ABSTRACT

Title of Thesis:	THE EXPERIENCES OF RELIGIOUS/SPIRITUAL JEWISH THERAPISTS WORKING WITH RELIGIOUS/SPIRITUAL JEWISH CLIENTS
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We used Consensual Qualitative Research (CQR; Hill, 2012) to investigate the experiences of eleven religious/spiritual (R/S) Jewish therapists working with R/S Jewish clients in psychotherapy. R/S concerns involved struggles with Jewish identity, relationships, and the Jewish community. Therapists used R/S and non-R/S interventions to help with R/S concerns, although therapists explicitly discussed Jewish laws, beliefs, and practices more in successful than in unsuccessful cases. Therapists in both cases experienced R/S countertransference, but therapists in unsuccessful cases more often expressed uncertainty and regret regarding their clinical decisions. Therapists perceived that effective therapeutic interventions led to client improvement. Factors associated with success included therapists' effective use of a shared R/S identity, ability to overcome tensions raised by R/S differences, and countertransference management; and clients' openness, stability, and motivation. Implications include therapists developing an approach that is sensitive to R/S identity and researchers investigating therapeutic dyads with cultural and value-based similarities and differences.

THE EXPERIENCES OF RELIGIOUS/SPIRITUAL JEWISH THERAPISTS WORKING WITH RELIGIOUS/SPIRITUAL JEWISH CLIENTS

by

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Table of Contents

Acknowledgements……ii
Table of Contents……iii
Chapter 1: Introduction to the Problem……1
Chapter 2: Literature Review……...7
Chapter 3: Statement of the Problem……18
Chapter 4: Method……20
Chapter 5: Results……27
Chapter 6: Discussion……56
Table……70
Appendices……73
References……84

Chapter 1: Introduction to the Problem

People with a strong religious/spiritual (R/S) identity have values, beliefs, and practices that permeate all aspects of their lives, including psychotherapy. Many R/S clients prefer that their therapists respect their R/S identity and integrate it into the treatment (Rose, Westefeld, & Ansley, 2008; Vieten et al., 2013). Indeed, integration of R/S identity into psychotherapy is often linked to positive physical and mental health outcomes (McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000). Therapists in principle believe in the importance of R/S identity and claim openness to discussing it (Post & Wade, 2009), yet many avoid addressing clients' R/S issues in therapy (Hathaway, Scott, & Garver, 2004; Lovinger, 1984). The current literature explores R/S therapeutic processes primarily with Christian samples (Norcross, 2002; Worthington & Sandage, 2002), but lacks empirical evidence of these processes with Jewish clients (Schlosser, 2006). Given that Judaism is a distinct cultural group (Langman, 1995) and many American Jews utilize psychotherapy services (Jacobs, 2012; Yeung & Greenwald, 1992), therapists would benefit from learning how to work with Jewish clients on R/S concerns. Therefore, the purpose of the present study was to investigate how experienced Jewish therapists address R/S concerns presented by R/S Jewish clients.

Defining Religion/Spirituality

Hill et al. (2000) proposed that *religion* is both the "feelings, thoughts, experiences, and behaviors that arise from a search for the sacred" and "the means and methods of the search that receive validation and support from within an identifiable group of people" (p. 66). Notably, "sacred" could include a divine being, divine object, ultimate reality, or ultimate truth, as understood by the individual. Hill et al. defined spirituality as "the individual's emotional

experiences of connection with their perception of that which is sacred." A person can identify as religious but not spiritual, spiritual but not religious, neither religious nor spiritual, or both religious and spiritual (Worthington, Kurusu, McCullough, & Sandage, 1996). Although religion and spirituality are not identical, separating the two concepts undermines their complexity (Paloutzian & Park, 2013). Therefore, as in previous literature, we refer to them together as religious/spiritual (R/S).

Preferences for Working with Religious/Spiritual Concerns in Psychotherapy

Many clients prefer that their health care professionals acknowledge, respect, and integrate R/S into their treatment (Rose, Westefeld, & Ansley, 2008; Vieten et al., 2013). In fact, approximately two-thirds of Americans desire to work with a mental health professional who has R/S values (Lehmann, 1993) and many want to integrate their R/S identity into therapy (Gallup & Bezilla, 1994; Vieten et al., 2013). For example, in a survey of 152 Mormon student clients in religious psychotherapy, Martinez, Smith, and Barlow (2007) found that clients appreciated when therapists referenced scripture, taught spiritual concepts, encouraged forgiveness, suggested R/S resources, and self-disclosed about R/S issues. Worthington et al. reviewed 148 empirical studies on religion and psychotherapy from 1984 to 1994 and concluded that "highly religious people may prefer religious counselors and explicitly religious counseling" (p. 459).

More specifically related to Jewish clients, Wikler (1989) found that of 20 Orthodox Jewish clients who had a total of 55 different therapists, 45% preferred Orthodox Jewish therapists, 40% preferred Jewish therapists of any denomination, and 15% had no preference. In Wikler's sample, 69% of the clients believed that their therapists' religious identity played a significant role in their treatment, with 48% saying it helped and 21% saying it hindered the treatment.

Although many clients hope for more integration of their R/S identity in therapy, they often fear that mental health professionals will either ignore their R/S beliefs, undermine them, or pathologize them (Rose, Westefeld, & Ansley, 2008). And, in fact, there is some support for these fears. Although the majority of clinicians in principle believe that R/S functioning is an important area to consider, fewer than half address clients' R/S beliefs and practices in therapy (Hathaway, Scott, & Garver, 2004; Lovinger, 1984). This avoidance may occur because therapists are disproportionally much less religious than their clients and substantially less likely to consider religion as personally salient (Bergin & Jensen, 1990; Delaney, Miller, & Bisonó, 2007; Pew Research, 2015; Shafranske, 2000, 2013). Therapists also hold implicit and explicit biases toward client religiosity (O'Connor & Vandenberg, 2005; Ruff, 2008), suggesting that they neglect R/S in psychotherapy because they might not value it. Finally, therapists may be reluctant to address R/S concerns with clients in psychotherapy if they lack training (Hage, 2006; Schafer et al., 2011).

Benefits of Integrating Religion/Spirituality into Psychotherapy

Not only do many clients want their R/S identity and concerns to be integrated into therapy, but also there is growing evidence that such integration is indeed beneficial for R/S clients (Bergin & Jensen, 1990; Pargament, 2007; Post & Wade, 2009; Smith, Bartz, & Richards, 2007). R/S clients can utilize R/S as a positive form of coping (Pargament, Falb, Ano, & Wachholtz, 2013), as R/S is associated with an overwhelmingly positive effect on physical and mental health (Koenig, McCullough, & Larson, 2001; Powell, Shahabi, & Thoresen, 2003).

Building on the links between R/S coping and positive health outcomes, researchers and clinicians have developed and evaluated R/S therapeutic approaches (Pargament, 2007; Shafranske, 2013). In a study comparing 59 religious, depressed, Christian clients randomly

assigned to different conditions with religious and nonreligious cognitive-behavioral treatments and therapists, as well as a pastoral counseling condition, Propst et al. (1992) found that participants in the religious treatment and pastoral counseling conditions reported significantly lower post-treatment depression and adjustment scores when compared with participants in the non-religious treatment and waitlist conditions. These results indicate that a religious treatment in and of itself may be therapeutically beneficial, even without the cognitive-behavioral components. Furthermore, there was a strong therapist-treatment interaction such that the nonreligious therapists performed better in the religious treatment conditions as opposed to the non-religious treatment conditions, suggesting that therapists do not have to be religious to effectively implement a religiously-adapted treatment with a religious population.

In a meta-analysis of 31 outcome studies conducted between 1981 and 2005 with a total of 1,845 clients, Smith et al. (2007) found a moderate effect size of 0.56 for R/S adaptations to psychotherapy compared to psychotherapy without R/S adaptations and 0.51 when comparing spiritual interventions to non-spiritual interventions. Although they concluded that R/S psychotherapy adaptations benefited R/S clients, they cautioned that the research has primarily involved Christian (73%) and Muslim (24%) clients. They also acknowledged an improvement in methodology since previous meta-analyses, but noted that several of the studies were still plagued by methodological flaws such as limited sample sizes, client attrition, and lack of attention to potential therapist allegiance effects.

Religious/Spiritual Concerns in Psychotherapy

Clients may in part want to discuss R/S concerns because they can be a source of distress. In a sample of 2,754 counseling center clients, 32% experienced at least some distress concerning R/S issues and 20% reported a clinically relevant level of distress related to R/S

issues (Johnson & Hayes, 2003). Some of these clients expressed confusion about their R/S beliefs; others worried that God might punish them for their sins. In a sample of 220 religiously-diverse counseling center therapists providing therapy to religiously-diverse clients, therapists reported that clients' most frequent R/S discussions involved incongruence between R/S beliefs and sexual behavior, departure from family's R/S traditions, use of R/S for positive coping, and exploration of R/S beliefs (Kellems, Hill, Crook-Lyon, & Freitas, 2010).

More specifically, Jewish R/S clients may seek therapy for many reasons, some of which may relate to their R/S identity. Schlosser (2006) suggested that American Jews may discuss Jewish identity, body image, gender identity, child rearing practices, interfaith and interdenominational relational challenges, conversion, antisemitism, sexual orientation, and the Holocaust. Milevsky and Eisenberg (2012) indicated that R/S Jewish clients often discuss intergenerational conflict associated with assimilation, family discord due to differing R/S practices, and tension during the dating process (*Shidduchim*).

Religious/Spiritual Interventions in Psychotherapy

Interventions used to work with R/S concerns can include non-R/S specific techniques that strengthen a R/S client's faith (e.g., direct guidance to engage with a supportive, R/S community), approaches modified to include R/S content (e.g., Christian cognitive therapy), or specific R/S interventions (e.g., in-session prayer) (Post & Wade, 2009). Koenig and Pritchett (1998) recommended six R/S interventions: (a) validating healthy forms of R/S coping, (b) highlighting helpful religious texts, (c) challenging maladaptive R/S beliefs or behaviors, (d) using the patient's R/S beliefs to alter maladaptive cognitions and encourage healthy behavior, (e) referring the patient to a clergy member, and (f) praying with patients. They emphasized that therapists can listen to the clients' R/S beliefs and practices regardless of the therapists' own R/S

background. Koenig, McCullough, and Larson (2001) encouraged medical professionals to take a religious history, support healthy religious beliefs, ensure access to religious resources (especially for hospitalized patients who might not be able to access these on their own), view clergy as part of the health care team, and use advanced R/S interventions (e.g., praying with patients) cautiously.

Researchers have administered surveys to samples of mostly Christian clients to empirically assess the frequency and type of R/S interventions used in therapy. The most frequent interventions are evaluating R/S history, referencing or reading sacred texts, encouraging prayer and forgiveness, and teaching R/S concepts; less frequent R/S methods include R/S assessments, in-session prayer, R/S meditation, and R/S relaxation and imagery (Ball & Goodyear, 1991; Raphel, 2001; Richards & Potts, 1995; Shafranske 2000, 2001). Kellems et al. (2010) found that therapists moderately often assessed clients' R/S background and incorporated R/S language and concepts into therapy. They also consulted with or referred clients to R/S leaders, explored different approaches to R/S, used literature with a focus on R/S, and confronted clients' R/S beliefs. However, despite identifying R/S goals as important, these therapists were cautious about using R/S interventions, used them fairly infrequently, and reported only using relatively neutral ones.

R/S clients prefer and benefit from R/S integration in psychotherapy, but therapists often avoid addressing R/S concerns or approach them with extreme caution. Learning from experienced therapists about their successful and unsuccessful use of R/S in therapy may help R/S therapists better work with R/S clients and R/S concerns.

