alike	1	2	3	4	5
Rigid, judgmental world-view	1	2	3	4	5
Ritualistic religious practice without understanding	1	2	3	4	5
Schizophrenic living (real self/religious self)	1	2	3	4	5
Sexual problems rooted in precepts of a particular R.O.	1	2	3	4	5
Shame/guilt-based interaction	1	2	3	4	5
Some R.O.s may be used to perpetuate dysfunctional family of origin rules, roles, hierarchy, etc.	1	2	3	4	5
Split loyalties	1	2	3	4	5
Undeveloped capacity for ethical decision-making due to strict adherence to dictates/laws	1	2	3	4	5
Underdeveloped capacity for independent thought	1	2	3	4	5
Us vs them mentality	1	2	3	4	5

DQII:9

Beliefs about R.O. most commonly held by families you see in context of family therapy

Statements	Rating scale				
Agreement on ethics	1	2	3	4	5
Association with others of similar R.O. is important	1	2	3	4	5
Beliefs, rules, moral codes are a guide to conduct	1	2	3	4	5
Biblical basis for living is optimal	1	2	3	4	5
Children should have education based on R.O.	1	2	3	4	5
Clash of values precipitates stress in family	1	2	3	4	5
Clear boundaries and roles are good	1	2	3	4	5
Evangelical	1	2	3	4	5
God caused/allowed this crisis	1	2	3	4	5
God is a central participant in the marital/family covenant	1	2	3	4	5
God wants me/us to be happy	1	2	3	4	5
Important that clients know therapists R.O.	1	2	3	4	5
Involvement with local church is important	1	2	3	4	5
Limited awareness that every moment of life is a religious experience	1	2	3	4	5
Love and forgiveness are central concepts	1	2	3	4	5
Only by the grace of God have I survived this (event)	1	2	3	4	5
Ours is the only truly acceptable R.O.	1	2	3	4	5
People often feel they are not living up to religious demands	1	2	3	4	5
Personal relationship wit God is essential to wellness	1	2	3	4	5
R.O. commitment is the reason to work out problems	1	2	3	4	5
R.O. is basis for respect	1	2	3	4	5
R.O. is foundational to family well-being	1	2	3	4	5
R.O. is important and helpful	1	2	3	4	5
R.O. is the basis for their family	1	2	3	4	5

Statements	Rating scale				
R.O. relates to a "higher" expression of family life	1	2	3	4	5
R.O. should be an important part of family life	1	2	3	4	5
R.O. viewed as a set of beliefs	1	2	3	4	5
"Secular" counselors will not be as effective as ones with R.O.	1	2	3	4	5
There must be a purpose in this	1	2	3	4	5
Unaware of the immensity of God's love for them	1	2	3	4	5
We/I am falling short of R.O. expectation	1	2	3	4	5
We ought to live according to the precepts of R.O.	1	2	3	4	5
Would not see a secular counselor	1	2	3	4	5

DQII:10

How R.O. can be an asset to therapy

Statements	Rating scale
Access to client-friendly resources (pastor, marriage enrichment, church activities, groups, etc.)	1 2 3 4 5
Access to power, healing and insight beyond client or therapist	1 2 3 4 5
Allows the therapist to investigate much broader and often neglected spiritual resources for change	1 2 3 4 5
Allows therapy to access God as a resource	1 2 3 4 5
Allows therapy to be truly "systemic" by including the Transcendent level of systems	1 2 3 4 5
Can provide basis for accountability	1 2 3 4 5
Common language, metaphor and stories from scripture can be helpful	1 2 3 4 5
Covenant as a central concept in many R.O.s provides basis for commitment to process	1 2 3 4 5
Exploration of beliefs can open avenues to behavioral and attitudinal change	1 2 3 4 5
Family history may have significant events which are best explored through R.O. context	1 2 3 4 5
Frees the therapist to honor the religious dimension	1 2 3 4 5
Great support systems available	1 2 3 4 5
If therapist is aware of the inbreaking grace of God, he/she is free to comment/build upon that grace	1 2 3 4 5
If therapist understands the language of R.O. it can be a bridge to enter system	1 2 3 4 5
Positive R.O. shares goals of therapy (personal affirmation, improved interpersonal relationships, healthy honest introspection, freedom honoring and life enhancing process)	1 2 3 4 5

Statements	Rating scale				
Provides extended network	1	2	3	4	5
Provides specific content beliefs, values, stories, metaphor that can be built upon or discussed in the context of therapy	1	2	3	4	5
Respect and understanding by therapist for R.O. of family reduces defensiveness and resistance	1	2	3	4	5
R.O. assumes grace and hope	1	2	3	4	5
R.O. assumes truth effects change	1	2	3	4	5
R.O. can provide grist for the construction of interventions	1	2	3	4	5
R.O. can provide guidelines for behavior and change	1	2	3	4	5
R.O. makes connection between self, family, larger systems and God	1	2	3	4	5
R.O. represents much of world view, general orientation, hope, expectations	1	2	3	4	5
Strengthens the sense of acceptance and forgiven-ness	1	2	3	4	5
Support for courage and risk associated with change	1	2	3	4	5
Supports forgiveness and reconciliation	1	2	3	4	5
Supports pursuit of integrity	1	2	3	4	5
The therapist can join with the family in witnessing the transforming Presence rather than attempting to engineer change	1	2	3	4	5
Therapeutic ceremony and ritual can be created in/for religious context	1	2	3	4	5
Therapeutic rituals	1	2	3	4	5
Therapy provides opportunity to re-evaluate R.O. and make adjustments if they so choose	1	2	3	4	5
Values understanding and reconciliation	1	2	3	4	5
Working with R.O. opens a significant pathway to therapeutic creativity	1	2	3	4	5

DQII:11

Problems that are associated with R.O.

