

Changes in Clients' Images of God Over the Course of Outpatient Therapy

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The authors examined the impact of outpatient counseling on clients' psychological symptoms and on their image of God. Thirty participants in a counseling treatment group and 68 participants in a no-treatment control group completed the Brief Symptom Inventory and the Adjective Checklist at 2 separate times. Counseled participants experienced significant reductions of psychological symptoms over the course of treatment whereas the control group showed no changes. Furthermore, ratings of God's agreeableness significantly increased (toward compassion) for clients in the treatment group, whereas no such changes were noted for the control group.

Theology and psychology have similar goals for human health and well-being. Both propose that a person live to her or his fullest potential by developing self-understanding. Theologians include understanding God as a part of this human development potential.

Personal development of the self also constitutes development of the experience of God: loss of self-identity is also a loss of the experience of God. These are two aspects of one and the same history of experience. (E. Johnson, 1992, p. 65)

Historically, however, theology and psychology have been alienated from one another. Freud fueled this schism, maintaining that religion was the universal neurosis that relieved individuals' sense of helplessness by relying on an invented exalted father figure (Freud, 1913/1953). Theologians viewed psychology as anti-God, and psychologists viewed theologians as lacking in scientific understanding (Hood, Spilka, Hunsberger, & Gorsuch, 1996). Several theorists challenged Freud's views, resulting in the alienation of psychology and theology (Allport, 1950; Fairbairn, 1952; Guntrip, 1949, 1953, 1956; Rizzuto, 1979; Winnicott, 1958, 1971). Others continued to work toward understanding the integration of religion and psychology despite the diverse views regarding its importance (Hall, 1904; James, 1902/1985; Jung, 1938).

Recently, there has been a renewal of interest in recognizing the importance and impact of spirituality and religious faith on human development, mental disorders, and treatment. Both the American Psychological Association

(1992) and the American Counseling Association (1995; Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2001) have embraced religion and spirituality as a diversity issue, thus requiring practitioners to attend to the significance of religious and spiritual concerns in understanding and treating clients. In 1994, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV) included the diagnosis "Religious or Spiritual Problem" in its section on the conditions that may be a focus of clinical attention.

The research of mental health professionals has supported the view that counseling and psychotherapy reduce the symptoms of mental disorders (Grissom, 1994; Lambert & Cattani-Thompson, 1996; Lipsey & Wilson, 1993). Grissom's analysis indicated that, in general, therapy was much better than no treatment and better than a placebo. While some researchers were considering whether psychotherapy was effective, others were examining whether there are correlations between a person's image of self and his or her perceptions of God. Spilka (1964), an early pioneer in a factor-analytical approach to the study of God representations, provided evidence that linked levels of self-esteem with perceptions of God. Individuals with high levels of self-esteem and self-acceptance held images of God that were positive, close, personal, and accepting. Low levels of self-esteem were associated with more wrathful, controlling, and distant images of God (Benson & Spilka, 1973; Spilka, 1964). Other researchers also observed that a high self-valuation or self-acceptance was consistent with holding positive images of God or an accepting deity who is involved in human affairs (Chartier & Goehner, 1976; Ellzey, 1961; Jolley & Taulbee, 1986; Luther, 1980; Spilka, Addison, & Rosensohn, 1975).

In connecting clinical research and changes in image of God, investigators began assessing whether there were differences between clinical and nonclinical samples. For example, Morgan (1979) demonstrated that patients viewed God as more dominant and viewed themselves as more hostile than did nonpatients. Another study of hospitalized patients reported less change in their negative views of God and others than did nonpatients (Abrahamson, 1978).

Sexual abuse, depression, and trauma have been linked to image of God (Carroll, 1992; Corzo, 1981; W. B. Johnson & Eastburg, 1992; Kane, Cheston, & Greer, 1993). Piedmont, Williams, and Ciarrocchi (1997) found that images of God were significantly related to self-personality, with levels of emotional distress, rigidity, and antagonism linked with more negative images of God. The images of God in Piedmont et al.'s (1997) sample seemed to mirror individuals' internal self-perceptions. An individual's image of God is more than simply a demographic or cultural variable; that image seems to have important psychosocial and emotional correlates. Such interrelatedness suggests that individuals' image of God should be incorporated in counseling.

