

## Impact of Religious Affiliation on Therapists' Judgments of Patients

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This study investigated the effects of therapists' and patients' religious affiliation on therapists' attraction to, prognostic expectations of, and diagnosis of the patients. Seventy-seven psychologists, divided into religious versus nonreligious therapists, listened to a 10-min audiotaped therapy session in which a depressed patient evidenced either a strong religious orientation or no religious orientation. The results yielded no differences in therapists' attraction to or diagnosis of the religious versus nonreligious patient. The religious patient was seen as requiring fewer therapy sessions than the nonreligious patient. However, religion was viewed as having a significantly greater impact on the problems of the religious versus nonreligious patient.

The impact of values on the psychotherapeutic relationship has been recognized by mental health workers for more than two decades. Most therapists have abandoned previous beliefs about value-free psychotherapy in the face of mounting data providing evidence to the contrary (Bergin, 1980; Kessel & McBrearty, 1967). Furthermore, some theoreticians have maintained that values shape therapists' initial diagnostic and prognostic evaluations. According to Szasz (1970), the more a patient deviates from a therapist's values, the more likely he or she is to receive a severe diagnosis and poor prognosis.

Researchers have sought to identify the value-relevant variables that might bias diagnosis, prognosis, and outcome. One would expect such biases to be elicited by socially and culturally charged patient attributes (e.g., sex and race) and to be influenced by relevant therapist characteristics. One possible source of bias, which has received scant attention to date, is religion. According to Bergin (1980), there is a significant contrast between the religious values typically held by therapists and those accepted by the majority of patients, with

patients tending to hold the more conservative religious values. The divergence between many therapists' and patients' religious beliefs may produce poorer diagnoses and prognoses for the more religious patients. In addition, several authors have suggested the presence of an antireligious bias among psychologists that might negatively affect their perceptions of religious patients. According to McClintock, Spaulding, and Turner (1965), psychologists are more likely than other social scientists to report no religious faith and were found to be the most antireligious of the social scientists. Sollad (1980) claims that psychotherapists have developed an antagonism toward religious values that evidences itself in practices such as the following:

. . . the bias against admitting overtly religious people into psychotherapy training programs, . . . the relative prevalence of non-religious people in the mental health professions as compared with their proportion in the general society and the absence of education in psychotherapy programs about the religious beliefs and practices of future clients. (p. 52)

Sollad's assertions have found some empirical and theoretical support. Researchers have found evidence of an antireligious bias in many of the most commonly used personality tests (Gartner, 1983). Gartner (1982) also found that professors of clinical psychology were less likely to admit a born-again Christian graduate school applicant than an identical nonreligious applicant.

Ex post facto studies have suggested a relation of diagnosis to religion (e.g., Weintraub

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& Aronson, 1974). However, because these studies were correlational, they shed little light on the question of whether clinicians' religious biases were causative of the diagnostic differences found. One recent analogue study attempted to explore whether psychologists' diagnostic practices are biased by their own and/or their patients' religious affiliations. Using ambiguous case reports in which patients' identified religion was varied (Latter Day Saints [LDS] vs. other), Wadsworth and Checketts (1980) asked psychologists (LDS vs. other) to make *Diagnostic and Statistical Manual of Mental Disorders (DSM-II)*; American Psychiatric Association, 1968) diagnoses. The authors found no effect of patients' or therapists' religion on diagnosis. Thus, the authors concluded that psychologists in Utah were not biased by their own religions, their patients' religions, or the interaction of the two when making formal diagnoses. These findings are interesting but are limited by the authors' methodology. First, the authors suggested that the ambiguity of the case reports should have increased bias if any existed. However, this very ambiguity might have reduced any evidence of bias because it produced such a wide range of diagnostic labels. The psychologists' inability to correctly diagnose the cases might have overshadowed the existence of any religious bias. Second, active religious prejudice may not be evoked merely by the presence of a denominational label, particularly in a state where that label is very common. In fact, the authors failed to run a manipulation check to determine whether or not clinicians were even aware of the differing patient religions. Finally, it may be that religious bias is evidenced less in formal diagnoses, such as a DSM-II label, and more in the less formal aspects of therapist opinion formation.