Statements	Rating scale				
Absence of clear boundaries (multi-level, multi-systemic)	1	2	3	4	5
Avoidance of responsibility	1	2	3	4	5
Biblical passages often taken out of context or misapplied	1	2	3	4	5
Black and white thinking	1	2	3	4	5
Changes in R.O. of family members	1	2	3	4	5
Confusion of genuine mental illness or addiction with a "weak will"	1	2	3	4	5
Cultic abuse	1	2	3	4	5
Denial of emotional or physical problems	1	2	3	4	5
Depression	1	2	3	4	5
Distrust of emotions	1	2	3	4	5
Exclusiveness/rejection of differing beliefs	1	2	3	4	5
Extreme self-righteousness	1	2	3	4	5
Failure to take personal responsibility	1	2	3	4	5
Families who think that their spirituality is not good enough	1	2	3	4	5
Gender issues	1	2	3	4	5
Guilt about own needs	1	2	3	4	5
Guilt-ridden/obsessed	1	2	3	4	5
Homophobia	1	2	3	4	5
Inappropriate child-rearing problems (either too rigid or too tolerant)	1	2	3	4	5
Lack of confidence	1	2	3	4	5
Lack of tolerance from persons associated with extremely "conservative" R.O.	1	2	3	4	5
Limited autonomy	1	2	3	4	5
Limited hope	1	2	3	4	5
Low self-esteem	1	2	3	4	5
Masochism	1	2	3	4	5

Statements	Rating scale				
Mental illness/substance abuse equated with sin	1	2	3	4	5
Narcissism	1	2	3	4	5
Negative self-image	1	2	3	4	5
Obsessive and/or compulsive behaviors	1	2	3	4	5
Over-dependence on spiritual explanation of all events	1	2	3	4	5
Paranoia	1	2	3	4	5
Perfectionism	1	2	3	4	5
Physical and sexual abuse	1	2	3	4	5
Post traumatic stress disorder	1	2	3	4	5
Racial prejudice	1	2	3	4	5
Religious platitudes viewed as solutions	1	2	3	4	5
Religious rationalization	1	2	3	4	5
Repressed sexuality	1	2	3	4	5
Rigid hierarchical structures	1	2	3	4	5
Rigid sex roles and stereotyping	1	2	3	4	5
Seems to be a high correlation between extreme fundamentalism and pentecostalism and family dysfunction	1	2	3	4	5
Self-hatred	1	2	3	4	5
Shame	1	2	3	4	5
Some R.O.s undermine emotional development	1	2	3	4	5
Split between "inner" and "outer" self	1	2	3	4	5
Strong desire for control	1	2	3	4	5
Unhealthy secrecy	1	2	3	4	5
Widely divergent views of R.O by spouses	1	2	3	4	5

DQII:12

Distinctions between spirituality and R.O.

Statements	Rating scale				
It is possible to have a R.O. and not be spiritual	1	2	3	4	5
R.O. and spirituality reciprocally shape each other	1	2	3	4	5
R.O. describes a relationship to the religious group	1	2	3	4	5
R.O. describes the individual's beliefs	1	2	3	4	5
R.O. has to do with knowledge and belief about God, while spirituality has to do with the individual's experience with God	1	2	3	4	5
R.O. is a commitment to an organized religious system	1	2	3	4	5
R.O. is formal	1	2	3	4	5
R.O. is one's basic attitude/stance toward life	1	2	3	4	5
R.O. is organized system of belief	1	2	3	4	5
R.O. is orthodoxy	1	2	3	4	5
R.O. is strongly influenced by family of origin, denominational heritage and interaction with other R.O.s	1	2	3	4	5
R.O. is that which links the spirituality of the individual to a religious institution	1	2	3	4	5
R.O. is the container for spiritual expression, development and maturation	1	2	3	4	5
R.O. is the outward expression of internal spirituality	1	2	3	4	5
R.O. provides the specifics of how the spirituality is experienced and practiced	1	2	3	4	5
Spirituality is a deep sense of the mystical	1	2	3	4	5
Spirituality is an all encompassing orientation of self in the universe	1	2	3	4	5
Spirituality is an external motivation whose source is God	1	2	3	4	5

Statements	Rating scale				
Spirituality is an internal sense of connection to God, persons and environment	1	2	3	4	5
Spirituality is basic life force which finds expression in a variety of ways	1	2	3	4	5
Spirituality is closely connected to maturity in other areas of life	1	2	3	4	5
Spirituality is core beliefs	1	2	3	4	5
Spirituality is fundamental	1	2	3	4	5
Spirituality is how a person relates to the mystery of creation	1	2	3	4	5
Spirituality is operational theology	1	2	3	4	5
Spirituality is personal experience of one's own beliefs	1	2	3	4	5
Spirituality is private devotional intensity	1	2	3	4	5
Spirituality is that aspect of humanity which seeks connection	1	2	3	4	5
Spirituality is the focus of personal awareness	1	2	3	4	5
Spirituality is the manifestation of God as Ground of Being	1	2	3	4	5
Spirituality is the practice of the fundamental R.O.	1	2	3	4	5
Spirituality is the practice of the integration of experience	1	2	3	4	5
Spirituality relates to one's personal experience with God	1	2	3	4	5

DQII:13

Definitions of R.O

Statements	Rating scale				
A belief system which spells out what that person values most in life, believes about life, death, meaning and eternity	1	2	3	4	5
Beliefs and behaviors based on the individuals understanding of meaning and truth	1	2	3	4	5
Beliefs regarding a Supreme Being	1	2	3	4	5
Broadly, an R.O. is any belief system pertaining to the Transcendent Being	1	2	3	4	5
Participation in spiritual communities	1	2	3	4	5
Personal expression of internal spirituality	1	2	3	4	5
R.O. focuses on the Ultimate and helps me accept my limitations and abilities	1	2	3	4	5
R.O. has both intra-personal component (belief system) and an inter-personal component (relationships)	1	2	3	4	5
R.O. is a description of one's unique experiences of divine mystery and grace	1	2	3	4	5
R.O. is a faith commitment to one who transcends self, community and society	1	2	3	4	5
R.O. is a set of guidelines for belief and behavior which an individual agrees to accept in order to become a member of a spiritually-oriented group	1	2	3	4	5
R.O. is generated by a community of faith and is grounded in an historical process	1	2	3	4	5
R.O. is the core of beliefs and object relations in relationship to that which one perceives as the Ultimate Reality (or God)	1	2	3	4	5
R.O. offers hope and awareness	1	2	3	4	5
Sense of meaning/purpose derived from religious experience	1	2	3	4	5
The manner in which one experiences the Ultimate in relation to self	1	2	3	4	5

Appendix C--DQIII

February 4, 1993

Dear ,

Thank you for your help in this study. We're making good progress, and here we go on Round III.

