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ABSTRACT

Although religious concerns are generally not clients' primary presenting problems in secular therapists' practices, religious beliefs and values can have a strong influence on clients' behavior and clinical progress. For this reason, knowledge about religion and its impact can be useful in intervention work.

Three case studies illustrate how sociology of religion can be a substantive resource in clinical sociology and sociological practice. In this paper, religion is defined as a belief system of denominational, sectarian or secular values which explains natural and supernatural phenomena.

As the concept of a supreme being is central in most Western belief systems, the three clients' perceptions of their relationships with a supreme being are examined. Clients' concepts of God are used to demonstrate the process by which clinical strategies can increase the meaningfulness of clients' choices of secular and religious values and their awareness of the consequences of holding specific beliefs for their everyday behavior.

The three clinical examples are based on life history data of contrasting patterns of behavior resulting from individual allegiances to different religious belief systems. These contrasts are summarized as patterns of "Deference/Fatalism," "Self as Equal to God," and "Copartner with Powerful God." It is proposed that sociology of religion can effectively inform principles and strategies for clinical intervention, as well as strengthen and enrich basic propositions of clinical sociology.

Religion was intensively studied by nineteenth century and early twentieth century sociologists, as well as by philosophers before that time (Birnbaum

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and Lenzer, 1969). Whereas Marx viewed religion negatively—as a tool of exploitation used by the upper classes, the opiate of the masses, and false consciousness—Durkheim documented religion as both a means and foundation of social solidarity (Durkheim, 1965). Weber later challenged the Marxian hypothesis that religion prevents social change by delineating the innovative role played by Protestantism in the development of capitalism (Weber, 1958).

These theories have relevance for both contemporary sociology and clinical sociology. Issues of social and individual change are central in these disciplines. As social values have changed at an accelerated pace in the last decades, questions continue to be raised about the role of religious beliefs and values in promoting and/or inhibiting change, and in the resulting quality of life.

The major contribution of clinical sociology within contemporary sociology is that it provides a broad, substantive base and conceptual context for intervention work at different levels of social organization (Clark, 1990). Clinical sociological perspectives range from individual reflection to community change (Glassner and Freedman, 1979). This orientation is innovative in that it allows for the consideration of more individual and social facts in assessing behavior than traditional mental health disciplines.

In contrast to general sociological concerns with the influence of all beliefs and values on everyday behavior, this article examines the effects of selected aspects of religious beliefs and values on interaction and clinical outcomes. Although religious concerns are generally not clients' primary presenting problems in secular therapists' practices, religious beliefs and values can markedly affect clients' behavior and clinical progress. For this reason, knowledge about religion and its impact can be useful in intervention work. In this study, specific contributions of sociology of religion to clinical sociology and sociological practice are outlined, in order to more precisely assess the appropriateness of working with religious beliefs and values in therapy.

In sociology of religion, in general, and in this study, specifically, religion is defined as a belief system of denominational, sectarian, and secular values which explains natural and supernatural realities (Birnbaum and Lenzer, 1969). The three case studies selected illustrate ways in which clinical discussions and analyses of clients' beliefs and values can increase their autonomy and effectiveness in everyday behavior and goal attainment.

A focus on religion links micro- and macro-sociological perspectives (Carbine, 1980; Paloutzin and Ellison, 1982; Alexander, Giesen, Munch, and Smelser, 1987). The contrasting beliefs in God specified in the following case studies demonstrate the manner in which the qualities and intensity of the values underlying these beliefs create significant consequences for self-concepts, identities, world views, and behavior (Meadow, 1980; Caughey, 1984). The

contrasting beliefs represent different perceptions of a supernatural power and each person's relationship with that supernatural power.

Clinicians can be more effective when they recognize that denominational and sectarian beliefs characteristically have contrasting degrees of salience for their adherents (Buber, 1958; James, 1961; Rosenberg and Turner, 1981). Sociologists of religion proffer that impersonal or detached formal behavior is typical of denominations, while intense religiosity or devotional fervor characterizes the more intimate interaction of sects (Ortony, Clare and Collins, 1988). Clinical data suggest that degrees of religiosity must be assessed in order to understand their potential strength of influence on all therapeutic and interpersonal change processes.