The present study examined the effects of patient and therapist religious affiliation on therapists' diagnostic and prognostic impressions. In order to improve upon the study by Wadsworth and Checketts (1980), we used taped patient interviews rather than written protocols. We felt the interviews would more closely approximate clinical reality in which religious patient language and religious problem conceptualization, as opposed to a denominational label, might evoke therapists' biases. In addition, we maintained a clear-cut

diagnosis across tapes in order to examine the less formal aspects of therapist judgment. Finally, the patient was portrayed as an Evangelical Christian in order to generalize results to another religious group.

## Method

### *Subjects*

A questionnaire and cover letter constructed and pre-tested for transparency of purpose by Wadsworth and Checketts (1980) was used to invite 123 Iowa psychologists to participate in the present study and to obtain information regarding their religious affiliations. Of these 123 psychologists, 77 (62.6%) returned complete usable data. Forty-three subjects failed to return either the initial questionnaire or the subsequent case material. Three subjects were eliminated because of their suspicions concerning the experimental manipulations.

All subjects were involved in either full-time or part-time clinical or counseling work and were licensed in the state of Iowa. Division into religious versus nonreligious therapists was made on the basis of subjects' religious affiliation. Forty psychologists indicating religious affiliations composed the religious group. This group included two Baptists, one Bible Church member, 12 Catholics, one member of Disciples of Christ, two from the Church of Christ, one Episcopalian, 10 Lutherans, seven United Methodists, and three Presbyterians. Thirty-three psychologists responding *none* to religious preference as well as four Unitarian-Universalists were included in the nonreligious group. The inclusion of the Unitarians in the nonreligious group was based on Maranell's (1974) study in which Unitarian-Universalists scored significantly lower than all other denominations on a general religious factor as well as on all religious scales with the exception of a ritualism scale (appreciation of the beauty of ritual). Even on this last scale, Unitarians were tied for second lowest. Thus, Unitarians scored more similarly to nonreligious than religious individuals.

The nonreligious group was composed of 30 men and 7 women. Thirty of the nonreligious psychologists held PhDs, 2 held EdDs, and 5 held MAs. The age range was from 32 to 60 years old, with a mean age of 44.2 years old. The mean number of years of clinical experience was 15.9. The religious group included 32 men and 8 women. The group contained 30 psychologists with PhDs, 4 with EdDs, and 6 with MAs. The age range was from 30 to 59 years old with a mean age of 41.2 years old. The religious psychologists averaged 14.1 years of clinical experience. The two groups did not differ significantly on any of the demographic variables previously noted.

### *Design and Procedure*

Psychologists who completed and returned the initial questionnaire were randomly assigned to one of two prepared audiotapes. Both tapes contained a 10-min clinical interview between the same male psychiatrist and depressed 54-year-old woman. A third-year psychiatric resident enacted the psychiatrist role, and a 54-year-old woman, recently treated for depression, played the patient role.

A script was prepared in which the patient acknowledged permission to have the interview taped and then gave some background information as well as details about her current depressive symptoms. Two versions of the script were taped—a religious and a nonreligious rendition. The tapes were identical except for three brief segments. During these segments, the religious patient used religious language to describe her symptoms (e.g., loss of relationship with God and inability to pray), whereas the nonreligious patient made parallel nonreligious statements. The religious patient also made reference at these points to participation in religious activities (e.g., Bible studies, Bible reading, and church), whereas the nonreligious patient discussed involvement in parallel secular activities (e.g., a class at the university and reading at home). Three recordings were made in each condition. Three independent judges were asked to listen to the tapes and to select one audiotape from each condition in such a way that the two tapes were matched as closely as possible for technical quality (e.g., volume, absence of background noise, and clarity) and performance quality (e.g., articulation, voice tone, speed of speech, frequency of pauses, and expressed emotion). The three judges unanimously agreed on two tapes. As a further check, two PhD psychologists who were blind to the classifications listened to both audiotapes. They correctly distinguished between the religious and nonreligious tapes and confirmed that the two tapes were uniform with regard to technical and performance aspects.