The purpose of this round of the study of Religious Orientation and Family Therapy is to firm up the data for the final profiles.

This questionaire represents the distillation of the large volume of information gathered in the first two rounds. The item lists have been reduced by more than 2/3 from DQII.

In order to keep the project on schedule please return the completed questionaire to me within **9** days or **by March 1, 1993**.

Thank you for your help and your interest!

W. Keene Carruthers

February 4, 1993

Dear ,

Thank you for your help in this study. We're making good progress and here we go on round III.

If you have been unable to participate in the study to date, your input will be very valuable at this juncture, and your expertise is appreciated. Please join us in wrapping this up.

The purpose of this round of the study of Religious Orientation and Family Therapy is to firm up the data for the final profiles.

This questionaire represents the distillation of the large volume of information gathered in the first two rounds. The item lists have been pared down by more than 2/3 from DQII.

In order to keep the project on schedule please return the completed questionaire to me within **9** days or **by March 1, 1993**.

Thank you for your help and your interest!

W. Keene Carruthers

Congratulations!

You could be a **winner** in the W. K. Carruthers-Doctoral-Candidate-Pushing-for-May-Graduation $75 Sweepstakes!

In a crass attempt to influence behavior through monetary reward, a **GIANT $75. 000000 Grand Prize** is being offered. Take someone to dinner, play a couple of rounds of golf, replace all the belts and hoses on your car, **do whatever you want, JUST ENTER TODAY!**

Rules: Just fill out the enclosed questionaire and a brief one to follow, mailing each by the stated deadline. Your number will then be placed in the coffee can making you eligible to hear those magic words "The check is in the mail!"

This is a genuine cash offer. No substitutions please. Chance of winning 1 in 30 (which is a whole lot better than Ed McMahon!)

If the thought of a monetary reward offends you, let me appeal to your sense of professional contribution, to your willingness to help a somewhat desperate graduate student complete his dissertation for graduation this spring.

Good luck and best wishes!

Instructions for DQIII

Items presented for your evaluation in this round are statements identified by at least 75% of Round II participants as "Very Important" or "Important" for inclusion in the final profile.

--Please indicate your response to the statements in terms of your level of agreement/disagreement for each item. A five point Likert scale will be employed.

Strongly Agree				Strongly Disagree
1	2	3	4	5

Please circle only one response per statement.

--A few questions ask that you rank-order your assessment of the five most important of the listed statements or characteristics. Please do so in the left margin next to the statement. Thank you!

DQIII

DQIII:1

Attributes or Characteristics of Healthy Religious Orientation (R.O.)

1 2 3 4 5
strongly agree strongly disagree

Acceptance of what is, of others and of difference	1	2	3	4	5
Balance in life and relationship	1	2	3	4	5
Balance of grace and law	1	2	3	4	5
Belief in transcendent God	1	2	3	4	5
Belief system congruent with the general demands of life, developmental tasks and world view	1	2	3	4	5
Capacity for compassion	1	2	3	4	5
Capacity for intimacy	1	2	3	4	5
Centrality of meaning	1	2	3	4	5
Clear sense of right and wrong	1	2	3	4	5
Cognitive framework within which the individual can work out life's struggles	1	2	3	4	5
Coherent with beliefs	1	2	3	4	5
Commitment to a community of faith	1	2	3	4	5
Compassion	1	2	3	4	5
Concern for justice and peace	1	2	3	4	5
Empowering for growth	1	2	3	4	5
Engaged with others	1	2	3	4	5
Enhances general well-being	1	2	3	4	5
Essentially life-enhancing	1	2	3	4	5
Expanded world view	1	2	3	4	5
Family of origin strongly influences the individual's view of God	1	2	3	4	5
Fidelity	1	2	3	4	5
Flexible	1	2	3	4	5
Forgiveness	1	2	3	4	5
Free to explore new ideas	1	2	3	4	5
God is fundamentally about unconditional love	1	2	3	4	5

God is just	1	2	3	4	5
God is only within one's self	1	2	3	4	5
God is trustworthy	1	2	3	4	5
God's love for me is a model for my love toward others	1	2	3	4	5
Golden rule	1	2	3	4	5
Holistic scope	1	2	3	4	5
Honest	1	2	3	4	5
Integrated thought, feeling and behavior	1	2	3	4	5
Internally motivated	1	2	3	4	5
Life is purposeful	1	2	3	4	5
Lifestyle characterized by love, forgiveness, reconciliation	1	2	3	4	5
Love and acceptance for self and others	1	2	3	4	5
Love motivated, not guilt driven	1	2	3	4	5
Mature decision-making based on values/ spiritual principles	1	2	3	4	5
Mature differentiation, clear self-developed boundaries coupled with flexibility and adaptability	1	2	3	4	5
Moral absolutes exist	1	2	3	4	5
Personal acceptance by God	1	2	3	4	5
Personal care of others	1	2	3	4	5
Personal integrity is very important	1	2	3	4	5
Positive self-image, self love because of God's love for me	1	2	3	4	5
Positive sense of full humanity; positive self concept	1	2	3	4	5
Priority of the divine	1	2	3	4	5
Promotes full humanity	1	2	3	4	5
Provides a framework within which experiences make sense	1	2	3	4	5
Regular practice of spiritual discipline	1	2	3	4	5
Relatedness to community	1	2	3	4	5
Relationship with God is personal, uniquely one's own	1	2	3	4	5
Religious community to provide support, challenge for growth, honest reflection and opportunity for service	1	2	3	4	5
Respect for life	1	2	3	4	5

Responsible use of freedom	1	2	3	4	5
Self-discipline results in freedom	1	2	3	4	5
Sensitive to presence and grace of God	1	2	3	4	5
There are many paths to God	1	2	3	4	5
Tolerant	1	2	3	4	5
Trustworthy	1	2	3	4	5
Willing to sacrifice for others' well being	1	2	3	4	5