Chapter 2: Literature Review

Defining Religious/Spiritual Identity

Although human beings have incorporated religion and spirituality into their lives since the beginning of existence, psychologists have struggled with coming to a consensus on their definitions. R/S researchers bemoan this challenge as it makes it difficult to ensure that different researchers are consistently measuring the same constructs. Attempts at defining religion and spirituality are typically either too narrow, excluding many concepts most would agree fall in the category, or too vague, encompassing any and all constructs remotely related to sanctity. For example, Zinnbauer defines religiousness as "a personal or group search for the sacred that unfolds within a traditional sacred context" and spirituality as "a personal or group search for the sacred" (Paloutzian & Park, 2013, p. 35).

Religion. Scholars disagree about the etymological roots of the word *religion,* citing various origins. Some say it emerged from the Latin term *religio*, meaning "reverence for God(s), conscientiousness, sense of right, and moral obligation" (Lewis, 1890). Cicero contended that the term developed from *relegere*, meaning "go through again" ("Religion," n.d.). Servius, Lactantius, and Augustine, as well as many modern scholars, connect *religion* with *religare,* meaning "to bind fast" ("Religion," n.d.). This interpretation symbolizes a bond between the human being and a non-human power (Hill et al., 2000). In an attempt to concretize the definition for more rigorous scientific investigation, Hill et al. (2000) proposed *religion* as both the "feelings, thoughts, experiences, and behaviors that arise from a search for the sacred," as well as "the means and methods of the search that receive validation and support from within an identifiable group of people" (p. 66). Here, the term "sacred" encapsulates a broad definition of the divine.

Spirituality. The word *spirituality* comes from the Latin root *spiritus*, meaning "breath" or "life." Historically, it has been used in the context of religion to denote aspects of the human spirit or soul. Its understanding has evolved and currently represents a broader concept than religion, one that includes "the individual's emotional experiences of connection with their perception of that which is sacred" (Hill et al., 2000).

Religious/Spiritual Identity. Although religious and spiritual constructs are not identical, they overlap considerably and have been used interchangeably to represent the same construct. Indeed, in a content analysis of definitions, Zinnbauer et. al. (1997) found that both definitions of religion and spirituality included personal beliefs about the sacred. However, since the popularity and growth of spirituality from the 1980s to the present, some suggest a dualistic definitional framework. Those promoting an explicit polarity between the two argue for a conceptualization of religion as formal, organizational, belief-based, and negative; and spirituality as informal, non-structured, emotion-based, and positive.

While separating the two constructs might seem methodologically meticulous, it ultimately provides a disservice to the inextricable link between the two and leads to an emergence of several limitations. While religion and spirituality may in fact present stark differences for certain individuals, their polarization is "not representative of the rich ways thoughts, feelings, behavior, motivation, and experiences come together to mark both religiousness and spirituality" (Paloutzian & Park, 2013, p. 28). Furthermore, defining religion as inherently "negative" and spirituality as inherently "positive" may reflect bias rather than sufficient analysis. Both religion and spirituality have been used for good and evil (Paloutzian & Park, 2013, p. 3).

Most people define themselves as both religious and spiritual when asked directly about

their own identities. In a survey on identification, Zinnbauer et al. (1997) found that 74% of participants identified as religious and spiritual, 19% identified as spiritual but not religious, and 4% identified as religious but not spiritual. Likewise, Corrigan et al. (2003) found that 63% of participants identified as religious and spiritual, 22% identified as spiritual but not religious, and 4% identified as religious but not spiritual. Furthermore, Zinnbauer et al. (1997) and Shahabi et al. (2002) found that self-perceptions of religiousness and spiritualty were significantly correlated. Therefore, as is commonly used in the literature (Hill et al., 2000; Kellems, Hill, Crook-Lyon, Freitas, 2010), we refer to both constructs together as religious/spiritual (R/S).

Judaism

Jewish Denominations. Among American Jews, there are three principal denominations of religious affiliation: Orthodox, Reform, and Conservative. Orthodox Judaism is characterized by strict adherence to a traditional interpretation of Jewish law. The movement emphasizes rabbinic authority and traditional practice, as passed down from God's revelation. Orthodoxy values Torah study, with a particular emphasis on learning Talmud (Jacobs, 2007). Reform Judaism began in the 19th century to align Judaism with the western European enlightenment. It emphasizes choice through knowledge, allowing an individual to make personal decisions about matters of ritual observance. The movement prizes Jewish values of social justice and ethics over Jewish law, and continually seeks to adapt tradition to modern day applicability (Kaplan, 2007). Conservative Judaism emerged out of the inherent tension between the Orthodox and Reform movements and a desire to conserve traditions discarded by the Reform movement. The Conservative movement subscribes to the obligatory nature of Jewish law, but believes that the law should change with time. Therefore, the movement has modified certain archaic practices, particularly in favor of egalitarianism, in order to acclimate with modern society while also

maintaining Judaism's core values (Golinkin & Panitz, 2007). In addition to these three main movements, others exist, such as Reconstructionist, Renewal, Humanistic, Non/Post-Denominational, Conservadox, Open Orthodox, Modern Orthodox, Ultra-Orthodox, Chassidic, and Karaitic. An explanation of each of these is beyond the scope of this study.

Religion/Spirituality in Judaism. Existing literature on R/S tends to reflect Christian orientations and might not be sensitive to other R/S affiliations (Hill & Pargament, 2003). Therefore, common understanding of R/S might not apply as specifically to Judaism. For example, existing literature on Christian populations typically focuses on institutional attendance as a measure for religiosity. Green (1986) emphasizes that Judaism is practiced both in the home and in the religious institution. Therefore, focusing on institutional attendance may not fully capture the Jewish experience of religious practice.

In addition to imprecise religiosity measurements in Judaism, there is also little consensus as to an understanding of spirituality within Judaism. Green (1986) defined it as "the cultivation of a life in the ordinary world bearing the holiness once associated with sacred space and time" (p. xiii). Others explain it as the "process of bringing God's values into the world," pointing directly to Jewish values like repairing the world (*tikkun olam),* and giving to or caring for those in need (*tzedakah*) (Sands et al., 2008, p. 240).

In a study on R/S among American Jews, Sands, Marcus, and Danzig (2008) used data from the National Jewish Population Survey (NJPS) to analyze the correlation and predictive factors of religiousness and spirituality. Sands et al. created a religiousness and spirituality index from the original 3,767 interviews with Jewish participants. They also looked at sociodemographic factors, stressors, and Jewish contextual factors as predictors of religiousness and spirituality. They found a modest correlation between religiousness and

spirituality ($r = .42$, $p < .01$). They also found that highly spiritual participants were more likely than less spiritual participants to be female, married, less educated, have a child at home, have experienced anti-Semitism in the last year, have marginal financial circumstances, have a more extensive Jewish background, have greater ethnic identity, and have higher social identity. The variables that were significant for both high religiousness and high spirituality were age (younger), education (lower), experiencing anti-Semitism, feeling connected to Israel, and being connected to other Jews. Replication of this study, as well as studies using different methodological approaches, would yield a more comprehensive understanding of R/S within Judaism.

History of Religion/Spirituality and Psychology

Founding figures of psychology, such as William James and G. Stanley Hall linked psychology and R/S. They understood psychology as "the study of the soul," inherently connected to religion and spirituality (Pargament, 2011). However, starting in the early 20th century, psychology in both research and practice largely began to distance itself from the topic of R/S (Collins, 1977; Pargament, 2011). Leading figures in psychology equated R/S with psychopathology; Sigmund Freud regarded religion as an "obsessional neurosis" (Freud, 1927/1961, p. 43) and John Watson referred to it as a "bulwark of medievalism" (Watson, 1924/1983, p. 1). Albert Ellis related religion to concepts that are typically linked to psychological dysfunction, such as emotional disturbance, intolerance, inflexibility, and irrational thinking (Ellis, 1980). Moreover, as a fairly new field, psychology had to prove itself as a rigorous, scientific discipline. It quickly shifted from an allegiance with philosophy and theology to a field more closely associated with the "hard" sciences (Plante, 2008, p. 4).

While these strong foundations continue to influence psychology today, the field has seen

an exponential increase in R/S interest and research. With the acknowledgment of the strong correlations between R/S and positive mental and physical health outcomes, large foundations and government granting agencies are funding more research on these topics. Additionally, the American Psychological Association (APA) is embracing R/S as a salient identity and a "necessary condition for a psychology of human existence" (Sue et al., 1999, p. 1065). The APA has published over a dozen books on the integration of R/S and psychology since 1998, when they previously had published none (Plante, 2008).

Religion/Spirituality Health Outcomes

An extensive body of research suggests that R/S typically has a positive effect on both physical and mental health. Several studies point explicitly to the negative association between religious involvement and physical health measures, including high blood pressure (Levin & Vanderpool, 1989), heart disease (Friedlander, Kark, & Stein, 1986), stroke (Colantonio, Kasl, & Ostfield, 1992), cancer (Jarvis & Northcott, 1987), and suicide (Kark, Shemi et al, 1996). A meta-analysis reviewing 42 samples representing 125,826 participants demonstrated a robust association between religious involvement and longevity, with those scoring higher on religious involvement measures having 129% of the survival odds than those who scored lower (McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000).

R/S also has been shown to have positive associations with mental health. For example, in a meta-analysis of 147 studies representing almost 99,000 participants, Smith et al. (2003) found a statistically robust inverse association between religious involvement and depression. In contrast, Koenig, George, Blazer, Pritchett, and Meador (1993) found no relationship between anxiety and religion, after controlling for low socioeconomic status, chronic illness, and greater functional disability.

It is also possible that R/S positively influences health through other variables, such as encouraging a healthy lifestyle, providing social networks and communities, eliciting positive emotions through rituals, and/or engendering salutary health beliefs. R/S may positively influence mental health through healthy lifestyle behaviors of avoiding smoking, alcohol, drugs, and unprotected sex (Koenig, 1998). Involvement in R/S institutions typically provides social relationships and support, which buffers the negative impact of stress and provides healthy coping strategies. Worship and other ritual activities may provoke feelings of hope, optimism, forgiveness, resilience, empowerment, and love, which could function as a strong placebo effect or help promote learned optimism. Some religious beliefs or worldviews may help the individual by influencing certain personality traits, including higher levels of self-esteem and internal locus of control (Koenig, 1998). Clearly, even beyond the absence of psychopathology, researchers and clinicians suggest that R/S promotes happiness, satisfaction, education, goal orientation, and meaning (Chamberlain & Zika, 1992; Ferriss, 2002).

Of course, there is some evidence to suggest that R/S has a negative effect on health. Certain mental health disorders might be more associated with R/S than others, such as obsessive-compulsive disorder (OCD). The ritualistic characteristic of religion may contribute to higher levels of religiosity being associated with an increased risk for OCD diagnosis (Koenig et a., 1993). Pargament (2011) encouraged clinicians to not only see spirituality as a solution, but to also entertain the possibility of it being "part of the problem" (Pargament, 2011, p. 12). Thus, although there is extensive evidence to suggest R/S has positive effects on health, we cannot dismiss evidence that suggests the opposite.

Client and Therapist Religious/Spiritual Gap

Although many therapists may view R/S as a background variable, for many clients, R/S

is seen as part of the foreground (Koltko, 1990). Patients with medical illness often seek alternative, R/S integrated therapy through prayer, ritual, clergy, and ritual healers (Lukoff, Lu, & Turner, 1992). In standard medical treatments, a significant number of clients report a desire for integration of R/S into their treatment (Post, Puchalski, & Larson, 2000).

Despite over 60% of patients wanting their clinicians to engage in R/S conversations, traditional approaches have not sufficiently addressed this issue (Harvard, 1997). Larson (2001) points to over 350 studies that highlight R/S as "the forgotten factor" when it comes to health. Ignorance and avoidance of R/S can easily lead to misjudgment, misinterpretation, and misunderstanding of significant aspects of a client's life (Pargament, 2011). As Pargament (2011) states, "Spirituality is a part of the psychotherapy process; our choice is either to look the other way and proceed with limited vision or to address spirituality more directly and knowingly" (p. 15).