### Dependent Measures

**Manipulation checks.** In order to assess the accuracy of the division of therapists into religious and nonreligious groups, four questions were used. First, psychologists were asked about their political attitudes on a 5-point scale ranging from *very liberal* (1) to *very conservative* (5). According to Maranell's (1974) study, religious people are more politically conservative than are nonreligious people. Second, subjects were asked to rate their own religious attitudes on a 5-point scale ranging from *very conservative* (1) to *very liberal* (5). Therapists were also questioned about their attitudes toward our culture's sex roles for women on a 5-point scale ranging from *very traditional* (1) to *very liberal* (5). It was assumed that psychologists holding religious beliefs similar to those expressed by the taped patient would also show more traditional sex role attitudes, resembling those implied by the taped patient. Finally, after completing the study, subjects were sent a questionnaire asking them to rate the importance of religion in their lives on a 4-point scale ranging from *strongly disagree* (1; with the statement "Religion plays an important role in my life") to *strongly agree* (4). This last question was based on Gorsuch and McFarland's (1972) findings that the general factor of preresligious attitude found in multiscale inventories is best measured by the single item of rated importance of religion. This single item was found to be as accurate a measure of general religiosity as were multiple-item scales. Five religious and two nonreligious psychologists failed to return the postexperimental questionnaire.

As a manipulation check for patient's religious orientation, therapists were asked to describe the patient on a 4-point scale ranging from *very evident religious orientation* (1) to *religious orientation not in evidence* (4). Finally, subjects were asked to indicate their perceptions of the taped

patient's sex role attitudes on a 5-point scale ranging from *very liberal* (1; in agreement with the views of the feminist movement) to *very traditional* (5; in sharp disagreement with the views of the feminist movement).

**Therapist impressions.** A modified form of the Therapist Personal Reaction Questionnaire (TPRQ), developed by Ashby, Ford, Guernsey, Guernsey, and Snyder (1957), was used in this study as a measure of counselor-perceived patient attractiveness. This form, shortened to 15 items (Davis, Cook, Jennings, & Heck, 1977), was considered appropriate for an analogue study (cf. Goldstein, 1971). The subjects responded to the 15 items along a 5-point scale, yielding a total attraction score for each subject such that the higher the TPRQ score, the higher the attraction to the patient. The 5-point scale was verbally anchored at each pole by the phrases *not characteristic of my present feelings* (1) and *highly characteristic of my present feelings* (5). There were nine positive subjective items (range = 9 to 45) and six negative subjective items (range = -6 to -30). Each subject's attraction score was derived by adding the positive and negative scale totals, resulting in a possible range of -21 to 39.

An eight-question schedule adapted from Graham (1980) was used to measure therapists' prognostic expectations. Of the eight questions, the first six required rating the patient on 4-point scales for appropriateness for therapy at a community mental health center, selection for the therapist's caseload, severity of impairment, motivation to change, capacity for insight, and likelihood of making substantial progress in therapy. Therapists also estimated the number of therapy sessions required for the patient to make substantial progress, as well as indicating whether or not they believed the patient should be hospitalized. A ninth question was added to the schedule that asked therapists' opinions about the impact of several factors, including the factor of interest, religion, on the patient's current disorder. Therapists rated the impact of religion on a 4-point scale ranging from *large impact* (1) to *almost no impact* (4).

Therapists were also asked to give a *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association; 1980) diagnosis for the patient. Finally, therapists were asked for their reactions to the research, including what they believed to be the purpose of the experiment.