DQIII:2

Attributes or Characteristics of Unhealthy Religious Orientation

1 strongly agree 2 3 4 5 strongly disagree

Abdication of responsibility	1	2	3	4	5
Absolute conformity to group standards	1	2	3	4	5
Afraid to explore other ideas/approaches to an issue	1	2	3	4	5
Autocratic	1	2	3	4	5
Avoidance of difficulty, pain or suffering at all costs	1	2	3	4	5
Belief in an entity outside of one's self that one must worship	1	2	3	4	5
Black or white thinking	1	2	3	4	5
Blaming	1	2	3	4	5
Closed-minded	1	2	3	4	5
Closed awareness	1	2	3	4	5
Confusing my will with God's will	1	2	3	4	5
Definite division between who is acceptable and who is not	1	2	3	4	5
Difference is equated with "wrongness"	1	2	3	4	5
Dogmatically exclusive	1	2	3	4	5
Fear driven	1	2	3	4	5
Fear-focused: paranoid us/them approach to life	1	2	3	4	5
Fear of a transcendent Being without an understanding of the nature of love and acceptance	1	2	3	4	5
Fear of punishment if performance is not perfect	1	2	3	4	5
Hostile	1	2	3	4	5
God is dangerous	1	2	3	4	5
God is detached	1	2	3	4	5
God is judgmental	1	2	3	4	5
God is non-accepting	1	2	3	4	5
God is punitive	1	2	3	4	5

Judgmental	1	2	3	4	5
Mine is the only correct interpretation	1	2	3	4	5
Narcissistic	1	2	3	4	5
Perfectionistic	1	2	3	4	5
Repression of "negative" emotions/thoughts	1	2	3	4	5
Resentful	1	2	3	4	5
Rigidly non-responsive to needs of others	1	2	3	4	5
Rules must be obeyed absolutely	1	2	3	4	5
Self-deception	1	2	3	4	5
Self-punitive, self-destructive behaviors	1	2	3	4	5
Self-serving	1	2	3	4	5
Spiritually superior	1	2	3	4	5
Strict, rigid suppression of growth	1	2	3	4	5

DQIII:3

Your Basic Assumptions about R.O.

	1 strongly agree	2	3	4	5 strongly disagree
A creator exists	1	2	3	4	5
A human being is a spiritual being	1	2	3	4	5
A religiously oriented individual generally participates in a religious community of like-minded people	1	2	3	4	5
Affiliation with a religious group can be healthy or unhealthy	1	2	3	4	5
Affiliation with an organized religious group can provide emotional support, social awareness, awareness of community, improved self-esteem and sense of security	1	2	3	4	5
Faith provides:					
reinforcement of values	1	2	3	4	5
stability during crisis	1	2	3	4	5
Gives greater depth to human relationships	1	2	3	4	5
God creates and calls individuals into partnership in that creation	1	2	3	4	5
Healthy R.O. can be a wonderful resource	1	2	3	4	5
Living one's faith, exposing others to it without imposing it is optimal	1	2	3	4	5
People have the power to choose to what extent they will relate to God	1	2	3	4	5
Personality dynamics and the nature of R.O. are closely related	1	2	3	4	5
Pursuing integration and integrity will result in heightened spirituality and wellness	1	2	3	4	5
Relationship to God and other people is vital to personal well-being	1	2	3	4	5
Religions tend to formalize the relationships of persons and God	1	2	3	4	5
R.O. is manifest in our relationships with others	1	2	3	4	5
R.O. is the basic context for all else	1	2	3	4	5
Scripturally based R.O. can be healthy	1	2	3	4	5
Unhealthy forms of R.O. are similar to other unhealthy mental structures and must be clarified and worked through	1	2	3	4	5

DQIII:4

Your Basic Assumptions about R.O. in the practice of therapy

1 strongly agree	2	3	4	5 strongly disagree
Addressing issues emanating from R.O. is central to well family functioning	1	2	3	4	5
All of religion is being, rather than doing	1	2	3	4	5
Concepts of love, acceptance and forgiveness (which are central to many religions) can be very helpful in healing relationships	1	2	3	4	5
Healthy R.O. promotes healthy family functioning	1	2	3	4	5
Individuation includes the R.O. dimension (ie, each individual making adult choices regarding beliefs and practices)	1	2	3	4	5
Issues of R.O. should be integrated into the training and supervision process	1	2	3	4	5
It is important to understand something of the client's religious culture	1	2	3	4	5
Proselytizing is unethical (re: specific beliefs, R.O. or concepts)	1	2	3	4	5
Religious organizations can provide a support system during crisis	1	2	3	4	5
R.O. is subject to change over time	1	2	3	4	5
R.O. issues are increasingly acceptable in MFT practice	1	2	3	4	5
R.O. should be actively explored by the therapist because it's so important to family dynamics	1	2	3	4	5
The core meanings and beliefs of clients and client systems are crucial to the therapy process	1	2	3	4	5
The operative belief system is more important than the professed	1	2	3	4	5
The R.O. of the parents is probably the most important organizing factor in the family	1	2	3	4	5
The therapist, in directing the therapy, must allow for grace	1	2	3	4	5

The therapist is never neutral in terms of values, belief and meaning systems	1	2	3	4	5
The therapist is not the healer, but provides the atmosphere where healing can begin or take place	1	2	3	4	5
The therapist must seek to not manipulate, convert, control or be intrusive into clients' values, beliefs and meaning systems	1	2	3	4	5
The therapist operates from a "value informed" position	1	2	3	4	5
The therapist's stance is that of love, acceptance, compassion and truthfulness	1	2	3	4	5
The therapist's stance must be respectful of R.O.	1	2	3	4	5
Therapists can be messengers of hope	1	2	3	4	5
Therapy is part of the co-creative partnership of individuals, the family, the therapist and God	1	2	3	4	5
Though a valuable resource, a health R.O. does not guarantee specific resolutions or outcomes of therapy	1	2	3	4	5
When issues of R.O. are introduced into the therapeutic process, deeper levels of significance are opened to exploration	1	2	3	4	5
When parents have a clear and congruent R.O., it provides the children with a means to express and explore their own spirituality	1	2	3	4	5