Furthermore, an estimated 68% of the global population considers religion to be an important component of their lives (Diener et al., 2011). In the United States, 75% of adults say that religion is "somewhat" or "very" important to them, and 89% believe in "God or a universal spirit" (Pew Research, 2015). Thus, the majority of adults in the United States identify as R/S, with this identity influencing their values, beliefs, attitudes, and behaviors (Peteet, 2014).

Therapists, in contrast, are disproportionally nonreligious compared to the general public. In a survey of 258 American Psychological Association clinician members, only 21% described religion as "very important" in their lives, and 48% described it as "unimportant" (Delaney et al., 2007). Furthermore, only 35% of the surveyed psychologists said that their whole approach to life was based on their religion, compared to 72% of the United States population (Delaney et al.,

2007). Therefore, it is likely that overall, clients seeking therapy identify as more religious than their therapists.

Religion/Spirituality in Psychotherapy

Spiritually integrated psychotherapy assumes that the spiritual dimension is interwoven with clients' problems (Pargament, 2011). Pargament suggested that spirituality can be a cause of psychological problems, but also that psychological problems can cause spiritual problems. Pargament argued that a therapist's R/S identity is not critical to conducting spiritually integrated psychotherapy. Rather, he suggested that therapists should have spiritual knowledge, openness and tolerance, self-awareness, and authenticity.

However, these components may be difficult to cultivate, especially because graduate school training and supervision in R/S is lacking. In a survey of APA clinical psychology training directors, only 17% offered coursework, supervision, and research in R/S (Brawer et al., 2002). Inadequate training and supervision can result in therapists who are uninformed about the topic, unfamiliar with R/S research, and unequipped to assess for spiritual needs and integrate spirituality in therapy. Therapists have the potential to address clients' R/S needs, but need the proper resources to do so.

Furthermore, the current literature draws on standardized R/S treatments and general recommendations for clinicians working with R/S clients. Twelve-step programs like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) have a strong R/S foundation and seamlessly integrate these concepts into their core framework. Similar to the 12-step programs, the Eight Point Program (EPP) emphasizes spiritual principles like spiritual communities, inspirational readings, and mantra repetition used to enhance psychological functioning (Plante, 2008). Researchers have developed R/S adaptations of standard cognitive-behavioral protocols to assess

their viability (McCullough, 1999). McCullough concluded that the religious approaches were no more or less effective than the standard approaches. However, he cautioned that the "most highly religious clients" do indeed prefer an approach that focuses on religious issues, and he used the results of his meta-analysis to suggest that religious-accommodative approaches should not be withheld from religious clients (McCullough, 1999, p. 95).

When adapting treatments to R/S clients, Lovinger (1984) cautioned against collapsing across denominations, noting that denominations within a specific religion differ widely. Furthermore, even within denominations, there are drastic differences among members in belief and practice. Thus, it is crucial to not only analyze differences between religions and differences within denominations, but also differences amongst individual clients (Pargament, 2011).

Summary

Most clients who recognize R/S as a salient aspect of their identity wish to integrate it into psychotherapy. Doing so can not only strengthen the therapeutic relationship by showing the therapist's attunement to the client's needs, but can also lead to positive physical and mental health benefits. The existing literature indicates that currently, therapists are largely ill-equipped to facilitate this integration. Additionally, therapists who wish to integrate R/S and psychotherapy and are working with clients who have a different religious affiliation than Christianity might have a difficult time extrapolating from the current literature. Due to the differences between Christianity and other religious faiths, the results may not generalize. Moreover, the majority of researchers in this field use quantitative measures. While these are certainly important, we need to use multiple methods in order to fully understand this construct. Furthermore, R/S is a challenging topic for many people as it can lead to controversial

disagreements. It can be beneficial to learn from experienced therapists about their specific successes and challenges with R/S clients and R/S topics.

Chapter 3: Statement of the Problem

Limitations to Research on Religion/Spirituality in Psychotherapy

The integration of R/S interventions within psychotherapy and the study of that integration have become more acceptable over the past 40 years given the increased consideration of multiculturalism (Vieten et al., 2013) and interest in trying to understand current client needs and preferences (Worthington et al., 1996). The literature has exponentially increased since the mid-1980s, and R/S interventions have been used with more frequency across all types of treatments and populations (Smith et al., 2007).

However, research is still trailing behind this shift in acceptance and there are several limitations to the existing research. Perhaps most importantly, the overwhelming majority of the existing studies focused on Christian samples. Although this is certainly an important and significant proportion of the U.S. population (85%), these studies might not capture the experiences of people who practice other faiths. Given that Judaism is the second highest reported religion in the United States (approximately 2%, between five and six million people, Gallup & Lindsay, 1999; Lipka, 2013; Singer & Grossman, 2005) and Jews are actually more likely to seek mental health treatment than some people of other religious faiths (Yeung & Greenwald, 1992), it makes sense to focus more specifically on this population.

Another limitation is that several of the existing studies on R/S client preference and attitude toward therapists used potential clients as opposed to actual clients. Importantly, results might differ between these two groups. Furthermore, many studies focused on R/S clients' perspectives (e.g., Knox, Catlin, Casper, & Schlosser, 2005; Rose et al., 2001), and therapist perspectives have been neglected.

Finally, many of the previous studies used quantitative measures and surveys to examine the role of R/S in psychotherapy (Smith et al., 2007). Although these studies provided valuable, foundational information, the complex nature of R/S and R/S concerns warrants an exploration of the depth and richness of these processes in psychotherapy.

Purpose of the Present Study

The purpose of this study was to extend the literature by examining the process of psychotherapy for R/S Jewish therapists working with R/S Jewish clients from the therapists' perspective. Our specific research question was: What is the process of successful and unsuccessful therapy for R/S Jewish therapists working with R/S Jewish clients on R/S concerns? More specifically, we wanted to explore whether R/S Jewish therapists differ in how they work with successful and unsuccessful cases of R/S Jewish clients in terms of R/S concerns, R/S interventions, transference and countertransference issues and their management, and factors associated with success and failure.

Because we wanted to ensure that results would apply to actual therapy, we interviewed experienced therapists about their practices. Furthermore, because little is known about the process of psychotherapy for Jewish therapists and clients, we specifically selected Jewish therapists working with Jewish clients. And, because we wanted to make sure that R/S concerns were foremost on their minds, we narrowed the selection criteria so that we interviewed R/S therapists working with R/S clients on R/S concerns. Finally, because this study was exploratory, we used consensual qualitative research (CQR; Hill, 2012; Hill, Thompson, & Williams, 1997) so that we could have a rich description of how R/S Jewish therapists work with R/S Jewish clients on R/S concerns in psychotherapy.

Chapter 4: Method

Participants

Therapists. Eleven White, Jewish therapists (10 female, 1 male; 7 psychologists, 4 social workers; age *M* = 50.64, *SD* = 13.82; years of post-degree clinical experience *M* = 22.27, *SD* = 12.95; 6 Conservative, 2 Modern Orthodox, 2 Reconstructionist, 1 Orthodox) served as the participants. Therapists scored an average of 4.82 (*SD* = 0.40) on a 5-point scale (1 = *not important*, 5 = *very important*) about the importance of their R/S identity. Therapists scored an average of 41.27 (*SD* = 3.31, range of 38 to 47) on the Religious Commitment Inventory (RCI-10, Worthington et al., 2003) and thus met Worthington's (1988) criteria for highly religious people (> 38). In addition, using 5-point Likert scales (1 = *not at all*, 5 = *completely*), therapists reported believing in and adhering to psychodynamic/psychoanalytic orientations an average of 3.65 (*SD* = 0.81), humanistic/experiential/existential orientations an average of 2.82 (*SD* = 0.87), and cognitive/behavioral orientations an average of 2.73 (*SD* = 1.19).

Clients. As described by the therapists, there were 11 (8 female, 3 male; age *M* = 38.91, *SD* = 17.67; 6 Orthodox, 3 Modern Orthodox, 1 Conservative, 1 Traditional) clients in the successful cases, and 11 (6 male, 5 female; age *M* = 39.82, *SD* = 12.38; 8 Orthodox, 3 Traditional) clients in the unsuccessful cases.

Auditor. An experienced, non-religious, 70-year old, White, female researcher, clinician, and professor served as the auditor and primary advisor to the project.

Interviewer. The first author, a 27-year old, White, female, Jewish counseling psychology doctoral student, served as the interviewer for the present study. She had participated in one other CQR study and was supervised by a mentor experienced in CQR.

Research Team. The primary research team consisted of nine people (7 female, 2 male; 8 White, 1 Asian; Age *M* = 22.89, *SD* = 3.30; 7 Jewish (3 Modern Orthodox, 2 Conservative, 2 Secular), 2 not Jewish; 3 doctoral counseling psychology students, including the first author, 6 senior Jewish undergraduate psychology students who had completed courses in counseling and clinical psychology). On a 5-point Likert scale about the importance of their R/S identity (1 = *not important*, 5 = *very important*), team members reported an average of 3.67 (*SD* = 1.22), and on the RCI-10, they reported an average of 27.22 (*SD* = 13.31, range of 13 to 44). All team members attended a large, mid-Atlantic, public university in the United States and were interested in the research topic and qualitative research method. After training, the larger group was divided into two teams, each with three undergraduate students, one graduate student, and the first author who served on both research teams to ensure consistency and monitor data analysis.

Prior to analyzing the data, research team members wrote about and discussed their biases and expectations. Seven team members valued R/S as a salient aspect of their identity and reported having positive experiences in their R/S communities. Six Jewish members worried that they might be judgmental about cases of Jewish clients who belonged to different denominations than themselves, and three members were concerned they may be biased against strict and rigid religious regulations. Two people anticipated that it might be difficult to find themes in the data given that Jewish clients are diverse and what works for one client might not work for another. Seven people expected to find that successful cases would involve therapists who were open and flexible, strong therapeutic relationships, and a close match between the therapists' and clients' R/S identity. Eight people expected to find that unsuccessful cases might involve therapists who dismissed their clients' R/S beliefs, challenged their clients, stereotyped their clients, or assumed

their clients had similar R/S experiences to themselves. All team members attempted to bracket their biases and expectations so that they could focus on the data, and they frequently returned to discussions of how their biases and expectations might influence the analysis.

Measures

Demographic Form. This form included questions about age, gender, race/ethnicity, degree in psychology, year degree was attained, years of post-degree clinical experience, and R/S identity. Participants were also asked to use a 5-point scale (*1 = low, 5 = high*) to rate themselves on each of the three major theoretical orientations (psychodynamic/psychoanalytic, humanistic/experiential/existential, cognitive/behavioral) and the importance of their R/S identity (Appendix A).

The Religious Commitment Inventory-10 (RCI-10, Worthington et al., 2003) (Appendix B) is a 10-item (*1 = not at all true of me, 5 = totally true of me*) self-report measure assessing one's intrapersonal and interpersonal commitment to religious values, beliefs, and practices (e.g., "My religious/spiritual beliefs lie behind my whole approach to life"). The measure is based on Worthington's (1988) theory of religious values. Similar to Kellems et al. (2010), we modified the scale by changing items that referred to "religion" to "religion/spirituality." The RCI-10 has correlated significantly with other measures of self-reported religious commitment, suggesting construct validity. Worthington et al. reported that a single-factor model was the best fit for the data, and that a score of 38 or higher justified categorizing a person as highly religious. Cronbach's alpha coefficients of .84 to .86 have been reported (Worthington et al., 2003); internal consistency alpha for the current study was .91.

Interview Protocol. The interview was semi-structured, with a standard set of questions that was asked of all of the participants for both the successful and unsuccessful cases;

unstandardized probes were used to elicit further individualized responses. The protocol was developed and piloted by the first author and reviewed by the auditor and several experts (Appendix C).