Atheism, spirituality and New Age beliefs may also have a strong impact on clients' conceptualizations of self and the universe. This occurs in ways congruent with the major values espoused in these particular belief systems (Helle and Eisenstadt, 1985). Furthermore, clients who adhere to more idiosyncratic combinations of values and beliefs as their most meaningful orientations to life, internalize and experience them as privatized or noninstitutionalized religions (Luckmann, 1967).

A clinical strategy of a deliberately constructed exploratory question, together with a probe question follow-up, can assist clients in the articulation of their deepest beliefs—those beliefs which exert the strongest influence on their behavior. Such "fundamental" beliefs necessarily include or imply the basic assumptions that clients make about human nature, together with the range of possibilities for changes in behavior that they expect.

This clinical focus on the articulation of clients' beliefs is predicated upon Weber's hypothesis that values are primary sources of motivation in individual and social action (Weber, 1958). An extension of Weber's thesis is that clients can increase their rationality and autonomy when they choose values which endorse their real interests and enhance their effectiveness in everyday behavior.

Case Studies

The following descriptions illustrate that contrasting values and belief systems have specific consequences for behavior. The summaries below are extracted from life history data collected while defining and redefining a variety of problems affecting the three clients. In most instances clients initiated the first discussions about their religious beliefs, while working on crises of loss, addiction, family violence, divorce, etc.

Deference/Fatalism

Joan, a middle-aged Jewish woman, sees herself as extremely inferior to God. Her understanding and practice of this central belief has disempowering consequences for her everyday life. She is unable to understand herself adequately or to know what she really wants. She is also unaware of her own real interests. She procrastinates in all her decision making, and has several chronic illnesses.

Joan is consistently passive in attitude and action, and she expects and prefers events to happen without her direct involvement. She makes no plans for the future, and she does not see herself as an actor in her life. Her relationships are distant, and she is not able to have satisfactory contact with the God she fears.

Self as Equal to God

Keith is a young white man who was raised in a traditional Roman Catholic setting. In his early adult life he discarded his trained belief in priestly mediation between God and believer. He is now convinced that he has a companionate, personal God who is ever-present in his daily activities. He has personalized his concept of God so much, however, that this God has become an equal and therefore can no longer guide Keith in perplexing situations.

Keith finds it frustrating to live with a concept of God which is dramatically diluted from his original traditional belief in God. He no longer feels able to depend on his concept of God. His diminution of the power and meaning he attributes to God has been accompanied by increased loneliness. Keith's sense of isolation from others seems to result from the fact that he is generally less trusting than before.

Copartner with Powerful God

Tricia is an elderly black Protestant woman who has courageously survived many family crises. In these times of painful change, she thrived by depending on her faith in a powerful and benevolent God. She supports herself effectively through her conviction that God always guides her in beneficial ways. Through her active participation in her partnership with a powerful God, Tricia achieves peace of mind and stability in circumstances which might otherwise be impossible for her to resolve.

Tricia's model of shared responsibility with a powerful God enables her to define purpose and direction in her life. She also enjoys her institutional

affiliation with Protestantism. She transformed her childhood ritualistic worship into meaningful applications of her religious beliefs in prayer and everyday decision making. Her health is good, and her relationships are satisfying.

Principles for Clinical Intervention

Although clinical sociology is defined by a broad range of "vital features" (Glassner and Freedman, 1979), some specific clinical principles can be strengthened or derived from understanding the influence of religious beliefs and values on behavior. Both Weber (1958) and Jung (Hanna, 1967; Progoff, 1985), for example, impressively documented a variety of ways in which religion is a primary source of meaning for many individuals' formulations of beliefs and values. Jung also emphasized the link between religious belief, clinical work, and behavioral outcomes, showing that mature religious belief is a predictor of healthy individual and social functioning (Jung, 1933).