DQIII:5

What about R.O. can be psychologically valuable for individuals

	1 strongly agree	2	3	4	5 strongly disagree
A healthy R.O. provides awareness of:					
a basis for love	1	2	3	4	5
a basis for trust	1	2	3	4	5
a framework to deal the guilt and forgiveness	1	2	3	4	5
a framework for moral justice	1	2	3	4	5
access to great wisdom	1	2	3	4	5
empowerment by being connected to a grace-filled and loving Higher Power	1	2	3	4	5
grace	1	2	3	4	5
hope	1	2	3	4	5
love	1	2	3	4	5
that God, not the individual, is the central fact of life	1	2	3	4	5
unconditional love from God	1	2	3	4	5
Ameliorates existential sense of aloneness	1	2	3	4	5
Biblical model provides rich source of affirmation, metaphor, symbol, meaning and sense of history	1	2	3	4	5
Can provide a sense of meaning for life and events	1	2	3	4	5
Can result in greater self-awareness and emotional freedom	1	2	3	4	5
Encourages:					
a more loving approach to others and the larger world	1	2	3	4	5
active membership in a supportive, challenging, validating community of faith	1	2	3	4	5
balanced life style	1	2	3	4	5
charity	1	2	3	4	5
creativity	1	2	3	4	5
empathy, caring	1	2	3	4	5
fearless moral inventory	1	2	3	4	5
growth orientation	1	2	3	4	5

healthy reflection, introspection, self-awareness	1	2	3	4	5
individual responsibility	1	2	3	4	5
Encourages:					
meaningful connection to others	1	2	3	4	5
people to trust the inner voice, spiritual intuition	1	2	3	4	5
positive self-image	1	2	3	4	5
self-actualization and self-transcendence	1	2	3	4	5
stable value system	1	2	3	4	5
world-view/focus beyond ourselves	1	2	3	4	5
Invites people into the loving freedom to be and to become themselves	1	2	3	4	5
Promotes:					
balanced individuated life	1	2	3	4	5
the value of humility	1	2	3	4	5
the value of commitment	1	2	3	4	5
Provides:					
a basis for confidence	1	2	3	4	5
a basis for constructing both identity and meaning	1	2	3	4	5
a basis for love, justice and hope	1	2	3	4	5
a relationship to the universe	1	2	3	4	5
a safe context to work through psychological difficulties	1	2	3	4	5
an optimal vehicle for personal growth	1	2	3	4	5
emotional, cognitive, interactional framework for healthy and optimal growth and development	1	2	3	4	5

DQIII:6

Aspects of R.O. which may be detrimental for individuals

1 strongly agree	2	3	4	5 strongly disagree

Acceptance of institutionalized biases	1	2	3	4	5
Authoritarian R.O. can lead to false guilt and inhibited emotional development	1	2	3	4	5
Autocratic control	1	2	3	4	5
Calcified guidelines	1	2	3	4	5
Closed-mindedness	1	2	3	4	5
Commitment to principles not your own	1	2	3	4	5
Denial of reality	1	2	3	4	5
Excessive dependence/co-dependence	1	2	3	4	5
Gender inequalities	1	2	3	4	5
Guilt/shame based motivation	1	2	3	4	5
Identity formation is retarded/restricted through enmeshment with rigid structures of dogma	1	2	3	4	5
Infantile dependency	1	2	3	4	5
Inordinate stress on God as punitive judge	1	2	3	4	5
Isolationism--unwilligness to engage new ideas	1	2	3	4	5
Mindless acceptance of statements, dictates, policies, etc.	1	2	3	4	5
Motivation by fear of punishment	1	2	3	4	5
Refusal to engage those who differ with us	1	2	3	4	5
Rigid/intolerant	1	2	3	4	5
Rigid refusal to change	1	2	3	4	5
Unrealistic expectations of self and/or others (perfectionistic)	1	2	3	4	5
Unrealistic role expectations (for/of family members)	1	2	3	4	5
Using God to excuse/perpetuate dysfunction	1	2	3	4	5
Withdrawal from society other than those of one particular group	1	2	3	4	5
"Works" based generalized anxiety	1	2	3	4	5

DQIII:7

Aspects of R.O. which can be assets to healthy family functioning

1 strongly agree	2	3	4	5 strongly disagree
Basis of respect	1	2	3	4	5
Basis of values	1	2	3	4	5
Common perspective on "meaning"	1	2	3	4	5
Common values	1	2	3	4	5
Encourages loving connection/intimacy	1	2	3	4	5
Encourages personal responsibility	1	2	3	4	5
Forgiveness	1	2	3	4	5
Improved self-concept (I am created by God and I am unique)	1	2	3	4	5
Loving, honoring and forgiving parents when an adult	1	2	3	4	5
Meaningful relationships	1	2	3	4	5
Mutual respect of husband/wife	1	2	3	4	5
Nurture by/of community	1	2	3	4	5
Parent/child bonding and mutual understanding through activities associated with religious practice	1	2	3	4	5
Provides framework for coping with stresses of life	1	2	3	4	5
R.O. promotes ethical responsibility	1	2	3	4	5
R.O. teaches the value of commitment/covenant	1	2	3	4	5
Shared activities (prayer together, hymns sung together, attending worship as a family, recreation in the context of R.O.)	1	2	3	4	5
Source of support	1	2	3	4	5
The family's mutual commitment and love include the Transcendent Being, the individuals in the marriage and their offspring	1	2	3	4	5
Validation	1	2	3	4	5
Values give family a central focus or core	1	2	3	4	5

*****Please rank what you believe are the five most important aspects of R.O. to well family functioning (number 1-5, where 1 = highest, in left margin for the items listed above.)*****