Procedures

Ethical Considerations. The Institutional Review Board at the host university approved this study. After therapists were contacted to schedule interviews and provide verbal consent, they were assigned code numbers to protect confidentiality. Therapists were sent the transcribed interviews to review for confidentiality and accuracy. Six therapists responded to the review request and three asked to make slight changes (e.g., removing information for confidentiality). All changes were made to the transcripts based on the therapists' feedback.

Recruiting Interviewees. Therapists were recruited using a snowball sampling technique. The first author invited Jewish therapists who she knew personally to participate. She then asked these therapists for names of other therapists who might be willing to participate and also asked them to send emails to therapists in their networks.

The recruitment emails (see Appendices D, E, and F) explained the recruitment criteria and procedures so that therapists could determine if they met the criteria and wanted to participate in the study. Therapists were told that they needed to (a) self-identify as a R/S Jew; (b) be currently or recently working with adult, R/S, Jewish clients; (c) be conducting individual psychotherapy in private practice as a licensed therapist; (d) be at least five years post graduate school; and (e) be psychodynamic or humanistic rather than strictly cognitive behavioral in their theoretical orientation. In order to answer the research question about working with R/S concerns in a Jewish population, we recruited Jewish therapists who worked with Jewish clients. We recruited therapists conducting individual psychotherapy in private practice so that therapists

could discuss their experiences in the individual relationship and were not bound by institutional restrictions. Therapists being five years post graduate school ensured at least some experience in the field and the ability to have worked with multiple clients. Lastly, we recruited based on theoretical orientation with the idea that therapists who do not strictly identify as cognitive-behavioral would have engaged in longer-term work with their clients and be more inclined to discuss transference and countertransference.

Data Collection. If therapists met the eligibility criteria and were interested in participating in the study, they clicked on the internet link in the recruitment email. Of the 31 therapists who completed the survey (both the demographic form and the RCI-10), 18 met all of the criteria listed above (identify as a R/S Jew, currently or recently work with adult, R/S, Jewish clients, conduct individual psychotherapy in private practice, be at least five years post graduate school, and be psychodynamic or humanistic in theoretical orientation), scored at least 4 on the 5-point item regarding the importance of their R/S identity, and scored at least 38 on the RCI-10. The first author contacted these 18 therapists to thank them for completing the survey and ask if they were interested in continuing with the interview (which would involve recalling a successful and unsuccessful case of therapy with R/S Jewish clients). Thirteen therapists scheduled an interview, three therapists did not respond after two attempts, and two therapists declined due to concerns over the time commitment. After scheduling the interview, the first author sent the prospective participants the interview protocol and encouraged them to review the questions in advance of the interview. Semi-structured telephone interviews were conducted with 13 therapists. Interviews lasted approximately 90 minutes and were recorded using two secure recording devices. One therapist who could not meaningfully address the interview questions was informed and dropped from the analysis. One therapist withdrew participation two months

after the interview due to an ethical conflict of interest; the recordings and interview transcriptions for this therapist were destroyed, leaving no trace of the interview. The 18 therapists who could not participate in the study (13 who did not meet the survey criteria and 5 who could not schedule an interview) were informed and thanked for their interest in the study.

Data Preparation. Research assistants transcribed and checked the interviews, removing all identifying information from the transcripts. Interview recordings were erased immediately after they were transcribed and checked for accuracy.

Recruiting and Training the Research Team. The first author emailed counseling psychology doctoral students in her program and invited them to participate on the research team and to recommend undergraduate students. Potential undergraduate team members were interviewed by the first author to determine if they were a good fit for the project (i.e., had research experience, understood the time commitment, expressed interest in the topic and qualitative method, had a strong academic record and competitive GPA, and had completed coursework in clinical and counseling psychology). Before each step of the data analysis, all team members read about and discussed the CQR process, as well as recorded their own biases and expectations for the study.

Data Analyses. Data for 11 therapists were coded and analyzed using CQR (Hill, 2012; Hill et al., 2005; Hill, Thompson, & Williams, 1997). Each team member first independently read all of the interviews and drafted a list of possible domains (i.e., discrete topics that emerged from the interviews). Next, the whole research team compared notes and consensually developed a list of domains that reflected the data. The auditor reviewed the emerging list after each interview and provided suggestions. Stabilization of the domain list occurred by the fourth

interview, although we continually modified the domain list throughout the remainder of the analysis.

Once the domain list was stable, the team members worked together to assign each block of data (a phrase, thought unit, sentence, or paragraph that covers the same topic area) in the first two transcripts to one or more relevant domains. Once all team members understood the domaining task, the team was divided into two groups (with equal numbers of undergraduate and graduate students, and the first author in both) to complete the remainder of the domaining.

The next step involved writing core ideas (i.e., clear summaries that capture the essence of the narrative in more concise terms, removing hesitancies, redundancies, and trivial details) from the domained data for two interviews. Once the teams understood the coring process, team members worked in pairs to construct core ideas for the remainder of the transcripts. The first author and then the auditor checked the consensus versions and provided feedback to the research teams, who discussed the feedback and incorporated it into subsequent versions. The teams and auditor continued to check the consensus versions for accuracy until convinced that the data were thoroughly, accurately, and appropriately reflected. The consensus versions of each case were combined into one master document sorted by domain.

The final step was the cross-analysis, which involved identifying common themes across cases. The first author and auditor developed a preliminary list of categories. The team then modified the list of categories and placed each unique core idea into one or more categories for each domain. The auditor reviewed the cross-analysis after the completion of each domain, as well as at the end of the cross-analysis. Revisions continued until everyone believed that the final cross-analysis adequately represented the data.

Chapter 5: Results

Table 1 shows the results of the cross-analysis for the successful and unsuccessful cases. Following guidelines in Hill (2012), categories were considered general if they emerged for 10 to 11 cases, typical for 6 to 9 cases, and variant for 2 to 5 cases. For categories to be considered meaningfully different between the successful and unsuccessful cases, frequency differences had to exceed 30% (Ladany, Thompson, & Hill, 2012). We provide quotes from the interviews, using ellipses (. . .) to indicate where we removed words to enhance readability. Quotes are attributed to case by randomly selected code numbers (1 to 11) and S for successful and U for unsuccessful (e.g., 3S or 4U).

Client Religious/Spiritual Concerns

Three categories emerged in this domain about R/S concerns. No differences were found between successful and unsuccessful cases in any of these categories.

Internal struggles with Jewish identity and beliefs. The category of R/S concerns (with two subcategories) represents clients' personal struggles with their Jewish identity.

Questioning theological beliefs and relationship with God. In both the successful and unsuccessful cases, clients typically questioned their theological beliefs and their relationship with God. Some felt conflicted about their religious practices or lack thereof, afraid of the repercussions of sinning and disobeying God, angry at God, fearful of God, or guilty and ashamed about their practices. Others had crises of faith, dreaded the Jewish holidays that focused on self-reflection (*Rosh Hashanah* and *Yom Kippur*), and questioned their obligation to others as people created in God's image and bound to Jewish law. Therapist 2S reflected that it "felt very much like kind of an existential crisis about her [client's] theology and about God and what it meant that she was dealing with all of what she had dealt with in her lifetime." In

describing a client's dread of the upcoming Jewish holidays, therapist 7S said, "His most fraught time of the year was, unsurprising for an Orthodox Jew, the *Yamim Nora'im* [High Holidays]. He had a really hard time between *Rosh Hashanah* [The New Year] and *Yom Kippur* [The Day of Atonement] and because the concept of *Unetaneh Tokef* [High Holiday prayer], of how we die and what happens to our soul, was profoundly terrifying for him. It actually shook him to his core."

Grappling with Jewish views of mortality, death, and grieving. Clients in both the successful and unsuccessful cases variantly discussed death. They raised the topics of anticipatory grief, mourning processes, and suicide as a religious sin. Therapist 4U explained that the client "was depressed to the point of having suicidal ideations and he knew that suicide was not an option, or believed that suicide was not an option, because he would not go to heaven because that was a sin."

R/S issues in relationships. The second category (with two subcategories) involved concerns about coping with R/S issues in relationships. This category included struggles with negotiating R/S differences and finding and maintaining relationships within a Jewish context.

***Navigating R/S problems in family relationships*.** Clients typically struggled with navigating different practices of Judaism (e.g., 6S described the client's issue as, "the kid not being religious in the way she [the client] wanted him to be"); disapproving of children's choice in partners because of R/S differences (e.g., the partner is less religious than the client, 11U); making difficult family choices related to R/S beliefs (e.g., considering divorce, but worrying about the religious stigma, 8S); negotiating Jewish values within the family (e.g., balancing peace in the home (*Shalom Bayit*), honoring parents (*Kibud Av V'em*), and raising children (*Mitzvot Ha'Av al Ha'Ben*), 8S); and female clients adjusting to traditional Jewish gender roles

when a male spouse was no longer able to carry out traditional roles due to illness or death (e.g., the client had to "unfortunately choose between sort of honoring her husband and keeping sort of the façade of his role in the family, which she was being encouraged to do. She had to choose between that and honestly protecting her children and making a home where they would feel more comfortable and could be children," 8S).

Navigating R/S problems in romantic relationships. Clients also typically had concerns about managing R/S issues in interfaith relationships (e.g., how to raise children, 8U), coping with breakups (e.g., believing they would never find a long-term partner, 3S), navigating the religious dating system (*Shidduchim*, e.g., making decisions about partnership compatibility, worrying about the pairings, 6U), adjusting to the partner's different R/S practices (e.g., needing to become more religious for the partner, 9S), and exploring sexual ethics and choices from a Jewish perspective (e.g., debating whether to refrain from physical contact with members of another sex (*Shmirat Negiah*), 5S, thinking about how to recover from an extramarital affair, 5U). One client (5S) in a romantic relationship struggled with defining his own sexual boundaries and understanding his girlfriend's sexual boundaries. He deliberated about whether or not to abide by the law of refraining from touching someone of another sex (*Shmirat Negiah*). The couple was "engaged in physical intimacy and she [his girlfriend] was constantly beating herself up about it and feeling guilty about it and wanting to stop and just try not to touch each other."

Tension with the Jewish community. The third category (with two subcategories) encompasses tension clients experienced with their R/S communities.

Feeling anxiety as a result of deviating from Jewish community norms. Clients in both the successful and unsuccessful cases variantly presented concerns about feeling tension because

of diverging from standards in their Jewish communities. Some clients were embarrassed by being different; worried about being ostracized; and self-conscious about being an outlier when they were not married, not as involved as they "should be" in the community, not heterosexual, not dressing according to the highest communal standards, or not practicing the same form of Judaism in public and private spaces. Therapist 3S explained,

> In the Orthodox world, there is a value of getting married, having a family. So many rituals, customs, and laws are surrounded and really revolve around family . . . your friends start to get married and start to have kids, you feel like you are left out. It's almost like, it feels like a status-thing. And it causes a lot of anxiety . . . There is a pressure, people are trying to constantly set people up, and meet people, and it's hard.

Therapist 11S reported that her client, who dressed differently than others in her community, asked, "Do I fit? I don't know if I fit. If I wear these stockings, does that kick me out of the community?"

Feeling disillusioned with Judaism and the Jewish community. Some clients felt betrayed by their Jewish community and upset by the lack of support they received. For example, one client (7S) had been sexually assaulted by several Rabbis during childhood and felt abandoned by the community, one client (8S) felt that the clergy provided invalidating advice, and another (6U) wished that the community had supported her through her divorce. In describing a client's disillusionment, therapist 8S said,

> She didn't feel as much abandoned by God as she did by her community and the Rabbi that she respected so much . . . In this time of need she really was struggling with this is her community, this is a place she wanted to turn to and had turned to for solace and for

support and for concrete help, and she was not, she wasn't really accepted with open arms, she found herself kind of at odds.

Summary. Therapists described their clients as deeply troubled by and consumed by R/S concerns. These clients specifically sought therapy to work through their R/S issues, many after having sought assistance from friends and clergy in their religious communities. The clients struggled with how their R/S beliefs and practices influenced their relationship with God, their families, their partners, and their communities.

