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RELIGIOUS VALUES AND CLIENT-THERAPIST MATCHING IN PSYCHOTHERAPY

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A recent debate on the roles of religious values in psychotherapy has focused on global issues rather than more meaningful issues of client-therapist matching. This debate is reviewed and the concept of religious value matching is introduced. As an example of the systematic variation in one's values as a function of religion, guilt accepting (G+) and guilt repressing (G-) values are considered. The four possible client-therapist matching categories are discussed and outcomes are considered from a tripartite model. Finally, recommendations for religious value matching and ethical implications are discussed.

Since the publication of Eysenck's (1952) evaluation of traditional psychotherapeutic effectiveness, the outcome issue has been a frequently considered topic for research and conceptual debate in the field of clinical psychology. While not all investigators have concluded, as Eysenck, that spontaneous recovery is at least as effective as psychotherapy, (see Bergin & Lambert, 1978; Smith & Glass, 1977; Strupp, 1963) there has not been unequivocal evidence which clarifies the magnitude of effectiveness of psychotherapy. One possible reason for the lack of such evidence is the inadequacy of traditional research designs in assessing the outcome issue (Parloff, 1979; Strupp, 1982). A less global, more idiographic (i.e. which therapist with which treatment for which client) approach to outcome evaluation may result in a better understanding of the outcome and process of psychotherapy (see Strupp, 1980a, 1980b, 1980c; Strupp & Hadley, 1977).

One aspect of the trend away from global research design in outcome evaluation has been the consideration of client-therapist matching (Luborsky, Auerbach, Chandler, & Cohen, 1971; Strupp, 1980a, 1980b, 1980c). Certain components of a particular therapeutic alliance may have positive or negative effects on the eventual outcome. An effort to understand important dimensions of client-therapist matching may lead to an increased understanding of the variance in past outcome research and, more importantly, of the significant aspects of the therapeutic alliance which lead to behavioral, cognitive, and affective changes.

A recent debate on the role of religious values in *The Journal of Consulting and Clinical Psychology* (Bergin, 1980a, 1980b; Ellis, 1980; Walls, 1980) has focused on a global issue rather than more meaningful idiographic issues in much the same way as psychotherapy outcome research. The practical relevance of religious values in psychotherapy exists primarily at the level of client-therapist matching, and not at the

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universal level described by authors on both sides of the debate.

Subsequent to reviewing the debate on religious values in psychotherapy, a position stressing the importance of matching religious values will be presented using the issue of guilt resolution as an example. Finally, recommendations for the implementation of religious value matching will be presented.

The Religious Value Debate

The argument presented by Bergin (1980a) was that "until the theistic belief systems of a large percentage of the population are sincerely considered and conceptually integrated into our work, we are unlikely to be fully effective professionals" (p. 95). The structure of his argument consisted of six theses some of which were countered by the arguments of Ellis (1980) and Walls (1980).

First, Bergin stated that "values are an inevitable and pervasive part of psychotherapy" (p. 97). As Strupp (1980d) points out, the traditional psychodynamic view that the therapist's values should play no role in therapy is unrealistic and can even be harmful. Implicit in Bergin's first thesis is the assumption that religious values are, either directly or indirectly, among those values which do affect psychotherapy. In contrast, religious values were not directly included in Strupp's (1980d) set of essential values for psychotherapists.

Bergin's second thesis was that professional change processes are affected by value-laden factors. This thesis was presented as little more than a statement of the relevance of nonspecific factors in psychotherapy outcome (see Frank, 1971). The second thesis implicitly assumes, however, that religious values are a significant part of the set of nonspecific factors which lead to therapeutic change.