Richards and Bergin (1997) cited two reasons that therapists should seek to understand how their clients perceive or visualize God. First, if clients have low self-esteem and perceive God to be harsh, vengeful, and imper-

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sonal, then spiritual interventions that enable them to personally feel God's love and support could have powerful healing effects on their sense of self-esteem and worth. Second, insight into a client's God image and how it is related to the client's image of self, parents, and significant others gives the therapist a more complete understanding of the client's internalized object relations and, thus, potentially more leverage for promoting therapeutic change (Richards & Potts, 1995).

Few empirical studies have explored the effect that psychotherapy may have on clients' images of God. Tisdale et al. (1997) explored the impact of inpatient treatment on the God image and personal adjustment of 99 evangelical Christians whose predominant diagnosis was major depression. The study continued to follow the patients in outpatient treatment. The authors found that inpatient treatment had a significant positive effect on the patients' personal adjustment and image of God. The improvement that was noted in the inpatient setting was maintained during outpatient treatment, but no further improvement occurred.

Our study investigated whether clients' images of God would change over the course of outpatient psychotherapy. Regardless of whether the treatment focuses on spiritual/religious issues, do decreases in emotional symptoms correspond to positive changes in individuals' images of God? We expected that patients who were in treatment would show significant shifts in image of God over time in comparison to a no-treatment control group. We also hypothesized that these changes would be significantly related to changes in counselor ratings of clients' symptoms as well as emotional and spiritual growth.

Method

Participants

A total of 98 individuals, ranging in age from 20 through 80 years ($M = 47$, $SD = 14$), participated in the study. Participants in the treatment group, 7 men and 23 women, were recruited when they began psychotherapy. Clinicians of the treatment group were contacted through national professional acquaintances, and they represented the professional counseling, pastoral counseling, and psychology professions. All clinicians who volunteered were included in the study. Clinicians were advised of the project and were asked to approach their clients about participating in the study. For the treatment group, the clinicians distributed packets of instruments to their clients who agreed to participate in the study. One hundred fifty packets were distributed to approximately 30 clinicians. Of the 150 packets, 43 potential treatment group participants returned packets. Of the 43 who completed the packets for the first measurement, 30 participants completed the packet of instruments for both measurement phases.

The control group consisted of 68 individuals (15 men and 53 women) who were recruited through professional and personal contacts. One hundred

packets were distributed to potential control group participants. In the first measurement phase, 72 individuals returned the packets; in the second measurement phase, 68 individuals returned packets.

For the control group, a demographic questionnaire was used to determine whether individuals were currently in counseling, psychotherapy, or spiritual direction. If they reported affirmatively, they were excluded from the control group and were not recruited for the treatment group. Two possible control group members were questioned and excluded before they completed the packets. Two individuals completed the packets and were then excluded, resulting in a final total of 68 members of the control group.

Measures

Adjective Checklist (ACL). Developed by Gough and Heilbrum (1983), this instrument consists of 300 adjectives from which individuals select the ones that they view as most descriptive. Using a panel of experts familiar with the five-factor model of personality, John (1990) created adjective marker scales for each dimension of the five-factor model by having these experts identify ACL items that are representative of each dimension. The following labels have been given to the five factors (Costa & McCrae, 1985): Neuroticism (an individual's tendency to experience negative affect such as anxiety, depression, and hostility), Extraversion (which reflects the quantity and intensity of one's interpersonal interactions), Openness to Experience (the proactive seeking and appreciation of new experiences), Agreeableness (the quality of one's interpersonal interactions on a continuum from compassion to antagonism, and Conscientiousness (the persistence, organization, and motivation exhibited in goal-directed behaviors). These rational judgments have been supported by empirical analyses that demonstrated both the convergence of these markers with other measures of the five-factor model (McCrae, 1990) and with relevant scales from the ACL (Piedmont, McCrae, & Costa, 1991).