Therapeutic Interventions for Religious/Spiritual Clients and Concerns

There were R/S-specific interventions and non-R/S-specific interventions. Both types were used to address R/S issues, but some were specific to R/S concerns, whereas others were generic interventions that could be used with any presenting problems.

R/S-specific interventions. Two interventions seemed specific to R/S.

***Discussion of Jewish laws/beliefs/practices/customs*.** Therapists used this intervention more often in the successful than in the unsuccessful cases. Therapists explained the Jewish model of mourning; explored Jewish values (e.g., refraining from physical contact with members of another sex (*Shmirat Negiah*), peace in the home (*Shalom Bayit*,) role of a Jewish parent); discussed High Holiday liturgy and writing one's own prayer; spoke about God and theology; identified differences between social and community standards, religious standards (i.e., Jewish law (*Halachah*)), and the client's personal standards; and explored prohibitions in the *Torah*. When clients questioned themselves, their religious beliefs, and their religious practices, therapists asked questions, helped clients explore their knowledge, identified gaps and areas of interest, and challenged clients to be true to themselves within the larger context of communal, religious practice. Therapist 5S said, "We started having this conversation about what it means to

be *Shomer Negiah* and whether or not it's realistic and how people grow up in the Orthodox world might believe that it's unrealistic and choose not to abide by it and also feel a lot of guilt and shame over not doing so, how to reconcile those two things." Therapist 7S, when discussing the client's upcoming fear of the High Holidays, said,

> I had a *machzor* [prayer book] in my office . . . he could sing things for me that brought him joy, and we could go back and forth and talk about moments that he had heard it, times that he had done it, ways that, and sort of living in those memories in a safer space as much as he could tolerate . . . Once he identified the *Unetaneh Tokef* [High Holiday prayer] piece then it became, it was an organic question of, "What would it look like to not be scared of that?" . . . The theme of it changed from it being about God's judgment to being about his judgment. It wasn't, "God was the all-forgiving essence," it was him as a human offering forgiveness, which is a powerful theological shift.

Here the therapist followed the client's lead, and made space for the client to safely explore his theology with the therapist.

Self-disclosed R/S beliefs/practices. In both successful and unsuccessful cases, therapists variantly self-disclosed their R/S beliefs or practices. Sometimes therapists disclosed beliefs about God or interpretations of Torah-based laws (e.g., "I don't believe in a God that punishes in that way," 2S). Other therapists disclosed their Jewish identity so that clients would feel comfortable and not have to define Jewish concepts (e.g., "In my trying to make him comfortable, I let him know that he wouldn't have to explain certain things to me, so I knew what he was talking about, and I could understand the nuances of what he was going through because I'm very familiar with that community," 5S). Yet other therapists disclosed about their own experience dating or becoming involved in a synagogue community to help clients feel

understood (e.g., “I just said I totally know what it’s like and remember that stage of life where there’s so much pressure and you feel like if you have a break up that there’s no one else out there,” 3S). The self-disclosures allowed therapists a way to challenge clients’ beliefs or enabled them to position themselves as fellow Jews.

Non-R/S specific interventions. Five sub-categories emerged here. No meaningful differences emerged between successful and unsuccessful cases.

Facilitated exploration and provided support. Therapists typically described being curious, empathic, and patient; actively listening, reflecting feelings, and gently questioning; and helping clients process their external and internal experiences, identify triggers, reflect on changes, and imagine their futures. Therapist 1S said,

> Most everything in life has a particular, individual meaning to each person, so I go into that with curiosity with trying to understand what this is about for the person I am working with. So, I think what’s useful and helpful is having a space to be able to say anything and examine anything that might be on her mind and maybe something that could feel unacceptable or acceptable, and just try to give her the space to make sense of that dilemma she found herself in.

Some therapists wanted to build clients’ self-esteem and help them reflect on their positive qualities, especially when they were disproportionately focusing on flaws. Therapist 9S recalled, “I wanted her to see that even before she came to me there was growth. And there was strength that she needed to bring to light, and use them to move forward. And I wanted her to see the comparison to that person who she was then to the person she was now. Even without me. She had done that on her own.” Therapist 7U explained,

> When you talk about an addiction like his and it was so much of what he was combatting every day was shame. So I really tried to pull from how can you try to do the zoom out and see that the world is not about you. And figure out that, in the grand scheme of it, you're not destroying the world, and you have the potential to be good. And you are good. And you are flawed, and that's okay. And you can still make the world better in a lot of different ways even though you have caused pain.

Some therapists normalized the client's experience (e.g., grief), validated and affirmed the client, and did not rush the client to resolve their pain. Therapist 8S said,

> I understand what it's like to be a part of a community and get support and solace from that community and I tried to really support her in those feelings and just to validate that those were real . . . it kind of helped her to kind of separate herself from them, which she really was having trouble doing, and even just conceptually, how could they all be wrong, how could her Rabbi be wrong? She [client] must be wrong.

Encouraged action. Therapists in unsuccessful cases typically suggested that clients use strategies to help them during times of need (e.g., encouraging self-awareness during a moment of fear), devise better ways of communicating to their partners, speak to Rabbinic figures, and make decisions that felt right for them, whereas therapists in successful cases variantly encouraged action. Therapist 8S recalled, "I wasn't going to make decisions for her about any of that, but what are the goals? What is the impact of doing this one way versus another way? Are there ways to mitigate the effect?"

Challenged. Therapists variantly identified cognitive distortions and false assumptions, highlighted community values as compared to Jewish law (*Halachah*), questioned the client's interpretation of Jewish law, and identified displaced anger. Therapist 8S indicated that the client

was distorting the Jewish value of maintaining peace in the home (*Shalom Bayit)*, "What does *Shalom Bayit* really mean? And is doing what her Rabbi is suggesting and leaders of *Shul* [synagogue] were suggesting, was it really going to result in *Shalom Bayit*? . . . I was able to challenge a bit."

Provided psychoeducation. Therapists variantly explained addiction, social norms, their rationale for interventions, "healthy" behavior, emotions, and the Jewish model of grieving. They opined that some religious practices are personal, whereas others require compromises. For example, therapist 11U told her client, "Nobody can tell you whether or not to put *t'fillin* [phylacteries] on . . . What you do on your own is on your own . . . But, when you're doing something together . . . if you're going to go to *shul* [synagogue] together, you have to figure out what shul you're going to go to."

Facilitated awareness or insight. Therapists variantly pointed out patterns or helped clients identify reasons behind behaviors. For example, in response to a client who was especially concerned with how the community might respond to his divorce, therapist 5U "point[ed] out the non-logic part of it. It went back to a pattern of his, you know, when we were trying to figure out how he got himself in this kind of situation. It was like he kind of had this pattern of always wanting to stand out and be loved and admired by other people in the community and so everybody's perception of him is very important to him."

Summary. When working with R/S concerns, therapists used R/S specific interventions, such as discussing Jewish practices (which they did more in successful than unsuccessful cases) and self-disclosing their Jewish beliefs. In addition, therapists also used non-R/S specific interventions, such as basic helping skills (e.g., being supportive and empathic, helping clients explore, facilitating insight, and encouraging action).

Therapist Internal Reactions to Self and Client

Four categories emerged in this domain. The only meaningful difference between cases was in the final category (uncertainty and regret about clinical decisions).

Countertransference reactions. Countertransference reactions toward clients were based in the therapists' personal history of emotional conflicts and vulnerabilities. There was no difference between successful and unsuccessful cases in terms of amount of countertransference, but more R/S countertransference than non-R/S countertransference was reported.

R/S Countertransference. Therapists typically reported countertransference based in their R/S identity. Sometimes, R/S countertransference involved an interaction with client transference (e.g., therapist 1S felt maternal in a "stereotypically Jewish-mother way" toward a client who pulled for maternal care). Other therapists found it difficult to listen to the clients' beliefs about Judaism when they held different beliefs (e.g., therapist was more liberal, felt obligated to help client not hate Judaism, or felt that being neutral with the client was going against the therapist's own R/S beliefs). Therapist 2S recalled, "I'm biting my tongue right, left, and center . . . because I think it's appalling . . . trying to stay with her worldview . . . It was different from me in a way that's very important to me . . . It really goes against my values, my family values, and it was in the name of Judaism, which means a lot to me, so that was hard." Therapist 8U reported, "My own religious and spiritual beliefs and practice and identity . . . definitely got in the way with him."

Non-R/S countertransference. Therapists variantly experienced non-R/S countertransference. Some had experienced similar issues as their clients had (e.g., parental divorce, parental death) and were thus either not able to engage deeply with the client or over-identified with the client. Therapist 1U reflected, "My own father died when I was fairly young

. . . that was probably a piece of my own barrier to asking about it . . . There was something that I wasn't prepared to hear in what she was going to tell me, in some really raw way." Other therapists had difficult previous experiences with certain client populations or even challenging personal experiences (e.g., addiction, abuse) and struggled to remain present when discussing these topics with their clients.

Negative reactions toward client. Therapists typically had negative reactions toward clients that were not explicitly linked to the therapists' own issues. These negative reactions involved feeling bothered by the clients' beliefs or actions, troubled by the clients' comments, annoyed by how the client acted, and hatred for the clients' belief system. Some therapists felt sad for the client, angry at the client, uncomfortable by the client's awkwardness or anger, hopeless about the client's prognosis, confused about the client's R/S background, devalued by the client, or conflicted about the client's religious beliefs and practices. After working with a client who had become more observant to appease her husband and then relinquished these religious practices, therapist 9S admitted, "It bothered me that she was giving up on the religion." When a client compared eating non-kosher food to being an addict, therapist 6S said in the interview, "To tell you the truth, I was stunned."

Positive reactions toward client. Therapists felt touched by the clients, enjoyed working with them, respected and admired them, and felt gratified and rewarded by the therapeutic work. Therapist 7S recalled, "I was very activated when I started working with him because it was really exciting work." Therapist 8S said, "It was very rewarding for me . . . having her be able to hold on to a system of beliefs that she loves and believes in, finding a way to not have to separate herself from that."

Uncertainty and regret about clinical decisions. Therapists more often questioned their clinical decisions in the unsuccessful than successful cases. Sometimes the therapists questioned their interventions (e.g., 2S worried about the impact of a theological self-disclosure, 4U believed they were not knowledgeable enough to challenge the client about Jewish law, 5U wondered whether they should have remained more neutral). Others regretted making a mistake by not intervening or not doing enough to help the client. Therapist (1U) remarked, "I felt ashamed that I knew I had really missed the mark and not been there in the way that's so simple, so I feel terrible." Therapist 7U reflected, "I have a savior complex, and it didn't help him. He just kept struggling, he kept really struggling, and I don't know if I did it right." In the unsuccessful cases, therapists were unsure if they had made mistakes, uncertain where they had erred, and unclear about what had happened to the clients.

Summary. Therapists experienced countertransference as well as both positive and negative reactions toward both of their clients. Countertransference reactions were more often based in the therapists' unresolved religious beliefs and experiences than in non-R/S conflicts. Of note, therapists regretted their clinical decisions more in the unsuccessful than successful cases.

Consequences of Therapeutic Interventions for Religious/Spiritual Clients and Concerns

Three categories emerged here, with therapists reporting more improvements in all categories in successful than in unsuccessful cases.

Client's initial response to therapeutic intervention. Two subcategories emerged here: some clients responded well and some did not. These subcategories reflect the clients' immediate, in-session response to the therapists' interventions.

Client responded well. Clients in successful cases generally felt understood, reassured, relieved, and more comfortable. Therapist 4S noted, "he [client] felt quite a bit of reassurance, he

felt understood, and subsequent to that he reported that it was helpful to hear that [the model of grief].” Some therapists described clients as having an “aha moment” in which they gained insight. For example, therapist 9S said, “You can see the physical change, you can see it in their face when they go ‘Ahhh.’ You know it’s almost like this light bulb goes off . . . She saw in herself all these strengths and all these great qualities and things that she could utilize moving forward and she never recognized them before.”