The third thesis was a source of disagreement for Ellis (1980) and Walls (1980). Bergin stated that two systems of values, humanism and clinical pragmatism, are dominant in the mental health professions. Both value systems, said Bergin, exclude religious values. While the general statement of the thesis is difficult to disagree with, Bergin's listing of specific values found within the clinical-humanistic system was perceived as unsatisfactory by Walls and Ellis. Bergin contrasted this list with a set of theistic values derived from religious writings. Walls (1980) stated:

> Bergin developed his theistic values by careful selection from religious writings. An equally discerning extraction is needed to compile an exemplary list of humanistic values. (p. 640)

Ellis (1980) presented an alternative list of values representative of the humanistic values of probabilistic atheists. In a reply to Ellis and Walls, Bergin (1980b) explained that his intention was to present a set of values which have become prominent in a form of "degraded" humanism, rather than the traditional humanistic values.

The disagreement over the third thesis of Bergin is illustrative of a common problem in any comparison of value systems — a tendency to state the preferred value system in a positive light and the contrasting value system in a negative light. The careful statement of theistic values and the understatement of humanistic values by Bergin shows this bias from the theistic perspective.

A similar bias can be seen from the humanistic perspective when Strupp (1980d) cites the writings of Fromm to support the view that traditional religion is authoritarian, has the goals of promoting powerlessness and obedience, and results in a prevailing mood of sorrow and guilt. In contrast, Fromm writes that humanistic religion has the goals of strength and virtue and results in the mood of joy. It is unlikely that Fromm's statements of religious values would find any more agreement among theists than Bergin's statements have found among humanists.[1]

[1]Just as humanists do not share a common set of values (as evidenced by the responses to Bergin's third thesis), theists do not necessarily hold identical values (Palout-

The fourth thesis of Bergin (1980a) was that values of mental health professionals are in contrast with values of the population in general. Bergin stated that 90% of the general population possesses some sort of belief in the existence of God. This is in contrast to the 50% of APA members with a similar belief. Bergin noted the discrepancy, but did not suggest a specific response for psychotherapists. From Bergin's statement, Walls (1980) inferred a response.

> Bergin's case seems to rest on the contentions that psychotherapists have an obligation to include theistic values as part of their own value systems in order to incorporate the public definition of "good" into therapeutic goals. (p. 640)

This inferred response of tailoring "our values to fit those of the general public" (p. 641) does perhaps go far beyond the intent of Bergin. Bergin's point may be better stated, in terms of Strupp and Hadley's (1977) tripartite model, that a comprehensive statement of treatment goals must include a consideration of the values of the client and values within the client's social system as well as the therapist's own values.

It is likely that Walls would also object to this milder interpretation of Bergin's fourth thesis. He intimates that therapists' values are in some way superior to those of clients.

> The fact cited by Bergin that, in general, the values of psychotherapists differ from the public's is not alarming; it is encouraging. Psychotherapists are involved in making value decisions that affect their clients and exercise considerable power. We should both expect and demand that the values of psychotherapists be more carefully reasoned and, on the whole, more adequate than the values of the general public. Assuming that mental health is an issue concerned with values, what could we offer if our values were not in some way more adequate than those of the clients who seek our help? (p. 641)[2]

As will be subsequently discussed in this article, this egocentric placement of the therapist's values above the client's values and/or society's values may result in an inaccurate assessment of outcome and may obfuscate appropriate client-therapist matching.

The fifth thesis of Bergin (1980a) was that because of the first four theses, clinicians should openly acknowledge the fact that they are implementing their own value systems. In addition, clinicians should be explicit about what values they hold, but only in the context of respect for the value systems of others. This thesis, which calls for open acknowledgment of one's own values and the role of those values in psychotherapy, is the basis of the model of client-therapist matching which will be presented in a subsequent section of this article.

The sixth thesis presented by Bergin (1980a) was that intuitive value systems should be transformed into hypotheses which can be openly tested and evaluated. Bergin listed nine such hypotheses which could be subjected to empirical analyses. Ellis (1980) concurred with Bergin's sixth thesis by offering alternative hypotheses for four of the nine suggested by Bergin. This scientific approach has opened the door for an empirical contribution to the debate of the role of religious values in psychotherapy. Nonetheless, the issue is fundamentally more than a scientific issue. It is unlikely that the experimental method will ever resolve the debate.