The following principles can be used as orienting premises for specific goals and questions in clinical discussions. Knowledge of religion and belief systems is the basis of these principles.

1. Regardless of clients' particular religious or secular world views, the articulation and definition of their deepest beliefs and values through clinical discussion increases their understanding of themselves, their families, social relationships, society and the universe (Jung, 1933; Pargament et al., 1988).

2. Therapists' understanding of their own religious beliefs and values as well as their understanding of clients' religious beliefs and values increases possibilities for change during clinical problem solving (Commission on Mental Health, 1978). Therapists need not necessarily have the same religious beliefs as clients in order to be trusted or to achieve clinical effectiveness, although clients frequently express strong preferences to work with ministers or therapists with the same religious orientation (Ferrell, 1990). One critical concern, whatever the specific religious beliefs, is that both therapist and client believe that particular changes can take place. Unless this belief is shared, it will not be possible for change to occur (Ashcraft and Scheflen, 1976).

3. Religion defines loci of responsibility for action: does God take care of me, or am I fully responsible for my own decisions (Benson and Spilka, 1973)? Clinicians can accomplish more significant interventions when they know whether their clients are willing to assume direct personal responsibility for the consequences and resolution of their problems.

4. Atheism is an influential belief system, even though it does not have self-evident institutional supports and endorsements. What matters for behavioral analyses and clinical intervention is that atheism, like religious belief systems,

has distinctive assumptions about self, society, and human possibilities. Atheistic belief systems, however, usually markedly emphasize individual and collective responsibility for behavior, life situations, and the well-being of society (Bercovitch, 1975).

5. A particularly significant factor for consideration in clinical interventions is the tenacity with which beliefs are held (Freud, 1949; Rieff, 1966; Fromm, 1967). Dogmatic, rigid beliefs tend to be much more closed, and frequently more difficult for individual adherents and their significant others to deal with, than flexible beliefs which characteristically value human interpretation and spontaneity. To the extent that religious beliefs and ethnicity are intensely interdependent, as in Judaism and some kinds of Roman Catholicism, religion necessarily becomes a very powerful influence on behavior (McGoldrick, Pearce, and Giordano, 1982).

6. When people value a supreme being or power highly and/or believe God to be omnipotent, this belief tends to be inversely correlated with their belief in their own strength and resourcefulness (Durkheim, 1965). In the copartnership model of religious belief, however, this relationship between God and believer is perceived to be in balance. Although God may be experienced as omnipotent, there is a reflective and communicative relationship between God and believer. The "Copartner with Powerful God" is not a pawn of God, or an equal to God, but rather an expression of God through cooperative action.

7. The use of concepts or values from religious traditions can deepen clients' understanding of their growth during therapy (Jung, 1963; Meserve, 1980; Pollner, 1989). Religious beliefs synthesize the microsociological and macrosociological perspectives of human experience, while at the same time defining believers as members of a particular religious community. People can see themselves as integral parts of the whole when traditional religions combine these perspectives in their definitions of reality (Eisenstadt and Helle, 1985).

8. Religion is an important source of values and meaning for both religious and secular goal-directed action (Weber, 1958). Religious beliefs are based on related sets of assumptions and suggest a variety of options for everyday behavior (Berger, 1967, 1977).

9. Knowledge of basic assumptions clients make about themselves and their worlds can be a significant starting point for sociological clinical intervention. After therapists and clients share reflections on these topics, clinicians can initiate discussions, along with a questioning or challenging of any regimented, restrictive, and overly conventional beliefs of clients which seem not in their best interests (Gallup, 1985).

Clinical Strategies

The clinical principles above were used as sources of orientation and discussion strategies in the three selected case studies. The descriptions below pinpoint some of the patterns in behavioral consequences of applications of these principles in exchanges between clinician and client. Although each of the patterns delineated could be functional for clients at different stages of clinical intervention or personal growth, it is the author's impression that the "Copartner with Powerful God" case study has significantly further reaching and lasting benefits than either the "Deference/Fatalism" or "Self as Equal to God" case studies.