Clients only variantly responded well in the unsuccessful cases. They sometimes expressed anger that was previously repressed, felt supported by the therapist, or gained insight.

Client did not respond well. One client in a successful case (5S) did not respond well initially to the intervention, although the mini-rupture was repaired within the session,

> At the beginning, he [client] was annoyed. I was laying it on very thick and talking about how the religion’s requirements can be very repressive and not realistic . . . He thought that I was being too negative and told me so, like “This is something that I’m choosing to live by, and I believe in, and I recognize that I’m not refraining from engaging in this sexual conduct, but it’s still something I think is important because I believe in this whole system, so you don’t have to bat me out of the whole system.

In the unsuccessful cases, clients typically did not respond well to the therapists’ interventions. They shut down, felt misunderstood, were not interested in or rejected the therapists’ ideas, questioned the therapists’ religiosity and R/S knowledge, were angry and defensive, or felt upset. Therapist 2U said her client was angry that she [therapist] did not understand her [client’s] R/S beliefs, “She was definitely mad . . . ‘Well, it just seems like you weren’t listening to me. I already explained that to you, and so that’s why I’m mad.’”

In one successful case and two unsuccessful cases, the incident was described as a rupture. In one successful case and four unsuccessful cases, therapists reported that clients specifically felt that the therapists were not attuned to their R/S beliefs.

Changes in therapy. Two subcategories emerged here: therapeutic process improved or deteriorated. These subcategories reflect longer-term outcomes in therapy following the interventions.

Therapeutic process improved. The therapeutic process more often improved for successful than unsuccessful cases. Clients in some successful cases were able to continue exploring the R/S concern and begin working through other issues. Therapist 7S noted, "It really felt like solid grounding for us and it [the prayer] was something that we could keep coming back to, and I think probably if anything it was grounding for us as a relationship." For others, therapy sessions felt more comfortable and the therapeutic relationship strengthened. Therapist 5S believed that "It opened things up both between us and between him and his girlfriend. I think for the therapeutic relationship, it reminded me to work from within the patient's perspective and check myself from imposing my own perspective on things. It made our conversation more comfortable in terms of talking about sexual issues." For others, clients had increased awareness and shifted perspectives during the therapy process (e.g., therapist 8S said the intervention helped the client understand and "describe [the consequences of the family interactions] in a way that sounded different").

In some unsuccessful cases, therapists noted that clients were able to continue exploring their issues in further sessions. For example, therapist 6U explained that "the patient continues to feel very supported, very much that she can talk about the things that wound her, that they are respected, and yet challenged."

Therapeutic process deteriorated. The therapeutic process worsened more often in the unsuccessful than successful cases. Five therapists indicated that the interventions led to premature terminations (e.g., "She left when I let her down," 1U), two therapists felt that the ruptures were never repaired, and three therapists stated that the therapeutic relationship weakened. A therapist (4U) who normalized a religious sin said, "He [client] probably devalued me . . . I probably lost some credibility in his eyes . . . There may have been some devaluation of me as an authority figure, as a knowledgeable person, or even possibly as a moral person. And I think that I probably lost him in those sessions rapport-wise." Some clients simply did not change. According to therapist 5U, "Therapeutically, I guess he was still in the same position that he was before, so I feel like it was unsuccessful."

Client's functioning and well-being improved. This category, which emerged more for successful than unsuccessful cases, reflects therapists' perspectives that clients improved as a result of the interventions. In successful cases, therapists noticed that clients were able to make decisions aligned with their values and goals, such as functioning better in relationships, coping with grief, or beginning to work. Some clients shifted from self-blaming to self-nurturing, from rigidity to flexibility (sometimes in a religious, theological realm), and from narrow-mindedness to open-mindedness. Still other clients became more themselves, felt more confident, improved their self-esteem, and increased their sense of agency. Therapist 1S commented, "There was a loosening of some rigidity, because she didn't have the same need that she had had earlier. So to me that's good; she was freer to be the person she wanted to be and felt herself to be." Therapist 8S remarked, "She was able to increasingly feel confident in her perspective and in her decision . . . She kind of claimed herself, or reclaimed herself, as a person, as the head of a family, as the person who can make decisions . . . that carried over to her, to her career."

In some unsuccessful cases, therapists noted that clients felt better. They cared less about others' judgment, felt less angry, became more involved in their Jewish community, and were better able to express their needs. Therapist 9U stated, "He was less angry and that he felt a little bit better, but to me that's a band-aid. The wound is still there, it's not healed."

Summary. In the immediate moment of the sessions, clients in the successful cases often felt relieved and understood, whereas clients in the unsuccessful cases often felt angry and misunderstood. Notably, in several of the cases (most of the unsuccessful cases and the one successful case that had a rupture and repair), clients specifically felt misunderstood regarding their R/S beliefs and practices, which wounded them and led to irreparable damage. In the longer term outcome, therapists noted effects on the therapeutic process, mostly characterized by improved functioning and well-being in successful cases and deterioration in unsuccessful cases.

Factors Associated with Success

Three categories emerged in this domain. More positive factors were reported for the successful than unsuccessful cases in all three categories (except for one subcategory).

Therapeutic relationship factors. Therapists attributed success, in part, to the therapeutic relationship. Subcategories emerged for R/S and non-R/S relationship factors.

R/S-Therapeutic relationship factors. More often in the successful than unsuccessful cases, therapists attributed the treatment success at least partially to the shared therapist-client R/S identity, which enabled therapists to understand the nuances of their clients' R/S conflicts. This understanding helped them be more empathic, which in turn helped the clients feel understood. Therapist 7S stated that she felt uniquely qualified due to her understanding of the client's R/S world to help the client who had "never been able to meld the worlds of this internal religious struggle and the external world of finding somebody who can help him muddle through

mental health challenges." Therapist 8S said, "She [client] really valued having a place to talk about those things with someone who sort of understood the concepts and believed in those concepts." Therapists typically specifically indicated that they were only able to provide the specific interventions because of their R/S identity, knowledge, and shared experience. Therapists recognized their ability to use a shared language (e.g., Hebrew, Yiddish, Aramaic, Talmudic phrases, specific Jewish concepts) to help clients feel comfortable expressing doubts, exploring their R/S concerns, and trusting the therapists. Therapist 3S indicated,

> She definitely identified with the fact that I come from a similar world . . . lots of different things about Judaism came up, where she was able to say things in Hebrew, and I would know what she was talking about. And we could talk about her moments where she didn't feel like she believed in God and felt like God didn't care about her, and I was able to understand where she was coming from and tell her it's okay to feel whatever she's feeling right now.

Therapist 7S spoke about their knowledge of the liturgy and Talmudic concepts, and how this knowledge strengthened the therapeutic relationship and helped make the therapy successful,

> I grew up in an observant, observant-Conservative world and I studied in yeshiva environments . . . we were able to talk in Talmudic terms . . . He loved the musical pieces and I also identify that as something I'm very competent and I enjoy doing, and so it gave me some street cred with him that I knew *Rosh Hashanah* and *Yom Kippur davening nusach* [High Holiday liturgical tunes] . . . I remember saying *kal va'chomer* [all the more so, a Talmudic phrase] about it, and he like I remember him like stopping in his chair and looking at me, and it was like early in our relationship, and he was like "Where

did you study?" . . . It was a moment, where like, I remember the moment of like "oh, you know this part of my world!"

In addition, in the successful cases, therapists and clients were typically able to overcome tensions arising from differences between them in R/S beliefs and practices. Therapists were respectful of R/S differences and intentionally worked to ensure that their clients felt comfortable despite differences between them. The therapists did not criticize the clients' R/S values and tried to work from within the clients' R/S perspective. When a client reacted strongly to a therapist's comment, therapist 5S "switched gears, like 'you're right, I am imposing my own perspective of this onto you and if that's something that's important to you, I shouldn't be skeptical of that, but let's work within what you find important and the feeling around it rather than deciding whether it's realistic or not.'" This allowed the therapist and client to repair their rupture within the same session.

Non-R/S-Therapeutic relationship factors. Therapists more often in successful than unsuccessful cases cited a strong therapeutic relationship as contributing to the success of therapy. Many of the clients had struggled to form relationships outside of therapy, and the therapeutic relationship enabled them to have a corrective relational experience. Therapist 7S remarked, "It was a good fit. And we were able to do, I would say, more forgiveness work than he had been able to do before because he was able to tolerate therapy in a different way." Another therapist (11S) reflected, "The relationship made it successful. She really began to value a great deal of the work and my interventions or being there and so you know I can present something and she can hear it. I don't know if she'd hear it from many other people."

Therapists in both cases also variantly reported that having clear therapeutic boundaries, especially when there was strong client transference, helped the therapy. Therapist 8S

intentionally "was really aware of trying to not [become the authority figure]. Not abandon her and so, I felt at times like I was working really hard to make sure that that connection stayed strong and that I was able to not take that role of being the authority." Therapist 11S noted that the client "may have seen me as cold and ungiving, but I'm absolutely steady. I think that's what she finally got, and is actually who I am I can say. I'm there! I'm not late. I'm there if you need me . . . But I don't have coffee with my patient or run over greatly."

Therapist factors. Two therapist factors contributed to the success of therapy, both of which therapists were able to do more in successful than unsuccessful cases.

Managed countertransference reactions. Managing countertransference sometimes involved holding back and not responding to the client; other times it meant being more empathic to meet the client's needs; and still other times it meant altering the original, natural responses. Therapist 3S believed that being able to manage her countertransference "helped validate [the client's] feelings and just made [therapist] extremely empathic to understand those worries and those pressures." In cases where the therapists were able to manage their countertransference, they noted that they were first aware of it, attuned to how it was affecting their ability to be therapeutic, and adept at using it appropriately.

Demonstrated a supportive, open, and non-judgmental stance. Therapists supported their clients by being non-judgmental, non-directive, and not overly-invested; giving the client space to explore; and not pushing the client to resolve their pain. One therapist (3S) described this approach as, "knowing how to go with the rhythm of the client. So I could tell that she wasn't in a place where she wanted to forgive her Dad and release her anger. She was in a place where she needed to be accepted with her anger." One therapist (4S) attributed the success, in part, to his "avoidance of judgment and directedness, especially given that he [client] is hungry a

lot, he wants the 'what should I do' sort of response . . . I presented a model for consideration rather than direct guidance or judgment about what should or should not be done." These therapists were thus gentle and supportive, allowing the clients to meet their therapeutic goals on their own terms, make their own decisions, and cultivate self-acceptance.

Client factors. Positive client factors (e.g., openness, engagement, motivation) were noted more often in successful than unsuccessful cases as contributing to the success of the interventions. Clients were cited as being flexible, hard-working, comfortable exploring and expressing doubts, open to new perspectives, motivated for therapy, receptive to the therapists' interventions, and resilient. For example, in describing her client, therapist 5S stated, "He's very open to considering other perspectives and in general was very open in therapy." Therapist 8S said, "I certainly give her a lot of credit: enormous strength, determination, and desire to do the right thing for her children."

Summary. Therapists attributed the success of therapy to therapeutic relationship factors, therapist factors, and client factors. These factors all seemed to work together to foster growth.

Factors Associated with Lack of Success

Three categories emerged in this domain. Factors associated with lack of success were mentioned more often in unsuccessful than successful cases for about half of the categories.

Therapeutic relationship factors. Therapists attributed their lack of success, in part, to problems in the therapeutic relationship. Some challenges were related to R/S; others were not.