## Results

### Manipulation Checks

The means and standard deviations for the manipulation checks appear in Table 1. A two-way (Religious/Nonreligious Therapist  $\times$  Religious/Nonreligious Tape) multivariate analysis of variance (MANOVA) using Wilks's lambda as the criterion was performed on questions regarding therapists' religious, political, and sex role attitudes. The MANOVA yielded a significant main effect for religion of therapist,  $F(3, 71) = 24.25, p < .001$ . The univariate analysis of variance (ANOVA) yielded a significant main effect for religion of therapist

Table 1  
Means and Standard Deviations for Manipulation Checks

Dimension	Religious tape				Nonreligious tape			
	Religious therapists		Nonreligious therapists		Religious therapists		Nonreligious therapists	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Political attitudes of therapists <sup>a,b</sup>	3.00	0.79	2.0	0.41	2.81	0.69	2.1	0.59
Religious attitudes of therapists <sup>a,c</sup>	3.50	0.89	4.55	0.61	3.25	0.91	4.57	0.60
Sex role attitudes of therapists <sup>a,d</sup>	3.70	0.65	4.00	0.90	3.75	0.71	4.26	0.45
Patients' religious orientation <sup>e</sup>	3.85	0.36	3.77	0.42	1.70	0.80	1.58	0.69
Patients' sex role orientation	4.70	0.57	4.66	0.48	4.55	0.60	4.36	0.76

<sup>a</sup> Multivariate analysis of variance: For religion of therapist,  $F(3, 71) = 24.25, p < .001$ .

<sup>b</sup> Analysis of variance (ANOVA): For religion of therapist,  $F(1, 73) = 29.14, p < .001$ .

<sup>c</sup> ANOVA: For religion of therapist,  $F(1, 73) = 45.65, p < .001$ .

<sup>d</sup> ANOVA: For religion of therapist,  $F(1, 73) = 6.56, p < .01$ .

<sup>e</sup> ANOVA: For tape,  $F(1, 73) = 296.52, p < .001$ .

on religious attitudes,  $F(1, 73) = 45.65, p < .001$ ; political attitudes,  $F(1, 73) = 29.14, p < .001$ ; and sex role attitudes,  $F(1, 73) = 6.56, p < .01$ . Religious therapists expressed significantly more conservative religious, political, and sex role attitudes than did their nonreligious counterparts. These findings are consistent with the differences one would expect to find between religious and nonreligious individuals on the basis of Maranell's (1974) findings. A one-way ANOVA (Religious  $\times$  Nonreligious Therapist) was performed on responses to the postexperimental questionnaire. A significant main effect was found for religion of therapist,  $F(1, 68) = 141.94, p < .001$ . Religious therapists agreed with the statement "Religion plays an important role in my life" ( $M = 3.32, SD = 0.71$ ), whereas nonreligious therapists disagreed with the statement ( $M = 1.42, SD = 0.61$ ). Again, these findings are consistent with the differences one would expect between religious and nonreligious individuals and thus serve to support the present division of therapists into the religious and nonreligious groups.

A  $2 \times 2$  ANOVA performed on therapists' ratings of the patient's religious orientation yielded a significant main effect for tape,  $F(1, 73) = 296.52, p < .001$ . Therapists saw the patient on the religious tape as highly religious

and found no evidence of religious orientation on the nonreligious tape. There were no significant differences in therapists' ratings of the patient's sex role attitudes. An inspection of the means indicated that both taped patients were seen as holding fairly traditional sex role attitudes.

### Dependent Measures

The means and standard deviations for all dependent measures appear in Table 2. A two-way ANOVA (Religious/Nonreligious Therapist  $\times$  Religious/Nonreligious Tape) was performed on data from the TPRQ. Neither therapist,  $F(1, 73) = 1.20, p < .05$ , nor patient religion,  $F(1, 73) = 2.01, p < .05$ , affected therapist attraction to the patient. A MANOVA was performed on the first seven questions of the schedule adopted from Graham (1980). A significant multivariate effect was found for tape,  $F(6, 68) = 2.13, p < .05$ . A significant univariate  $F$  was obtained for only one of the seven questions, that of number of therapy sessions required. Therapists saw the religious patient as requiring significantly fewer therapy sessions than the nonreligious patient,  $F(1, 73) = 3.96, p < .05$ . Although the multivariate  $F$  for religion was not significant,  $F(6, 68) = 1.08, p < .05$ , there was one significant uni-