The ACL was used to determine participants' perceptions of God across these personality dimensions. Participants were given the following instructions for completing the ACL:

Who is God? Who do you feel this being is? Based on your understandings and/or experiences, what kinds of personal images do you hold of this being? We are interested in knowing what qualities and dispositions you associate with your images of God. The following form contains 300 adjectives that can be used to describe an individual's personality. Read through the list and check all those adjectives you feel would describe your images of God. Work quickly; your first guess is your best.

To score responses, self-reported normative values for the five-factor dimensions were used (Piedmont, 1989).

Brief Symptom Inventory. Developed by Derogatis (1993), this 53-item, self-report inventory was designed to capture psychological symptom patterns across nine primary, clinically relevant dimensions and three global

indexes. These nine dimensions are Somatization (distress arising from perceptions of bodily dysfunction), Obsessive-Compulsive (thoughts, feelings, and actions that are experienced as unremitting and irresistible and of an unwanted nature), Interpersonal Sensitivity (feelings of personal inadequacy and inferiority), Depression (dysphoric mood and affect), Anxiety (nervousness, tension, panic attacks, and dread), Hostility (thoughts, feelings, or actions characteristic of anger, aggression, irritability, rage, and resentment), Phobic Anxiety (persistent fear response that is irrational and disproportionate to the stimulus), Paranoid Ideation (disordered thinking, including hostility, suspiciousness, and grandiosity), and Psychoticism (a graduated continuum from mild interpersonal alienation to dramatic psychosis). The global index used in this study, the Global Severity Index, combines information concerning the number of symptoms reported with the intensity of perceived stress.

The Derogatis Psychiatric Rating Scale (DPRS). Developed by Derogatis (1978), the DPRS is an 18-item psychiatric rating scale that was designed to determine the therapist's assessments of clients' symptoms. The scale contains 17 symptom dimensions and a Global Pathology Index. The therapist rates the clients' intensity of symptoms on a Likert-type scale from 0 (*absent*) to 6 (*extreme*). The Global Pathology Index (GPI) provides an overall assessment of pathology on a 0 (*absent*) to 8 (*extreme*) Likert-type scale. Perconte and Griger (1991) showed that the DPRS successfully discriminated among different types of treatment responses in Vietnam veterans who had been diagnosed with posttraumatic stress disorder. Counselors completed this instrument on each client at both pre- and posttreatment.

Counselor Treatment Ratings. At the end of treatment, counselors rated each client according to how much emotional and spiritual growth they believed the client had experienced. These ratings were made on a 7-point Likert-type scale: 1 = *no growth* and 7 = *significant growth*.

Procedure

All participants were measured at two separate times. For the treatment group, the first measurement occurred within the first 4 weeks of counseling. Clients were asked to complete the instruments in their packets (i.e., a demographic questionnaire, the ACL, the BSI) and to sign an informed consent form. Clinicians were asked to complete a counselor information form and a DPRS for each of their clients who participated in the study. The second measurement occurred at the end of 6 months or at termination (range = 6-19 months, $M = 6.7$ months; range = 2-52 sessions, $M = 20$ sessions), whichever came last. Clinicians were sent the second measurement packets after their clients had been in counseling for 6 months. Despite instructions, a few clinicians kept the packets and distributed them at the termination of counseling. In the second packet, the treatment group received the ACL, with the aforementioned instructions for describing their perceptions of God,

and the BSI. In the second measurement phase, the clinicians were asked to complete a DPRS on each of their participating clients and the Counselor Treatment Ratings, which elicited counselors' ratings on their clients' emotional and spiritual growth.

For the control group, initial ratings occurred when a person was contacted and agreed to participate in the study. The packets contained the same instruments and instruction that were in the treatment group packets. The second measurement phase occurred 2 to 6 months later ($M = 4$ months), and they again provided ratings of their image of God (using the ACL) and psychological symptoms (using the BSI).