R/S-Therapeutic relationship challenges. One challenge that emerged variantly in both cases was the therapist's R/S identity impeding their therapeutic work. Some therapists felt ill-equipped to approach their clients' issues because they lacked knowledge of the clients' R/S traditions and practices. Therapist 4U recalled, "There were times where we would engage in

somewhat of a debate almost. And there's no way that I would have wanted a debate, he was far more knowledgeable, but I would still challenge his way of thinking . . . pulling in the Bible, pulling the *Torah*, but probably not doing a wonderful job of it relative to his knowledge." Therapist 8U felt that her strong Jewish identity complicated the client's ability to deeply explore his R/S concern, "It was really threatening to me to connect with him I think in a place where he was feeling so much pain from a community that I drew so much comfort from and identified with so much."

Another variant R/S-therapeutic relationship challenge in both cases centered on a R/S mismatch between the therapist and client. Although both were Jewish and identified as R/S, they often saw the world differently. Sometimes they had a different understanding of how much power Rabbis should hold, and sometimes they had differences in their R/S belief systems. Therapist 4U speculated, "I do wonder how much of a role my ignorance or not sharing the same or respecting his beliefs [contributed to the lack of success]. Maybe I didn't respect him, I guess, because I challenged them [his beliefs] as being invalid. I could've lost him there."

A third variant challenge in both cases was therapists feeling that clients judged them for their R/S identity and belief system. In some cases, the therapist's manner of dressing was not compliant with the client's R/S standards; some therapists were not as religious as the clients and therefore not able to understand their R/S issues. A therapist (5U) remembered a client "questioning my perspective because I wasn't like as much of an insider as he was."

Non-R/S-Therapeutic relationship challenges. Therapists more often in the unsuccessful than successful cases reported a weak therapeutic relationship which hindered their ability to intervene appropriately and thwarted the clients' ability to explore and feel comfortable. They described the relationships as formal, awkward, distant, or weak. Therapist 3U said, "The match

wasn't good;" therapist 8U said, "I didn't feel like we had a good connection. I felt like there was really some sort of obstacle."

In addition, therapists more often in the unsuccessful than successful cases indicated that unresolved transference contributed to the lack of success. For example, one therapist (8U) indicated, "I just became all the anger as the family and the Rabbi and any Jewish person he interacted with who did not do right by him. I mean, I think I actually had rarely encountered somebody so angry."

Therapist factors. Three therapist factors were associated with a lack of success. These factors emerged only for the unsuccessful cases.

Lacked empathy and understanding of client's R/S beliefs and practices. In the unsuccessful cases, therapists typically lacked empathy and had difficulty understanding the clients' R/S beliefs. Sometimes these therapists judged their clients, were too invested in clients changing, or did not understand the clients' belief system. Therapist 5U stated, "I lost my objectivity, and he picked up on that, and he thought that I was not looking at things from his perspective." Therapist 8U admitted, "I was really trying to be empathetic and help him with the pain . . . but I was still, 'no, we can't lose you!' To myself, you know. I think I became a much better therapist when I was willing to lose somebody, sort of to the people."

Inability to manage countertransference. In the unsuccessful cases, therapists variantly reported an inability to manage their countertransference reactions. Some therapists were aware that they did not explore the client's emotions in depth, or were more directive with the client than was typical. For example, when a client was discussing the eulogy she had shared at her father's funeral, therapist 1U was unable to ask further about it because of unresolved feelings about her own father's death, "I was afraid to go there."

Lacked experience, training, and awareness. In the unsuccessful cases, therapists variantly reported that a lack of experience, training, and awareness contributed to the lack of treatment success. Therapist 1U felt constrained due to her inexperience, "She [client] needed me to want to know and to ask about what she had said, it was the simplest thing in the universe, and something kept me from doing it, and I think it was my own relative inexperience."

Client factors. Two client factors were associated with a lack of success. Both emerged only for unsuccessful cases.

Presented with challenging problems. Therapists in the unsuccessful cases typically reported that the treatment was unsuccessful in part due to the clients' psychopathology, medical disorder, and/or challenging personality. Therapist 10U shared, "I think that through her own you know pathologies, the places she was coming from, it was hard for her to maybe accept what I was saying to her." Therapist 8U said, "He was mean, he was very gruff. I found it hard to make a connection with him. And so, he had this sort of this rough, angry. I mean I think again I don't know if I've had a client in all these years that's been so angry with me."

Low motivation for therapy. In the unsuccessful cases, therapists variantly reported that the treatment was unsuccessful in part because clients were not engaged in therapy. Therapist 4U explained, "I don't know exactly why he was in therapy. There was definitely a part of him that did not want to change his way of thinking." Therapists found it difficult to work productively with clients when clients were not motivated and engaged.

Summary. Similar to the factors associated with success, the factors associated with a lack of success involved therapeutic relationship factors, therapist factors, and client factors. Three specific challenges emerged due to differences in the R/S identity between the therapist and client: the therapist's lack of knowledge, differing worldviews, and the client's negative

judgment of the therapist. Therapist factors included being unable to understand the client's R/S beliefs, struggling with managing strong countertransference reactions, and feeling hindered by inexperience and lack of awareness. Finally, therapists found the cases difficult when clients were challenging and not motivated for therapy.

Illustrative Case Examples

In order to paint a clearer picture of a comprehensive case, we include an example of a successful and unsuccessful case. These case summaries are amalgamations of multiple cases to protect confidentiality, with identifying information masked.

When Bad Things Happen to Good People--The Successful Case. Rivka was a 42-year-old, heterosexual, White, cis woman who identified as an Orthodox Jew. Her top priority was taking care of her 5 children and managing the home, although she was also involved in her Jewish community by visiting the sick (*bikur cholim*) and preparing food for after services (*kiddush*). She enjoyed writing poems and created homemade cards for friends and family. A year after her husband of 23 years died by suicide, Rivka started therapy with Leah (a 65-year-old, Modern Orthodox Jew), to whom she had been referred by the Rabbi's wife.

Rivka broke down in tears when she first entered Leah's office. Rivka knew her husband had been depressed, but nothing had prepared her for his death. He was her emotional rock, partner in life, and confidant. As a pillar of the community, her husband had led services every week, read Torah, and facilitated study sessions. As the breadwinner, his pay checks allowed them to provide just enough for their family. Rivka was now struggling to make ends meet. Her oldest son studied at a private religious, educational institution (*yeshiva*) and her oldest daughter was starting to rebel against Judaism (eating unkosher food and using her phone on *Shabbat*).

While the community was supportive right after her husband's death, Rivka's friends suggested that Rivka should be moving on once the one-year memorial mark occurred.

As they built the therapeutic relationship, Rivka felt more comfortable opening up to Leah. When Rivka used Hebrew and Yiddish phrases, Leah understood them. Furthermore, Leah responded to Rivka with compassion and kindness, and did not rush Rivka to move on from her grief. Rivka revealed that she had two stillborn children before her first son was born, and her relationship with her husband had been contentious at times, although he was the head of the household and she admired his resilience and scholarship. Rivka was angry at her husband for abandoning her, but she was even more angry at God, "Why is God making me suffer like this?" She expressed fear that she might not make it through *Yom Kippur* (the Day of Atonement). The themes of accounting of the soul (*cheshbon nefesh*), reflection and judgment, and life and death shook her to her core. She questioned what happened to her husband's soul after his death and wondered what might happen to her as well.

Leah had a different, more compassionate, view of God. Her impulse was to gently challenge Rivka's theology, giving her an alternative way of understanding God's role and helping her reduce her self-blame. When Leah suggested to Rivka that there are many ways to understand God's role in the world and offered her own belief that God does not punish people by giving them hardships, Rivka became quiet and withdrew from the conversation. Leah recognized that her countertransference may have led her to self-disclose in a way that was not beneficial for Rivka. She realized that Rivka was not ready to hear a different perspective and recognized that Rivka was probably not amenable to changing her theology.

Instead, Leah supported Rivka and facilitated exploration of Rivka's R/S beliefs about death. Rivka opened up about her shame surrounding her stillborn children, her inability to have

more children as her husband had wanted, and her guilt for not seeing the extent of her husband's pain and preventing his suicide. When Leah noticed that Rivka was invoking phrases from the High Holiday liturgy (e.g., "Who shall live and who shall die?" and "On *Rosh Hashanah* it is written and on *Yom Kippur* it is sealed"), she opened a High Holiday prayer book (*machzor*) in session and helped Rivka explore personal understandings of the prayers.

As the holidays approached, Rivka strongly felt her husband's absence. But her anger and guilt had softened, and she refocused on her sadness and forgiveness. Rivka continued to write her own interpretations of the prayers, inspired by the liturgical texts and her newfound emotional depth. She started a blog and published her poems and prayers as resources for other religious, Jewish widows. She began teaching English in her children's school and was able to financially support her family.

In reflecting on her work with Rivka, Leah attributed the success to her ability to manage her countertransference and Rivka's strength and motivation to engage in therapy. Leah worked on separating her feelings toward her strict and controlling father from her feelings toward Rivka. As she continued to reflect on her early experiences with her father as well as form a coherent conceptualization of Rivka, she was able to respond to Rivka with calmness and empathy. In addition to effectively managing her countertransference, Leah was able to speak Rivka's language (literally and figuratively), work within Rivka's R/S belief system, and help Rivka feel comfortable exploring her feelings about her R/S beliefs in a safe environment.

Romantic Entanglements--The Unsuccessful Case. Ezra was a 30-year-old, heterosexual, White, cis man, married with 3 children, corporate litigator, who identified as a Modern Orthodox Jew. He was an active member of his Jewish community and on the board of his synagogue's finance committee. Ezra had been experiencing sleep issues that left him feeling

irritable with everyone. During a recent law case, he befriended a client and started an affair with her. When he began feeling helpless and ashamed, he decided to seek therapy from a Jewish therapist.

Ezra liked working with Adina (a 35-year-old, previously Orthodox, currently Conservative Jew), who allowed him to speak about whatever was on his mind and did not condemn him for having an affair. He disclosed that he had proposed to his high school girlfriend when he graduated from college, as he felt pressure from his parents and his community to get married. While he felt immense love for his children, his marriage felt like a burden. The only time Ezra felt alive was when he was engaging in sexual intercourse with his former client, but he could not bear the guilt of betraying his family and sinning against God.

Adina found Ezra charming and looked forward to their sessions. She also felt that he was manipulative, at times flirting with her, not telling the whole truth, and vilifying his wife. Their sessions were always intense, with Adina needing to decompress after and at times confer with her peer consultation group. She recognized that Ezra reminded her of her brother, but could not discern how, if at all, that influenced her work with him.

After a year of exploring Ezra's presenting concerns, addressing his emotions, and troubleshooting his sleep issues, Adina felt frustrated. Ezra seemed the same as when he first walked in to her office. Adina wanted him to either divorce his wife or end the affair, but she could not tolerate his ambiguous situation. She thought about her older brother who divorced his wife, left their four kids, and moved across the world.

She tried to help Ezra make a decision by telling him more about the divorce process and encouraging him to separate from his wife. Under his breath, he mumbled, "You went '*off the derech* [you are no longer religious],' right? You're not part of the community anymore." Adina

asked Ezra why he believed she was no longer part of the community. He replied, “You just don’t get it. I can’t leave my wife! I will be shamed if people find out what happened. And they will find out. There’s no question about it. Word travels quickly.” Adina disclosed, “I do understand. I know what it’s like to be part of such a tight-knit community. It has its blessings and its burdens. But you’re right- I am not as religious as I used to be growing up.” At the end of the session, Adina encouraged Ezra to speak to his Rabbi. He refused because he was too ashamed.

The next week, Ezra told Adina he was ending therapy because he was not making progress. Adina helped him explore his feelings, but did not try to convince him to stay in therapy. When he walked out the door for the last time, Adina felt a mixture of confusion, sadness, and relief. She was sad for Ezra, but felt relief that she would no longer have to cope with his painful indecision.