To summarize this review of the recent debate on the role of religious values in psychotherapy, two points must be re-emphasized. First, implicit in the first two theses of Bergin's (1980a) argument was the assumption that religious values are similar to other values operating in a client-therapist relationship. Since this assumption was not attacked by Bergin's critics, and since some assumptions are presently necessary to con-

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zian, Jackson, & Crandall, 1978). Psychotherapists may recall anecdotal evidence of the sorrowful, guilty religious clients they have seen. The existence of such theists cannot be denied. However, the existence of humanists with similar symptoms is also difficult to deny. Therefore, the merits of theism or humanism should not be determined by the biased client samples of psychotherapists.

[2]In addition to placing an arbitrary significance on the values of the therapist, this statement includes the unsubstantiated assumption that humanistic values are more carefully reasoned than theistic values. Cogent evidence for the rational basis of theistic values is not difficult to find (McDowell, 1975, 1979).

sider the applicability of religious values to psychotherapy, I will continue with Bergin's assumption for the purpose of this article, although on a more explicit level.

Second, overstatements and generalizations have contaminated the appropriate consideration of religious values in psychotherapy. Bergin's presentation of clinical-humanistic values has been criticized by several authors (Ellis, 1980; Strupp, 1980d; Walls, 1980) as misrepresenting the essence of humanism. On the other hand, Fromm (see Strupp, 1980d) has misrepresented theistic values and Walls (1980) has claimed near sovereignty of the humanistic position while misinterpreting Bergin as saying that therapists should adjust their personal values to fit the values of the public. It is my contention that these overstatements on both sides of the issue have directed our attention away from the more meaningful question, namely, What role do the religious values of the therapist vis-à-vis the client play in the therapeutic alliance and/or outcome?

Therapeutic Orientations to Guilt

It is evident from the debate just reviewed that therapists differ in their views of religious values. It is clear that differences in religious values affect viewpoints on the nature or existence of God, the nature of personal identity, the definition of love, the role of guilt in personal distress, and many other personal and interpersonal issues (Ellis, 1980). For the purposes of this analysis only one of these issues — the role of guilt resolution in psychotherapeutic outcome — will be considered. This issue will be evaluated at both a conceptual and a clinical level.

Conceptual Analysis

On a conceptual level, guilt is perceived by many theists as a potential change agent. Bergin (1980a) lists the following as a theistic value: "Personal responsibility for own harmful actions and changes in them. Acceptance of guilt, suffering, and contrition as keys to change. Restitution for harmful effects" (p. 100).

In contrast, guilt is perceived by many humanists as a detrimental factor which must be reduced in order to produce change. Ellis (1980) lists the following as a clinical-humanistic-atheistic value:

> Personal responsibility for own harmful actions and changes in them. Maximizing responsibility for harmful and immoral acts and minimizing guilt (self-damnation in addition to denouncing one's acts). No apology or "cop-out" for effects of one's unethical behavior. Restitution for harmful effects. (p. 636)

In sum, guilt accepting values (G+) are typical of theists and guilt suppressing values (G-) are typical of humanists. This is not intended as a categorical classification, but rather as a statement of general tendencies of values toward guilt.