Table 2  
*Means and Standard Deviations for Dependent Measures*

Therapist impression	Religious tape				Nonreligious tape			
	Religious therapists		Nonreligious therapists		Religious therapists		Nonreligious therapists	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
TPRQ	18.30	7.10	15.50	6.75	15.05	7.40	14.21	7.59
Appropriate for CMH <sup>a</sup>	3.75	0.78	3.77	0.42	3.65	0.49	3.52	0.84
Want client for caseload <sup>a,b</sup>	3.35	0.59	2.89	0.76	3.25	0.55	3.05	0.78
Degree of client disturbance <sup>a</sup>	2.00	0.45	2.00	0.69	2.10	0.31	2.05	0.52
Motivation to change <sup>a</sup>	2.90	0.72	2.78	0.81	2.65	0.59	2.68	0.82
Understanding of problem <sup>a</sup>	2.25	0.79	2.16	0.70	2.30	0.57	2.42	0.69
Likelihood of prognosis <sup>a</sup>	3.20	0.70	3.00	0.84	3.20	0.41	3.00	0.58
No. of sessions needed <sup>a,c</sup>	14.37	5.86	10.31	3.77	15.68	10.02	18.39	10.67
Impact of religion on client's problem <sup>d</sup>	2.20	1.00	2.06	0.87	2.70	1.12	3.11	.88
Hospitalization (yes-no)	1.85	0.37	1.77	0.43	1.70	0.47	1.79	0.41

Note. TPRQ = Therapist Personal Reaction Questionnaire; CMH = Community Mental Health.

<sup>a</sup> Multivariate analysis of variance: For tape,  $F(6, 68) = 2.13, p < .05$ .

<sup>b</sup> Analysis of variance (ANOVA): For religion of therapist,  $F(1, 73) = 4.55, p < .03$ .

<sup>c</sup> ANOVA: For tape,  $F(1, 73) = 3.96, p < .05$ .

<sup>d</sup> ANOVA: For tape,  $F(1, 73) = 11.72, p < .001$ .

variate main effect for the therapists' religion. Although this univariate effect must be interpreted very tentatively due to the nonsignificant MANOVA, it is an interesting finding that deserves mention. The significant main effect for therapists' religion was found on the question concerning whether or not therapists would want the taped patient as part of their own caseloads. Religious therapists were significantly more likely to select the patients on both tapes for their caseloads than were nonreligious therapists,  $F(1, 73) = 4.55, p < .03$ .

A  $2 \times 2$  ANOVA was performed on therapists' ratings of the impact of religion on the taped patient's current disorder. A significant main effect for tape was obtained,  $F(1, 73) = 11.72, p < .001$ . Thus, religion was seen as having a significantly larger impact on the problems of

the religious patient as compared with the nonreligious patient.

Chi-square tests performed on therapists' responses to the question concerning the taped patient's need for hospitalization indicated no effect for therapist or patient religion,  $\chi^2(1, N = 77) = 0.01, p < .05$ , and  $\chi^2(1, N = 77) = 1.01, p < .05$ , respectively.

### Diagnosis

Presented in Table 3 is a distribution of the diagnoses given to the taped patient across the four experimental groups. (Four psychologists failed to give a DSM-III diagnosis.) As expected, psychologists were quite consistent in their diagnoses of the patient. Chi-square analyses indicated that neither clinicians' re-

Table 3  
*Distribution of Diagnoses by Clinicians' and Patient's Religions*

Diagnosis	Religious therapist		Nonreligious therapist	
	Religious tape	Nonreligious tape	Religious tape	Nonreligious tape
Major depressive disorder	18	15	14	14
Adjustment disorder	1	1	0	1
Dysthymic disorder	1	4	1	1

religious affiliation,  $\chi^2(2, N = 73) = 0.02, p < .05$ , nor patient's religious orientation,  $\chi^2(2, N = 73) = 1.75, p < .05$ , was related to the tendency to assign a particular diagnostic label.