DQIII:8

Aspects of R.O. which may be detrimental to healthy family functioning

	1 strongly agree	2	3	4	5 strongly disagree
Absolute obedience to person in higher positions in hierarchical structures	1	2	3	4	5
Can block intimacy	1	2	3	4	5
Conflicting R.O.s, when rigidly held by family members can produce a variety of family problems	1	2	3	4	5
Cult brainwashing	1	2	3	4	5
Denial of ambiguity	1	2	3	4	5
Differences in degree of commitment to religion can cause tension	1	2	3	4	5
Doctrinal differences can be barriers to communication	1	2	3	4	5
Equating parents' words with God's law	1	2	3	4	5
Fear of autocratic rules	1	2	3	4	5
High pressure to conform to rigid rules	1	2	3	4	5
Intolerance	1	2	3	4	5
Lifestyles characterized by excessive neediness, enmeshment/fusion	1	2	3	4	5
Negative labeling with religious vocabulary	1	2	3	4	5
Painful differences in values	1	2	3	4	5
Promotion of stern and severe concept of God	1	2	3	4	5
Promotion of stern and severe "discipline" of kids	1	2	3	4	5
Religion used as reason for keeping unhealthy secrets	1	2	3	4	5
Repression of freedom to explore	1	2	3	4	5
Right belief means all think alike	1	2	3	4	5
Rigid, judgmental world-view	1	2	3	4	5
Schizophrenic living (real self/religious self)	1	2	3	4	5

Sexual problems rooted in precepts of a particular R.O.	1	2	3	4	5
Shame/guilt-based interaction	1	2	3	4	5
Some R.O.s may be used to perpetuate dysfunctional family of origin rules, roles, hierarchy, etc.	1	2	3	4	5
Split loyalties	1	2	3	4	5
Undeveloped capacity for ethical decision-making due to strict adherence to dictates/laws	1	2	3	4	5

DQII:9

Beliefs about R.O. most commonly held by families you see in context of family therapy

1	2	3	4	5
strongly agree				strongly disagree

Association with others of similar R.O. is important	1	2	3	4	5
Beliefs, rules, moral codes are a guide to conduct	1	2	3	4	5
Biblical basis for living is optimal	1	2	3	4	5
Love and forgiveness are central concepts	1	2	3	4	5
Personal relationship wit God is essential to wellness	1	2	3	4	5
R.O. is basis for respect	1	2	3	4	5
R.O. is important and helpful	1	2	3	4	5
R.O. should be an important part of family life	1	2	3	4	5
"Secular" counselors will not be as effective as ones with R.O.	1	2	3	4	5
There must be a purpose in this	1	2	3	4	5
We ought to live according to the precepts of R.O.	1	2	3	4	5

DQIII:10

How R.O. can be an asset to therapy

	1 strongly agree	2	3	4	5 strongly disagree
Access to client-friendly resources (pastor, marriage enrichment, church activities, groups, etc.)	1	2	3	4	5
Access to power, healing and insight beyond client or therapist	1	2	3	4	5
Allows the therapist to investigate much broader and often neglected spiritual resources for change	1	2	3	4	5
Allows therapy to access God as a resource	1	2	3	4	5
Allows therapy to be truly "systemic" by including the Transcendent level of systems	1	2	3	4	5
Can provide basis for accountability	1	2	3	4	5
Common language, metaphor and stories from scripture can be helpful	1	2	3	4	5
Exploration of beliefs can open avenues to behavioral and attitudinal change	1	2	3	4	5
Family history may have significant events which are best explored through R.O. context	1	2	3	4	5
Frees the therapist to honor the religious dimension	1	2	3	4	5
Great support systems available	1	2	3	4	5
If therapist is aware of the inbreaking grace of God, he/she is free to comment/build upon that grace	1	2	3	4	5
If therapist understands the language of R.O. it can be a bridge to enter system	1	2	3	4	5
Positive R.O. shares goals of therapy (personal affirmation, improved interpersonal relationships, healthy honest introspection, freedom honoring and life enhancing process)	1	2	3	4	5
Provides specific content beliefs, values, stories, metaphor that can be built upon or discussed in the context of therapy	1	2	3	4	5

Respect and understanding by therapist for R.O. of family reduces defensiveness and resistance	1	2	3	4	5
R.O. assumes grace and hope	1	2	3	4	5
R.O. assumes truth effects change	1	2	3	4	5
R.O. can provide guidelines for behavior and change	1	2	3	4	5
R.O. makes connection between self, family, larger systems and God	1	2	3	4	5
Strengthens the sense of acceptance and forgiven-ness	1	2	3	4	5
Support for courage and risk associated with change	1	2	3	4	5
Supports forgiveness and reconciliation	1	2	3	4	5
The therapist can join with the family in witnessing the transforming Presence rather than attempting to engineer change	1	2	3	4	5
Therapy provides opportunity to re-evaluate R.O. and make adjustments if they so choose	1	2	3	4	5
Values understanding and reconciliation	1	2	3	4	5
Working with R.O. opens a significant pathway to therapeutic creativity	1	2	3	4	5

*****Please rank what you believe are the five most important aspects of R.O. to well family functioning (number 1-5, where 1 = highest, in left margin for the items listed above.)*****

DQIII:11

Problems that are associated with R.O.

1	2	3	4	5
strongly agree				strongly disagree

Biblical passages often taken out of context or misapplied	1	2	3	4	5
Black and white thinking	1	2	3	4	5
Confusion of genuine mental illness or addiction with a "weak will"	1	2	3	4	5
Denial of emotional or physical problems	1	2	3	4	5
Families who think that their spirituality is not good enough	1	2	3	4	5
Gender issues	1	2	3	4	5
Guilt about own needs	1	2	3	4	5
Inappropriate child-rearing problems (either too rigid or too tolerant)	1	2	3	4	5
Lack of tolerance from persons associated with extremely "conservative" R.O.	1	2	3	4	5
Negative self-image	1	2	3	4	5
Over-dependence on spiritual explanation of all events	1	2	3	4	5
Perfectionism	1	2	3	4	5
Religious platitudes viewed as solutions	1	2	3	4	5
Religious rationalization	1	2	3	4	5
Repressed sexuality	1	2	3	4	5
Rigid hierarchical structures	1	2	3	4	5
Rigid sex roles and stereotyping	1	2	3	4	5
Shame	1	2	3	4	5
Some R.O.s undermine emotional development	1	2	3	4	5
Strong desire for control	1	2	3	4	5
Widely divergent views of R.O by spouses	1	2	3	4	5

Which of these would you say are the 5 most frequent problems associated with R. O. in your experience? (Number 1-5, where 1 = most frequent, in left margin.)