Clinical Analysis

The effect of guilt in therapeutic outcome has been considered by previous writers. Ellenberger (1966) traced the pathogenic effects of "secrets" through history. Mowrer (1973) suggested that the stress leading to personality disorder is caused by dishonesty, irresponsibility, and unconcern for others. Mowrer (1960) writes:

> For several decades we psychologists looked upon the whole matter of sin and moral accountability as a great incubus and acclaimed our liberation from it as epoch-making. But at length we have discovered that to be "free" in this sense, i.e. to have the excuse of being "sick" rather than sinful, is to court the danger of also becoming lost. This danger is, I believe, betokened by the widespread interest in Existentialism which we are presently witnessing. In becoming amoral, ethically neutral, and "free," we have cut the very roots of our being; lost our deepest sense of self-hood and identity; and, with neurotics themselves, find ourselves asking: Who am I? What is my destiny? What does living (existence) mean? (p. 303)

As a solution to this "moral crisis," Mowrer (1972) has developed a group therapy approach which he labels integrity groups. This therapeutic approach emphasizes honesty, responsibility, and mutual concern. There has been empirical (Johnson, Dokecki, & Mowrer, 1972) and anecdotal (Mowrer & Veszelovszky, 1980; Smrtic, 1979) evidence supporting Mowrer's claims of a connection between psychopathology and moral accountability,

but according to Mowrer and Veszelovszky (1980), the evidence has been selectively ignored by psychologists.

Other writers have suggested that guilt itself, rather than the actions leading to guilt, is a cause of psychopathology. Ellis (1960) writes:

> If, in this thoroughly objective, non-guilty manner, we can teach our patients (as well as the billions of people in the world who, for better or worse, will never become patients) that even though human beings can be held quite accountable or responsible for their misdeeds, no one is ever to blame for anything, human morality, I am sure, will be significantly improved and for the first time in human history civilized people will have a real possibility of achieving sound mental health. The concept of sin is the direct and indirect cause of virtually all neurotic disturbance. The sooner psychotherapists forthrightly begin to attack it the better their patients will be. (p. 192)

It is understandable that Ellis' position on the role of guilt in psychopathology would lead him to the G- therapeutic orientation which was discussed earlier. The reduction of guilt, independent of the guilt-producing action, would be expected to result in therapeutic change. In contrast, a therapist holding Mowrer's position of the role of guilt-producing behavior in psychopathology would embrace the G+ orientation. The resolution of the guilt by changing the guilt-producing action would be expected to result in therapeutic change.

Hence, two generalized therapeutic orientations can be characterized by their proposed treatment of guilt. The G+ orientation begins with the premise that behaviors which produce guilt also produce stress and eventually psychopathology. Therefore, guilt feelings are useful in identifying those behaviors which can be altered to produce therapeutic change. The G- orientation begins with the premise that guilt itself produces psychopathology and therefore it must be reduced, with or without changing behaviors, in order to provide therapeutic change.[3]

The G+ orientation is consistent with theistic values as they are described by Ellis (1980). This is not to say, however, that all theists hold the G+ orientation or that all humanists hold the G- orientation.

The point of this analysis is not to argue intuitively or to review empirical evidence in an attempt to verify the validity of the G+ or G- orientation. Rather, I will attempt to discuss the implications of matching therapists and clients, each having their own guilt orientation. Clearly, the results of each matching combination is best stated as an empirical hypothesis rather than a logically predictable outcome.

Therapist-Client Matching

The four possible combinations of therapist-client matching on guilt orientation will be considered within the tripartite framework of outcome evaluation (society, individual, professional) suggested by Strupp and Hadley (1977). Of course, not all clients seen in therapy are facing problems of guilt feelings. Some are experiencing guilt feelings, but the guilt would be described as irrational by virtually everyone. For example, a client may be experiencing guilt feelings because of the behavior of a grown child over whom the parent has no control. Likewise, a client may report guilt for a past event with irreversible consequences, such as the suicidal death of a parent or spouse. In such cases a realistic goal of any effective treatment is to reduce the feelings of guilt independent of present behaviors because present behaviors are inconsequential to the guilt-producing event. In other cases, however, guilt feelings are presented by the client which coexist with behaviors which cause or exacerbate feelings. The subsequent analysis refers only to these clients with problematic guilt feelings which coexist with controversial or socially proscribed behaviors.