Results

Demographic Information

There were no differences between the treatment and control groups in education, culture, marital status, gender, or religiousness. However, there was a significant age difference: mean age for the treatment group = 39.3 years; mean age for the control group = 50.1 years; $t(96) = 3.71, p < .001$. On average, those in the control group had 16 years of education (range, 11-24 years). Thirty individuals (23 women, 7 men) were in the treatment group; 68 individuals (53 women, 15 men) were in the control group. These individuals received no psychotherapy or spiritual direction during the study.

The therapists who participated in this study were professional counselors, pastoral counselors, and psychologists who used a variety of therapeutic approaches. All stated that they had a belief in God or a higher power. On average, the therapists had practiced professionally for 14 years.

Changes in Symptom Experience

The first analyses attempted to determine the impact of therapy (treatment vs. no treatment) on symptom experiences over time. We focused on the significant interaction effect between experimental group and time of assessment, in which scores significantly declined over time only for participants who received treatment. A 2 (psychotherapy vs. control) \times 2 (preassessment vs. postassessment) mixed-model multivariate analysis of variance (MANOVA) was performed using the nine BSI scales as the dependent variables. A significant interaction emerged, Wilks's lambda = .67, multivariate $F(9, 88) = 4.93, p < .001$. The univariate effects indicated significant interactions across all nine BSI dimensions. Examination of the pattern of those interactions revealed the same effect: Scores for the treatment group declined significantly from pretest to posttest, whereas scores for the control group remained constant. A significant main effect for experimental group was also obtained, Wilks's lambda = .68, multivariate $F(9, 88) = 4.56, p < .001$. Examination of the univariate means showed that the treatment group was significantly higher than the control group on all nine dimensions of

the BSI. Thus, the therapy group experienced significantly more psychological symptoms than did the control group, and symptoms declined significantly over the course of treatment.

Changes in Image of God

Another 2 x 2 mixed model MANOVA was conducted using the previously mentioned independent variables but also including, as the dependent variables, the ratings of God on the five personality domains. A main effect of time of assessment emerged, Wilks's lambda = .83, multivariate $F(5, 91) = 3.66, p < .005$, indicating significant changes in overall image of God ratings over time. Univariate analyses indicated that ratings of God's Neuroticism declined over time, $F(1, 95) = 7.74, p < .007$, and ratings of God's Agreeableness, $F(1, 95) = 7.42, p < .008$, and Conscientiousness, $F(1, 96) = 7.94, p < .01$, increased over time, $F(1, 96) = 7.94, p < .01$.

Finally, a significant interaction emerged, Wilks's lambda = .89, multivariate $F(5, 91) = 3.66, p < .05$. This effect indicated that changes in the image of God were different over time for the two groups. Univariate analyses indicated effects for image-of-God ratings of Neuroticism, $F(1, 95) = 3.87, p < .05$, and for Agreeableness, $F(1, 95) = 9.85, p < .002$. Plots of these interactive effects showed that ratings of God's Neuroticism declined for the therapy group, whereas scores remained constant for the control group. For the Agreeableness of God, scores increased for the treatment group, whereas the scores of control group participants remained stable over time.

Individuals in the control group perceived God as being low on Neuroticism and high on Agreeableness, which was a perception of God as being slow to anger and reluctant to express it when it arises. God was seen as someone who prefers to forgive and forget and works toward a common ground in resolving disputes. This image was stable over time for this group. Treatment group participants, however, developed this image over the course of treatment. Although God was originally perceived as being low in Neuroticism (scores lower than 45 are considered low, whereas those above 55 are considered high), over time God was seen as more emotionally stable and robust. However, there was also a significant increase in ratings of Agreeableness; treatment clients came to experience a more loving and caring God.

Relating Therapeutic Change to Image of God

To determine if changes in symptom experience could be related to changes in participants' images of God, a series of analyses were performed using only treatment group participants. First, raw change scores were obtained for the five image-of-God ratings by subtracting participants' scores at Time 1 from their scores at Time 2. In a similar manner, raw symptom change scores were obtained using counselor ratings of clients' symptom experi-

ence. We believed that correlating these two indices would determine if shifts in rated symptom experience were related to shifts in participants' images of God. The only significant correlation was found for the Conscientiousness of God, $r(28) = .54, p < .01$, indicating that increases in counselor ratings of symptoms were associated with perceptions of God as being more competitive, goal oriented, and controlling.