DQIII:12

Distinctions between spirituality and R.O.

1 strongly agree	2	3	4	5 strongly disagree				
R.O. describes the individual's beliefs				1	2	3	4	5
R.O. is organized system of belief				1	2	3	4	5
R.O. is strongly influenced by family of origin, denominational heritage and interaction with other R.O.s				1	2	3	4	5
R.O. is the container for spiritual expression, development and maturation				1	2	3	4	5
Spirituality is an all encompassing orientation of self in the universe				1	2	3	4	5
Spirituality is an internal sense of connection to God, persons and environment				1	2	3	4	5
Spirituality is closely connected to maturity in other areas of life				1	2	3	4	5
Spirituality is personal experience of one's own beliefs				1	2	3	4	5
Spirituality is that aspect of humanity which seeks connection				1	2	3	4	5
Spirituality relates to one's personal experience with God				1	2	3	4	5

DQIII:13

Definitions of R.O

1 strongly agree	2	3	4	5 strongly disagree

A belief system which spells out what that person values most in life, believes about life, death, meaning and eternity	1	2	3	4	5
Beliefs and behaviors based on the individuals understanding of meaning and truth	1	2	3	4	5
Broadly, an R.O. is any belief system pertaining to the Transcendent Being	1	2	3	4	5
R.O. has both intra-personal component (belief system) and an inter-personal component (relationships)	1	2	3	4	5
R.O. is generated by a community of faith and is grounded in an historical process	1	2	3	4	5
R.O. is the core of beliefs and object relations in relationship to that which one perceives as the Ultimate Reality (or God)	1	2	3	4	5
Sense of meaning/purpose derived from religious experience	1	2	3	4	5

Appendix D--DQIV

March 5, 1993

Dear _____,

Here we are at the Final Event! The Sprint to the finish is under way. Thank you for your perseverence and timely completion of your part in this project.

This final segment is different from what has gone before. Part One is a Participant Profile questionaire. Part Two will ask you to evaluate a proposed definition of Religious Orientation. Parts Three and Four will ask you to build on some of the information developed in this study.

Please return this final questionaire (!) within ten (10) days of receipt or mail before March 26, 1993. (Ed McMahon is waiting.)

Results will be sent to you in early summer.

With deepest appreciation,

W. Keene Carruthers

DQIV

Part One--Participant Profile

1. Please provide name and Title_____

2. What is your Age?_____ Gender?_____ Race?_____

3. What educational degrees have you earned? (Please specify fields and dates.) _____

4. Please indicate number of years of MFT experience in the following areas:

Clinical	_____years
Supervision	_____years
Teaching	_____years
Research	_____years

5. What percentage of your work week do you spend in these activities? (Please circle one per category.)

Clinical	0-20%	21-40%	41-60%	61-80%	81-100%
Supervision	0-20%	21-40%	41-60%	61-80%	81-100%
Teaching	0-20%	21-40%	41-60%	61-80%	81-100%
Research	0-20%	21-40%	41-60%	61-80%	81-100%
Administration	0-20%	21-40%	41-60%	61-80%	81-100%
Consultation	0-20%	21-40%	41-60%	61-80%	81-100%

6. Context of Employment

Academic	_____% of time
Community Practice	_____% of time
Medical	_____% of time
Private	_____% of time

7. If you have specific areas of interest or training regarding religious orientation or spirituality, please describe briefly:

8. Please list publications or presentations about Religious Orientation/Spirituality on the back of this sheet (or include a vita if you prefer.)

9. Did any of your MFT course work focus on spiritual or religious orientation issues? If so, please describe briefly:

10. Please identify your religious affiliation, if any :

11. How many years have you been integrating religious orientation in the practice of therapy?

Clinical _____years
Training/Supervision _____years
(which you provide)

Theoretical Orientation

12. How would you describe your theoretical orientation to clinical practice? Please indicate the three (3) approaches you employ most frequently by placing the appropriate numeral in the left margin next to your choices (1 = most frequent, 2 = next most frequent, 3 = third most frequent.)

Behavioral Modification
Communications (Satir)
Client-Centered
Experiential
Gestalt
Linguistic (Goolishian)
Problem Solving (MRI)
Psychodynamic/Object Relations
Rational-Emotive
Solution Focus (DeShazer)
Strategic (Haley, Madanes)
Strategic (Milan)
Structural
Structural-Strategic
Neuro-Linguistic Programming
Transgenerational
Other (please specify) _____

DQIV
Part Two

1. To what extent would you agree with the following as an adequate definition of religious orientation?

"Religious Orientation is a set of beliefs about life, the world and its structure that posits an external guiding force, separate from, yet encompassing the natural world, which provides values, direction, and purpose for individuals, families and societies."

Strongly Agree				Strongly Disagree
1	2	3	4	5

What modifications would you make in order to more accurately represent your own perspective?

DQIV
Part Three

The participants in this project have identified several problem areas sometimes associated with religious orientation. Those identified by 80% or more of the participants are listed below.

Please briefly indicate the kind of therapeutic approach you might take when the difficulty is:

a. Biblical passages taken out of context or misapplied

b. Black and white thinking

c. Guilt about one's own needs

d. Perfectionism

e. Shame

f. Strong desire for control

g. Widely divergent views of religious orientation by spouses

DQIV
Part Four

In May 1990 a report following a two day Washington DC conference on research into well-family funtioning was published. This report detailed 13 prominent researchers' findings and discussions at the conference. Several characteristics of well-family functioning were identified.

Instructions

In this final segment you will be asked to indicate your personal assessment of the strength of possible relationships between characteristics of religious orientation identified in this study and characteristics identified by the well-family panel. (The enclosed unattached sheet provides brief descriptions of the terms in the 1990 study.)

The 1990 and RO characteristics are paired by means of a column/row grid. Please indicate your perception of the strength of relationship by placing a numeral (1-5) at the intersection of the row/column under consideration. 1= very strong relationship, 5 = no relationship.