[3] An example can be seen in the case of marital infidelity. A G+ therapist might use the guilt as a sign of a behavioral problem and guide the client toward the discontinuance of extra-marital relationships. A G- therapist might reduce the guilt independent of the behavior, and then evaluate the behavior on the basis of other effects of the extra-marital relationship or on the basis of the motives which underlie the relationship.

Matching Category One (Th: G+; C: G+)

This is perhaps the most congruous of the four categories. Not only are the therapist and the client aligned with similar orientations regarding the role of guilt, but society also is predisposed toward a similar orientation. Bergin's (1980a) fourth thesis is evidence of the current theistic value system of American society. As we discussed earlier, the theistic value system is consistent with a G+ orientation.

Throughout therapy, the therapist and the client will work together to change guilt-producing behavior. As that therapeutic goal is reached, the client's feelings of guilt will give way to feelings of self-efficacy. The therapist will consider the outcome successful as he or she observes a change in the client's responsibility (Kaiser, 1955) and the client will consider therapy successful because of the cessation of guilt. Societal expectations will be met by the client's increased responsibility and the client may become a more productive member of society because of the affective changes. Since all three outcome criteria result in positive assessments of the therapeutic effects, this first matching category is considered very successful.

Matching Category Two (Th: G+; C: G–)

This situation might arise when a client comes to a G+ therapist with a desire to "feel less guilty" but with no interest in making behavioral changes. Alternatively, the client may be willing to change his or her behavior, but may perceive no connection between the presenting complaint (guilt feelings) and the therapeutic approach (behavior change). Under these conditions, the outcome will be generally unsuccessful.

The therapist will attempt to reduce the client's guilt by changing the behavior. If the client is unwilling to change, a therapeutic stalemate is immediately reached. If the client is willing to change, but sees no connection between behavior change and the troubling guilt feelings, there may be a motivational deficit on the part of the client. In either situation, behavior change is slow or absent.

From the perspective of the therapist, the outcome is not favorable because the client has made no progress toward guilt resolution via behavior change. From the perspective of the client, the outcome is not favorable because the guilt feelings have never been a direct target of change in therapy. From the perspective of society, no change has occurred because neither the behavior nor the guilt feelings have been altered. Since none of the outcome criteria result in positive assessments of the therapeutic effects, this second matching category is considered very unsuccessful.

Matching Category Three (Th: G–; C: G+)

This category is characterized by the client who is plagued by guilt feelings, believes those feelings to be the direct result of behavioral patterns, and thus comes to a therapist with a G+ orientation. In contrast to the client, the therapist believes the behavior to be independent of the guilt feelings. From the therapist's perspective, the guilt feelings must be reduced while the behavior may or may not be a problem.

One of the therapist's goals, as noted in quotes cited earlier by Walls and Ellis, is to transform the client's value system to conform to the therapist's values which are perceived by the latter to be more rational. The client's "irrational" connection of behavior and guilt will gradually be eroded and the G- orientation will develop in the client.

Apart from any ethical implications of imposing values upon clients,[4] therapists need to consider the interpersonal tension and

[4] I am not attempting to naively assert that clients' values do not or should not change during therapy. Rather, as will be noted later, I am suggesting that to the extent possible, clients should be given a choice as to which therapist's values they will expose themselves to. Clients who share common religious values with their therapists may find more support for peripheral value changes in their own social milieu than clients who are not matched with their therapists on religious values. This assumes that some value changes fostered by therapists vary with religious values, as is the case with guilt orientation.

dysphoria that such an imposition may cause when the values being changed are religious in nature. For many individuals, to change basic religious values requires either changes in massive social support systems or the acceptance of chronic inner turmoil. By changing a client's values on the causes of guilt, for example, dissonance may be created in religious values, in family relationships, and in interpersonal relationships. Graham (1980) states the point well:

> Quite early in the treatment process, the patient begins to use words like good and bad, and it is our tendency as therapists to diminish the intensity of these words since they relate to a value system within the individual which has led to the current state of stress. My own personal view of the last thirty years of psychotherapy is that we have collectively done an excellent job of diminishing the demonstration of good and bad and a very poor job of replacing these concepts with acceptable definitions which allow the individual self-acceptance and peace. (p. 370)

From the perspective of the therapist, the outcome might be quite successful with this matching category. The client has adopted the therapist's values toward guilt and can verbally deny the guilt feelings which caused the client to initiate therapy. From the client's perspective, however, the long-term effectiveness of therapy may be negligible or even negative. In order to achieve equilibrium in those areas of life thrown awry by his or her value changes, the client may be uprooted with the long-term result of more discomfort than was initially experienced. From the perspective of society, the outcome could range from positive to quite negative, depending upon the client's satisfaction and the degree of social stress caused by the client's change of values.

One other possible outcome must be considered. If the client refuses to accept the values of the therapist, then the outcome can be assessed in the same way as Matching Category Two.

Since only one of the outcome criteria (therapist) clearly results in a positive assessment of the therapeutic effects, and the other outcome criteria may result in negative effects, the third matching category is considered unsuccessful.

Matching Category Four (Th:G–; C:G–)

This category is characterized by the client who does not perceive a necessary connection between guilt feelings and behavior and who goes to a therapist with the same guilt orientation. The behavior of the client may or may not be an issue in therapy.

The therapist will attempt to reduce the client's guilt feelings by emphasizing their common values of the irrationality and non-productivity of guilt. The client will not need to change existing support systems to accommodate the therapist's values.

From the perspective of the therapist, the outcome will be favorable as the client reduces the self-imposed guilt feelings. From the client's perspective, the therapy will be successful since the guilt feelings have been reduced. If the reduction of guilt feelings does positively affect behavior (a supposition of Ellis that is not yet empirically clear), then the outcome will be favorable from the perspective of society as a whole. If the reduction of guilt does not affect behavior, then the outcome will be neutral from the societal perspective. Since two or three of the outcome criteria are assessed positively, the fourth matching category is considered successful.

In sum, the outcome is most favorable when the therapist and the client are of the same guilt orientation. Since guilt orientation is a variable which tends to differ systematically with religious values, it is reasonable to suspect that outcome is positively affected when the client and the therapist share common religious values. As mentioned earlier, guilt resolution is only one dimension of many on which people differ on the basis of religious values. There may be many benefits, in addition to obtaining common guilt orientation, of client-therapist matching on religious values.

This is not to say that religious values are always involved in problems which arise in psychotherapy or that the values of clients never cause the symptoms for which they seek help. The important point is that clients have the right, both ethically and practical-

ly, to choose whether their specific values will be evaluated by therapists with similar general religious values. To do otherwise is to impose a belief that the therapist's set of religious values is superior to the religious values of others and, perhaps more significantly, to deny the existence of an entire social support system in which the client's religious values are intertwined. Therapy may then become an exercise in proselytism without consent.[5]

Recommendations for Religious Value Matching

At this point it will be helpful to discuss the potential application of religious value matching. A radical interpretation of the position which I have taken in this article would be that I am suggesting clients and therapists must be from the same church affiliation or, on the other hand, that therapists should make no attempt to change their client's values. This is not what I am suggesting, but rather, that general values, including religious values, which may affect psychotherapeutic outcome should be openly discussed in the early stages of therapy, especially if there is a significant discrepancy between the therapist's values and the client's values.

It is widely accepted that therapist's values do affect the values of their clients (Strupp, 1980d; Walker, Ulissi, & Thurber, 1980; Weisskopf-Joelson, 1980). To suggest that this value transfusion should not occur would be to deny a basic element of therapy. Rather, I am suggesting that the full implications of the value transfusion should be considered prior to the onset of therapy.