### Discussion

The results of this study generally provide support for the findings of Wadsworth and Checketts (1980) that psychologists' diagnoses are not biased by their own and/or their patients' religions. However, the findings of this study do suggest areas of potential bias that are in need of further empirical exploration.

The present study adds to the Wadsworth and Checketts (1980) study in several important ways. First, it documents the lack of bias in the more personal, less formal arena of therapists' prognostic evaluations and impression formation. Second, it extends the generality of Wadsworth and Checketts's findings to another religious group, that of Evangelical Christians. Finally, it reports these findings in an analogue that more realistically approximates the therapeutic setting.

Although therapists failed to show evidence of bias in terms of attraction to the patient and in relation to several prognostic variables, they did see the religious patient's spiritual orientation as having a large impact on her difficulties. Because the symptoms of depression presented in the religious and nonreligious tapes were virtually identical, it is interesting to note that psychologists found religion to be a very important factor in one case and of relatively little or no importance in the other. Unfortunately, it is difficult to determine the basis for psychologists' distinction between the two tapes. It may be that the therapists felt that whenever religion is a central concern in patients' lives, it inevitably has a large impact on the way they perceive and deal with their problems. On the other hand, therapists' responses might indicate the feeling that religion was somehow a causative or contributive factor in the patient's difficulties. Such a therapist judgment might have serious negative implications for the therapy relationship, particularly if the therapist saw the patient's religious commitments as unhealthy and in need of change.

Another area of potential bias is indicated by the results of the question concerning the

number of sessions needed by the taped patient. Therapists estimated that the religious patient would require significantly fewer therapy sessions than would her nonreligious counterpart. This judgment was especially true for nonreligious therapists, who saw the nonreligious patient as needing almost twice as many therapy sessions as the religious patient. It is possible that therapists believed that the religious patient's progress would be enhanced by her religious orientation or that she would receive help from those within the church, and thus she would require fewer therapy sessions. However, it is also possible that the estimates of number of sessions needed indicate the presence of a phenomenon similar to that found by Cole, Branch, and Allison (1962) as well as by Hollingshead and Redlich (1958). In the former study, it was found that social class was positively related to acceptance for treatment. In the latter study, lower social class was associated with fewer outpatient visits and treatment by pharmacotherapy as opposed to psychotherapy. Thus, it is possible that religion may operate in a manner similar to social class, with religious patients being viewed as poorer candidates for long-term treatments. Obviously, more research is needed to determine if predictions of treatment length are evidence of bias.

Finally, the finding that religious therapists were more likely to select both the religious and nonreligious patients for their caseloads was an interesting result. It is possible that religious therapists saw the traditional values espoused by both patients as more similar to their own values than did nonreligious therapists. This notion is supported by the fact that the religious therapists were significantly more conservative than were the nonreligious therapists in their view of sex roles for women. Furthermore, there were no significant differences in therapists' ratings of the patients' sex role attitudes. Both patients were viewed as holding traditional values. It may be that the more traditional therapists felt that they would be more comfortable working with a conservative woman than did therapists with more liberal views about women's roles.

A few cautions regarding the validity and generality of the results of this study bear mentioning. First, although a large percentage of the psychologists contacted agreed to par-

ticipate in the study, they were not a random sample, but rather volunteers who may not be completely representative of the population of psychologists in Iowa. Second, these results cannot necessarily be generalized to other geographic regions or to other religious groups. Due to the somewhat more conservative nature of the state and to the prevalence of religious involvement, Iowans may display less religious bias than may be found in large metropolitan communities. Furthermore, although the subjects in the religious group answered in the expected direction on scales of political, religious, and sex role attitudes, they still represented a heterogeneous group. A strong affiliation with one religious group or ideology may mean something very different from a strong affiliation with another. Had the religious therapists represented a group of individuals unified by beliefs identical with those expressed by the religious patient, their ratings of that patient might have differed more dramatically from ratings made by nonreligious therapists. Finally, the analogue nature of the experiment limits generalizability to some extent. Face-to-face contact with religious patients may elicit bias that is not present in the more impersonal analogue situation.

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