Deference/Fatalism

Clinical discussions about how Joan's beliefs influence her personal resourcefulness helped her to acknowledge them as major inhibiting forces. She was able to gradually become more responsible for her beliefs, with the realization that they reflect and generate her own values, behavior and goals.

Continuities in the give and take of clinical discussions made Joan more aware of the choices of belief that she has within the Jewish tradition, as well as in relation to other religions and belief systems. She released some of her previous dogmatism and bigotry, with the result that her attitudes and relationships became more open, flexible and satisfying.

Self as Equal to God

As clinical discussions focused on Keith's willingness to grow and change, he expressed an interest in developing his spirituality. His privatized religion became more integrated with his original Roman Catholic beliefs, and he was able to see himself as newly directed or inspired through his union with God.

Keith's changed beliefs enabled him to clarify and live according to his strong preferences for nonmaterial rather than material values. In this respect, he sacralized his life and made it more meaningful. As he increased his trust in his empowered concept of God, his relationships with family and friends become more personal and more meaningful.

Copartner with Powerful God

Tricia chose to deliberately enhance her faith and relationship with God through increasing the regularity and duration of her prayer and meditation. She

used both her own resourcefulness and the divine guidance she believed in to improve her life situation at all times.

One result of Tricia's sustained effort to strengthen her religious faith was that she balanced her efforts with a positive acceptance of the external circumstances of her life. She increased her life-satisfaction by proving to herself that a rational approach to her values and beliefs increased her resourcefulness, sense of purpose and effectiveness in attaining her goals. Her family relationships were satisfying, and her friendships were supportive and inspiring to her.

Conclusion

Analyses of clinical data, together with reviews of research in sociology of religion and pastoral counseling, generate propositions which can be applied in sociological practice and used in theory construction in clinical sociology. Some of these propositions are:

1. Religions orient and pattern behavior, and serve as important sources of meaning for their adherents (Caplan, 1972).

2. The articulation of religious values and beliefs in clinical discussions can enhance clients' awareness of their priorities and goals in decision making (Berger and Neuhaus, 1977).

3. Religious values and beliefs frequently serve as foundations for identities. Clients may empower themselves through clinical scrutiny as they deliberately identify with the beliefs and values which define both their religious affinities and their real interests most accurately (Mol, 1978; Hammond, 1988).

4. Religious beliefs provide one of the broadest possible contexts for an effective and meaningful examination of an individual's behavior. This perspective and breadth of vision contributes toward a fuller understanding of self than is possible by merely observing everyday situations (Mead, 1934).

5. Examining one's religious beliefs and values serves to clarify distinctions between beliefs that are highly valued and those that are relatively peripheral: clients become able to distinguish between their more sacred and more profane beliefs in this process of refinement.

6. Although some sociology of religion research documents religious influences which inhibit social change (Birnbaum and Lenzer, 1969), clinical data suggest that church/synagogue participation may effectively reduce clients' isolation by encouraging them to participate in meaningful, action-oriented community settings. Active membership in religious congregations can modify clients' attitudes and behavior, frequently improving their overall functioning (Clinebell, 1970).

7. Self-report data suggest that clients' increased participation in sects and denominations—or in atheistic and ethical groups—tends to enhance their life-satisfaction. Participation alone, however, may not necessarily correlate with life-satisfaction (Moberg, 1962; Stark and Glock, 1968).

8. Spirituality is a key concept underlying clients' conceptualizations of a supreme being and their relationships with a supreme being (God, Life, Spirit, the Universe, etc.). Attention to clients' spiritual growth can increase the "enchantment" factor in our rational-legal society (Weber, 1958). In this respect, everyday beliefs are effectively relinked to what has been described as the religious core of culture (Geertz, 1969), at the same time promoting individual, social, and evolutionary change (Teilhard de Chardin, 1959).

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