> As practitioners, psychologists know that they bear a heavy social responsibility because their recommendations and professional actions may alter the lives of others. They are alert to personal, social, organizational, financial, or political situations and pressures that might lead to misuse of their influence. (Ethical Principles of Psychologists, 1981, p. 663)

As was previously discussed, to change a client's religious values may result in significant conflicts in his or her social milieu. These possible changes need to be considered prior to their occurrence.

Who is to decide which clients will be harmed by an attempt to change their religious values? The Ethical Principles of Psychologists (1981) suggest an answer to this question:

> Psychologists respect the integrity and welfare of the people and groups with whom they work. When conflicts of interest arise between clients and psychologist's employing institutions, psychologists clarify the nature and direction of their loyalties and responsibilities and keep all parties informed of their commitments. Psychologists fully inform consumers as to the purpose and nature of an evaluation, treatment, educational, or training procedure, and they freely acknowledge that clients, students, or participants in research have freedom of choice with regard to participation. (p. 636)

Potential clients are to be ultimately responsible for the choice of participation after they have been fully informed. Hence, the following recommendations are offered with the understanding that the application of these recommendations are possible only in some employment and therapeutic situations.

1. In conducting intake interviews, psychologists recognize first, the relationship, if any, between the client's presenting complaint and religious value issues, and second, the complexities of interacting religious values and, when appropriate, seek to assess the religious value systems of the prospective client. While some clients may not be able to clearly articulate religious values, most will be able to respond to probing questions which are carefully designed to evaluate religious values.

2. During the beginning phases of therapy, psychologists attempt to communicate their own religious values in a clear manner to those clients whose therapy may be affected by value issues. In addition, the potential complications of conflicting religious values are openly discussed with clients. In some cases, especially with insight-oriented psychotherapies, it may be countertherapeutic for a therapist to recite

[5]This is not meant as a condemnation of persuasion in the therapeutic process, as long as the client is informed. Persuasion without prior consent, however, is not the proper activity of psychotherapists and should be left to evangelists and activists.

religious values early in therapy. Even in these cases, however, the psychologist can be specifically listening for areas in which religious value conflicts might jeopardize a positive outcome. With long-term intensive psychotherapy, it will be important to understand these conflicts early on in therapy so that appropriate alternatives can be considered.

3. As the psychologist's and client's religious values are revealed, the client's choice to continue or discontinue therapy is discussed openly. As usual, if either the psychologist or the client chooses to discontinue therapy, the psychologist offers referral information when possible. This is not to say that a major portion of each therapy session be devoted to religious values, especially if the client's presenting problem bears no obvious connection to religious values. From time to time during the initial phases of therapy the religious value match could be considered by the therapist and discussed with the client only if appropriate.

In most cases, the above recommendations would serve to assess conflicts (such as described earlier in Matching Categories Two and Three before the therapeutic process begins, and therefore would potentially avoid ineffective or negative outcomes due to religious value conflicts. Several difficulties in the implementation of these recommendations deserve to be mentioned.

1. Most individuals, including therapists, believe that their own religious orientation is right. The above recommendations are difficult in that they necessitate giving the client a free choice even though the therapist perceives his or her own value system as the correct one.

2. The above recommendations assume that therapists have a working relationship with other therapists of different religious orientations to whom they can refer clients. For many therapists, this is already the case, but for others it will be necessary to begin to work with professionals with disparate religious views.

3. In settings where the intake interviewer is not the potential therapist, an open communication of religious values between the therapist and the intake psychologist will be necessary. Further, an accurate presentation of the therapist's religious values to the clients may at times be the responsibility of the intake psychologist, even though his or her own religious values may differ from the therapist's values.

As areas of inappropriate client-therapist matching are delineated and alternatives suggested, it is hoped that outcomes in psychotherapy will be positively affected. The sacrifice of psychotherapists who must give up dogmatic efforts to persuade the "fanatic" or the "ungodly" without consent is perhaps a small price to pay for upholding our ethical commitment to our clients' freedom of choice.

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