For instance:

	Well-family characteristics			
	A	B	C	D
Healthy RO characteristics				
RO Characteristic #1	3	5	1	

This indicates that the perceived relationship between
#1 and 'A' is moderate (3);
#1 and 'B' is non-existent (5); and
#1 and 'C' is very strong (1)

Characteristics of Well-Family Functioning

Characteristics of Healthy R. O.								
Forgiveness	___	___	___	___	___	___	___	___
Framework for coping with stress	___	___	___	___	___	___	___	___
Improved self-concept	___	___	___	___	___	___	___	___
Intimacy, loving connection	___	___	___	___	___	___	___	___
Mutual respect (husband/wife)	___	___	___	___	___	___	___	___
Personal responsibility	___	___	___	___	___	___	___	___
Values are central focus/ core	___	___	___	___	___	___	___	___

Characteristics of Well-Family Functioning
(1990 Group)

1. Adaptive Ability: refers to the family's ability to adapt to predictable life-cycle changes as well as stressful events.

2. Clear Roles: refers to a clear and flexible role structure in which family members know their roles and responsibilities and thus are able to function effectively in times of crisis as well as during normal times.

3. Commitment to Family: involves both the recognition of individual worth and acceptance of the value of the family as a unity.

4. Communication: refers to clear, open and frequent communication patterns.

5. Encouragement of Individuals: refers to the family's ability to encourage a sense of belonging at the same time individual development is encouraged.

6. Expression of Appreciation: refers to doing things consistently that are positive for the other person simply for their sake.

7. Shared Time: refers to the sharing of both quality and quantity of time by family members and the degree to which this is enjoyable for family members.

8. Social Connectedness: refers to a connection to the larger society--extended family, friends, neighbors and participation in community activities.

Appendix E

Self-Specified Demographics of Delphi Participants

Section #1: Section #1 of this description represents the participants' self described religious affiliation by group. Numerals indicate the number of individuals identifying themselves with each specified group.

Christian	1	No affiliation	1
Episcopal	1	Plymouth Brethren	1
Jewish	1	Presbyterian	4
Lutheran	1	Protestant	1
Methodist	2	Southern Baptist	3
		United Church of Christ	1

Section #2: Race. All participants identified themselves as Caucasian.

Section #3: Age Distribution

31-40	41-50	51-60	61-70	70+
3	5	4	3	2

Appendix F

Delphi Participants List

Douglas Anderson, Ph. D.
Executive Director
Presbyterian Counseling Service
564 N. E. Ravenna Boulevard
Seattle, WA 98115

Ken Ackerman, Ph. D.
Manatee Glens Child and Family Center
377 6th Avenue West
Bradenton, FL 34205

Bill Balch, Ed. D.
P. O. Box 11328
Knoxville, TN 37939-1328

Laurel Arthur Burton, Th. D.
Department of Religion and Health
Rush University
1653 W. Congress Pkwy
Chicago, IL 60612

Elsworth Campbell, Ph. D.
1460 W. 16th Place
Yuma, AZ 85364

Shuford Davis, Ph. D.
831 Maderia Circle
Tallahassee, FL 32312

Marcus Earle
Psychological Counseling
7530 East Angus
Scottsdale, AZ 85251

George Endsworth, Ph. D.
Charis Psychological Services
Liberty Tree Medical Building
140 Commonwealth Ave.
Danvers, MA 01923

James Griffith, M. D.
Department of Psychiatry and Human Behavior
2500 North State St.
Jackson, MS 39216-4505

Gene Harvey, M. S. W.
4301 So. Pine, Suite 517
Tacoma, WA 98409

Jim Hine, D. D.
4961 North Calle Luisa
Tucson, AZ 85718

Leo Howard, Th. M.
Pastoral Counseling Center
214 Mountain Ave., SW
Roanoke, VA 24014

Merle Jordan, Ph. D.
98 North St
Stoneham, MA 02180

Elaine Katzman
10849 Shoshoni Dr
Phoenix, AZ 85044

David Peterson, Th. M.
Total Life Counseling, Inc.
4656 Brambleton Ave, S. W.
Roanoke, VA 24018

Sandra Phinney, Ph. D.
Charis Psychological Services
Liberty Tree Medical Building
140 Commonwealth Ave
Danvers, MA 01923

Layne Prest, Ph. D.
University of Nebraska Medical Center
600 South 42nd St
Omaha, NE 68198-3075

Jerry Smith, S. T. D
Pastoral Therapy Associates
625 Commerce St, #400
Tacoma, WA 98402

James Trotzer, Ph. D.
Renew Counseling Center
P. O. Box 506
Rye, NH 03870

Everett Worthington, Ph. D.
Department of Psychology
Box 2018, 810 West Franklin St
Richmond, VA 23284-2018

Vita Curriculum

William Keene Carruthers, III

P. O. Box 9711, Hollins College
Roanoke, VA 24020
(703) 362-6650

Education

Ph.D., Marriage and Family Therapy, Virginia Polytechnic Institute and State University, 1993;
AAMFT Training in Family Therapy, Southern Connecticut State University, 1986-1987;
Th.M., Mid-America Baptist Theological Seminary, 1983;
B.A. Economics, University of Vermont, 1972.

Applied Counseling Experience

Roanoke Family Services, Staff Therapist, 1993-

Lewis Gale Psychiatric Hospital, Intern, 1991-1992

Center for Family Services, Staff Therapist, 1988-1990

Pastoral Counseling Center, Pastoral Counselor, 1987-1988

Naugatuck Youth Services, Program Coordinator and Staff Therapist, 1987

Branford Counseling Center, Youth Services Intern, 1986-1987

Pastoral Ministry

Pleasant Valley Baptist Church, Groton, CT 1983-1986

Gallup Hill Baptist Church, Ledyard, CT, 1984-1985

Cherokee Baptist Church, Memphis, TN, 1981-1983

St Francis Hospital, Memphis, TN, 1981-1982

Publications and Presentations

"The Case of the Sneaky Sleep Thief: White's externalizing technique within a broad strategic frame." Journal of Strategic and Systemic Therapies, 10: 3-4, 1991.

"Ethical Structures of Supervision," presented to the Tri-State Conference on Human Resources, Knoxville, TN, 1989.