At the end of treatment, counselors rated each client according to how much emotional and spiritual change the counselor observed during treatment. Participants in the therapy group were divided into high and low treatment change groups. Changes in participants' images of God were then compared. Table 1 presents the results for the emotional change dimension. Participants who were in the low emotional change group showed a significant increase in God's rated Extraversion, $t(15) = -2.54, p < .05$. Individuals in the high emotional change group indicated significant declines in God's rated Neuroticism, $t(13) = 2.12, p < .05$, and Extraversion, $t(13) = 2.60, p < .05$, and a significant increase in God's rated Agreeableness, $t(13) = -3.12, p < .01$. For the high emotional change group, God was perceived as becoming more emotionally stable, less assertive, and more compassionate and loving.

These analyses were repeated using counselors' ratings of clients' spiritual change over the course of treatment. Table 2 presents the results of these analyses. Individuals in the low spiritual change group evidenced no significant shifts in their image of God. However, individuals in the high change group noted a significant increase in God's rated levels of Agreeableness, $t(17) = -2.89, p < .01$. For participants who showed spiritual growth, there was a concomitant increase in perceiving God in a more loving, compassionate, and caring manner. Thus, changes in the image of God over treatment were moderated by how much growth was experienced.

TABLE 1

Image of God (IOG) for Clients Grouped by Counselors' Ratings of Emotional Growth Over the Course of Treatment

IOG Dimension	High Emotional Growth (n = 14)			Low Emotional Growth (n = 16)		
	Time 1	Time 2	t	Time 1	Time 2	t
Neuroticism	47.53	41.28	2.12*	41.24	39.58	0.60
Extraversion	51.91	48.41	2.60*	45.53	48.52	-2.54*
Openness	48.36	50.57	-1.07	51.82	52.14	-0.27
Agreeableness	49.70	57.14	-3.12**	57.28	58.73	-1.12
Conscientiousness	49.53	51.36	-0.85	52.19	55.23	-1.86

* $p < .05$; ** $p < .01$, two-tailed.

TABLE 2

Image of God (IOG) for Clients Grouped by Counselors' Ratings of Spiritual Growth Over the Course of Treatment

IOG Dimension	High Spiritual Growth (n = 18)			Low Spiritual Growth (n = 12)		
	Time 1	Time 2	t	Time 1	Time 2	t
Neuroticism	45.56	40.73	2.01	42.10	39.83	0.62
Extraversion	50.07	48.29	1.32	46.17	48.42	-1.33
Openness	49.50	50.78	-0.69	51.27	52.34	-1.40
Agreeableness	51.93	57.56	-2.89**	56.45	58.63	-1.17
Conscientiousness	49.83	52.28	-1.35	52.63	55.54	-1.33

** $p < .01$, two-tailed.

Discussion

Does one's psychological status have a direct effect on spiritual well-being, or does one's perception of God have a direct impact on psychological well-being? This chicken-and-egg question has important implications for counselors who are interested in the value of spirituality. Answers to this question will determine whether spirituality is merely a psychological outcome or if it is an important contributor to psychological health. If an individual's psychological status has a direct effect on spiritual well-being, then spirituality is an output of each person's psychological system. Individuals who are depressed tend to have disparaging images of not only their lives in general, but of God in particular (Rizzuto, 1980). If this is true, an individual's image of God serves as a marker of more serious psychological issues. However, if one's perception of God has a direct effect on psychological well-being, then an individual's image of God represents a factor in one's psychological stability. Disturbances in one's relationship with God may exacerbate or even create psychological symptoms. Thus, interventions that do not focus on an individual's spirituality may not be as successful in alleviating the symptoms as treatment that focuses on spirituality because the client will not be reconciled with the higher power object that is central to the presenting problems (Rizzuto, 1980). Although this study did not directly address the question of causality, it does show that image of God was related to therapeutic change and as such may have played a role in that process. Future research could examine changes in IOG over time and document the impact such changes may have on various psychosocial experiences and outcomes.

Implications for Counseling

This study offers support for E. Johnson's (1992) theological idea that personal development of the experience of the self is related to the personal experience

of God and that these experiences mutually influence each other. Support is also offered for researchers' findings that psychotherapeutic change affects and is affected by spiritual concerns (Benson & Spilka, 1973; Spilka, 1964; Tisdale et al., 1997). When an individual makes a decision to enter into the therapeutic process, he or she brings the whole person into the therapeutic relationship, including religious faith and/or personal spirituality. On the basis of our results, we suggest that therapists embrace the diversity stance for spiritual/religious beliefs that the American Psychological Association (1992) and the American Counseling Association (1995; CACREP, 2001) propose; we also suggest that therapists become more aware of the impact of spiritual dimension of clients' lives and consider using the client's image of God as a point of discussion in the therapeutic process. Further, clients in acute distress may feel vulnerable in their relationship with God. In exploring the sources of distress, the therapist might reflect with the client on how he or she views God, how the person describes his or her relationship with God, and the feelings that are associated with that view. A client with a view of an antagonistic, uncaring God has a story to tell that sheds light on the high level of distress as well as on the evolution of experiences, whether church or personal, that contributed to such a negative view of God. Our findings suggest that integrating image of God work into the therapeutic process would be appropriate because of its potential for predicting psychological well-being over time. Specifically, our data suggest that images of God and psychological symptoms have some relationship to one another, especially in the amount of agreeableness, neuroticism, and conscientiousness that clients attribute to God.

Limitations of the Study

Although our data are encouraging for counselors who are interested in religious/spiritual constructs, some caveats should be mentioned. First, the treatment group consisted of a relatively small number of participants and, thus, the many null findings may be the result of low power. Also, 13 clients either dropped out of treatment or failed to return the second packet and, therefore, did not provide any posttreatment data. Thus, it is not clear whether the findings are a function of a mortality confound. Third, the control group was not comparable with the treatment group in terms of age. The stability in image of God noted for the control group, therefore, may have been a selection artifact. More longitudinal research using large, representative samples is recommended. Finally, our data do not clarify the degree to which spiritual/religious issues were addressed explicitly in the treatment process. Perhaps clients who initiated discussions of spiritual issues experienced more image-of-God change than those who did not raise such issues. Future research could focus on controlling for the types of interventions or topics that are covered in treatment. Perhaps a direct comparison of spiritually oriented versus more secular treatments is warranted.

With the advent of the *DSM-IV's* (American Psychiatric Association, 1994) new diagnostic category, Religious or Spiritual Problem, therapists should not only be aware of different spiritual orientations but should also have some comfort and competence in being able to solicit and therapeutically manage this type of information. The psychological and spiritual selves of clients may be integrally connected; thus, when something shifts for one part of the self, it shifts for another part of the self as well. Although this connection may be obvious to individuals who embrace a faith in God, the secular field is much less convinced. These data provide beginning support for the potentially powerful influence that spirituality may have on an individual's ongoing psychological growth and healing.

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Ending of Native OSS

literature includes numerous refer-
 es of interviews with Native Ameri-
 ritual pain experienced as a result
 at continue to affect their families
) "tasks of mourning" provided the

h grief and loss in their personal as-
 es. They have experienced some of
 eir clients—for example, the death
 and the loss of jobs. Until recently,
 ay not have been aware of the nature
 -based loss. Multicultural counseling
 rially related loss and has shown that
 id belief systems are not understood
 ace for many years (Arredondo, 1999;
 Morgan, 1997; Mahalik, Worthington,
 z Pearce, 1996; Robinson, 1999).

th the magnitude of the losses that
 ans and the prejudice and discrimi-
 ers in multicultural counseling have
 eness of culture-based concerns by
 ill-development sessions at profes-
 nuating to make contributions to the
 ognizing the need for more atten-
 tions, offered recommendations for
 ls by learning to express "cultural
 irected to dominant-culture coun-
 be reminded of the significance of
 ethods, history, relocation, oppres-

ten extensively on counseling with
 ehensive article on working with Na-

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