Adina felt that the therapy with Ezra was unsuccessful because the therapeutic relationship had been unsteady, likely due to his unresolved transference and her unmanaged countertransference. She felt strongly that he should not be having the affair and wondered whether she was violating her own R/S values by not explicitly advising him to end the affair. Furthermore, she identified with his wife and the woman with whom he was having the affair, and she worried about his young children. He did not seem to want to change any aspect of his life; rather, he just wanted support and sympathy. Although Adina had fond memories of growing up in an Orthodox community, she was removed from one now and did not understand the extent that Ezra’s community impacted his actions. They disagreed about how the community might respond, with Adina believing the community would move on quickly and

Ezra believing he would essentially be shunned. In addition, Adina was offended when Ezra said that she had left the fold and therefore implied that she could not understand him.

Chapter 6: Discussion

We interviewed 11 experienced, R/S Jewish therapists who each reported on a successful and an unsuccessful case of an R/S Jewish client presenting with R/S concerns. When clients presented salient R/S concerns, therapists used both non-specific R/S interventions (e.g., support) and R/S interventions that seemed targeted to Jewish clients (e.g., talking about Jewish laws, beliefs, and practices; self-disclosing about R/S beliefs and experiences). Although many factors seemed applicable to any psychotherapy process (e.g., a strong therapeutic relationship), we found some factors that seemed specific to therapy with R/S Jewish clients (e.g., needing to have an awareness of and ability to manage countertransference related to Jewish beliefs). Effective therapeutic interventions led to client improvement whereas ineffective interventions led to client deterioration. In sum, it appeared that R/S Jewish therapists were able to help some R/S Jewish clients work through R/S concerns, but they also identified several barriers to such work.

Religious/Spiritual Concerns

Clients presented with internal struggles around Jewish identity and relationship with God, issues navigating R/S differences in relationships, and tension with their Jewish communities. As Schlosser (2006) suggested, these Jewish clients questioned their R/S beliefs and considered how these beliefs impacted their ritual practices. The R/S concerns often overlapped; for example, an R/S family issue caused clients to question their theological beliefs and relationship with God. Many clients struggled with how their beliefs evolved over time and how this evolution impacted their relationships, especially when their families' and partners' beliefs conflicted with their own. This aligns with Kellem et al.'s (2010) finding that R/S clients frequently discussed how they departed from their families' R/S traditions and Milevsky and Eisenberg's (2012) conclusion that Jewish clients may discuss family conflict due to differing

R/S practices. Although some of the R/S concerns seemed relevant to any R/S client (e.g., reflecting on death, comparing private vs. public ritual practice, experiencing family tension around R/S), many seemed specific to Judaism (e.g., dreading the Jewish holidays, following Jewish law, living by Jewish values).

All of the R/S concerns involved interpersonal relationships, suggesting how deeply R/S concerns are intertwined with family and friendships. Clients in the present study contemplated the intersection of their individual beliefs and practices with those of their community and experienced anxiety and betrayal when they passed thresholds of similarity and their communities failed to support them.

No differences emerged between the successful and unsuccessful cases in terms of R/S concerns. These results suggest that it is not the particular R/S concern that makes a difference, but rather how therapists and clients work with the concern in therapy.

Therapeutic Interventions

R/S specific interventions. Therapists typically discussed Jewish laws, beliefs, practices, and customs more often in successful than unsuccessful cases, which fits with Koenig and Pritchett's (1998) recommendation to openly explore the client's R/S faith. Similar to therapists working with Christian and Mormon clients (Shafranske 2000, 2001), Jewish therapists in this study also evaluated R/S history, referenced or read sacred texts, taught R/S concepts, encouraged forgiveness, and used prayer in session. When clients raised R/S concerns, therapists openly explored the clients' thoughts, feelings, beliefs, attitudes, and experiences related to them. They engaged in discussions about how the client wished to practice Judaism (e.g., how the client wanted to practice the law of refraining from physical contact with members of another sex (*shmirat negiah*)) and sometimes explained Jewish practice to the client (e.g., the Jewish

model of grieving). Therapists perhaps provided a different perspective than religious leaders by thinking specifically about how R/S impacted mental health and by not explicitly or implicitly pressuring clients to practice in a certain way.

Therapists variantly disclosed about their R/S beliefs, practices, or experiences to supportively challenge the clients' R/S beliefs (e.g., "I believe that what you are doing is not a sin according to my interpretation of the Torah") or to support their clients (e.g., "I remember what the *shidduch* process feels like when you are trying to find a life partner"). These results support the findings that there are many subtypes of therapist self-disclosure, with different intentions and consequences (Hill, Knox, & Pinto-Coelho, 2018).

In the current study, there was a meaningful difference between the frequency of therapists discussing Jewish laws, beliefs, practices, and customs in successful and unsuccessful cases, but no meaningful difference between the frequency of therapist self-disclosure of R/S beliefs and practices. Perhaps therapists need to focus specifically on the R/S aspect of the concern for therapy to be successful, but they need to only self-disclose in specific circumstances. This fits with Worthington et al.'s (1996) conclusion that highly religious clients prefer counseling that focuses on religion and R/S self-disclosures could facilitate or inhibit counseling.

Non-R/S specific interventions. Non-R/S interventions were used equally often in both cases. Therapists empathically validated and normalized their clients' experiences and gently helped clients explore their internal and external experiences by asking questions and reflecting feelings. They also variantly used other interventions, including encouraging clients to take action, challenging clients, providing psychoeducation, and facilitating insight. Similar results have been reported for working with other salient topics in psychotherapy (e.g., dreams, Hill,

2004; meaning in life, Hill, 2018), suggesting that some interventions are common across clients' concerns.

Therapist Internal Reactions

Therapists in both successful and unsuccessful cases experienced a variety of emotional and cognitive reactions, some of which seemed to be based in countertransference (their emotional conflicts and vulnerabilities). R/S countertransference seemed to emerge particularly when therapists were insecure about relating to Jews with different practices than their own (e.g., a Conservative Jewish therapist working with an Orthodox Jewish client). Some of these therapists vehemently disagreed with the clients' R/S beliefs and practices, finding it challenging to remain calm and present. Similarly, Spero (1981) asserted that countertransference issues specific to R/S therapists treating R/S clients may derive from R/S differences between the therapist and client.

Therapists less often experienced positive reactions and more often experienced doubts about their clinical decisions in unsuccessful compared with successful cases. These results, along with the data about more challenging clients (to be discussed below), suggest that client factors made it difficult to work with some clients' R/S concerns.

Consequences of Therapeutic Interventions

As would be expected given that we asked for successful and unsuccessful cases, the consequences of the therapeutic interventions for R/S concerns differed between the cases. Clients in successful cases started showing increased awareness and insight, continued exploring the R/S issue, began working through related concerns, and had long-term effects (clients made decisions with more clarity, functioned better in relationships, improved their self-esteem and confidence, became more open-minded, and developed into their authentic selves). For some, the

interventions strengthened the therapeutic relationship and helped clients and therapists feel more comfortable with each other. Unsuccessful cases, in contrast, were riddled with unrepaired ruptures, impaired therapeutic relationships, lack of progress, and premature terminations.

These findings illustrate that effective therapeutic interventions, including R/S specific interventions, can lead to client improvement when working on R/S concerns. When therapists cannot help R/S clients address their salient R/S concerns, clients deteriorate. Similarly, benefits of working with R/S concerns have been highlighted in previous literature (Bergin & Jensen, 1990; Pargament, 2007; Post & Wade, 2009; Smith et al., 2007).

Factors Associated with Success and Failure

Relationship factors. A strong therapeutic relationship and clear therapeutic boundaries contributed to success, whereas a weak therapeutic relationship and unresolved transference negatively affected the unsuccessful cases. Psychotherapy researchers have historically identified the therapeutic relationship as a key element in the therapeutic change process (Gelso, 2019), and researchers have consistently found an association between the quality of the alliance and therapy outcomes (Flückiger, Del Re, Wampold, & Horvath, 2018).

Therapists also typically cited specific R/S-relationship factors that contributed to treatment success and failure. In particular, therapists reported that having a shared R/S identity and overcoming tension raised by R/S differences helped clients. Whether or not the therapists explicitly labeled the tension as a "rupture," it appears that several of them were able to communicate and negotiate differences with their clients. Research suggests that if successfully repaired, ruptures can positively impact outcomes (Strauss et al., 2006). Relatedly, Chang and Berk (2009) found that with cross-racial therapist-client dyads, mismatches introduce unique

challenges to the therapeutic relationship, and differences in worldview require context-specific approaches.

In parallel, challenges in the R/S-therapeutic relationship contributed to a lack of success. A mismatch in R/S identity (e.g., Orthodox and Conservative) hurt the alliance, which in turn compromised the therapy. Some therapists lacked knowledge about the nuances of the client's Jewish beliefs and practices. Other therapists believed so strongly in a different way of practicing Judaism that they struggled to not be judgmental about the client's viewpoint. Occasionally, therapists felt that clients negatively judged them, especially when therapists struggled to understand clients' R/S views. Overall, the combination of the mismatch in R/S identity, therapist's R/S identity impeding the work, and therapists feeling that clients judged them based on the therapist's R/S identity coalesced to inhibit treatment success.

Therapist factors. Therapists cited a supportive, open, and non-judgmental stance as leading to success. These factors align with core facilitative conditions, often espoused as necessary in a successful therapeutic process (Rogers, 1957). Furthermore, although all therapists reported experiencing countertransference, they cited countertransference management as an essential factor contributing to success. Similarly, Gelso and colleagues noted that effectively attending to, understanding, and working with countertransference is a significant element of effective psychotherapy (Gelso, 2019; Hayes, Gelso, Goldberg, & Kivlighan, 2018).

In contrast, three therapist factors were associated with lack of success. The first was an inability to cultivate empathy for the client's R/S beliefs. When therapists were confused about, overly-invested in, not understanding of, or judging the client's R/S beliefs and practices, the therapeutic process deteriorated. It is possible that clients felt misunderstood and disconnected from their therapists, a common feature cited by clients in dissatisfying therapeutic relationships

where there are salient cultural differences (Chang & Berk, 2009). The second was the inability to manage countertransference. In reflecting on the cases, therapists recognized and acknowledged their countertransference, but during the therapeutic work, they were either unable to do so or unable to use their countertransference reactions effectively. Finally, therapists variantly attributed the lack of success to limited training and experience. Similarly, others have noted that psychology training programs rarely incorporate explicit training in working with R/S clients, and clinical faculty report minimal competence in R/S integration (Hage, 2006; Schafer et al., 2011).

Client factors. Client factors have often been cited in psychotherapy research as significantly influencing therapy process and outcome (Bohart & Wade, 2013). In this study, client openness, strength, and motivation were reported as factors associated with success. Client engagement and investment in personal change often assists in bringing about positive results (Overholser, 2005; Ryan & Deci, 2008).

In contrast, clients in the unsuccessful cases often had substantial mental health problems (e.g., traumatic brain injury, borderline personality disorder, substance use disorder) and/or challenging personality characteristics (e.g., awkward, angry, mean). Therapists struggled with working with these clients and therefore treaded cautiously. Similarly, Bachelor, Laverdiere, Gamache, and Bordeleau (2007) suggested that clients with severe symptomatology may lack the ability to become engaged in the therapeutic work.

Strengths and Limitations

To our knowledge, this is the first study to investigate the process of psychotherapy with R/S Jewish therapists and R/S Jewish clients working on R/S concerns. In addition, it is the first study that we know of to use a qualitative method to more deeply examine the therapeutic factors

associated with success and failure in R/S work with a Jewish sample.

A major limitation involves the sample. All of the therapists were White, in private practice of individual psychotherapy, experienced, and volunteered to participate in this study. Most of the therapists were female, psychodynamic/humanistic in theoretical orientation, living in the Mid-Atlantic U.S., and fairly homogenous in terms of Jewish beliefs and practices (e.g., most were liberal and open-minded, observant but progressive; none were Chassidic). Results may differ for other types of therapists. We also examined only the therapists' perspective. We suspect that clients might have had different experiences and thus cannot generalize findings to clients. Furthermore, 73% (8 of 11) of the successful clients were female, whereas 45% (5 of 11) of the unsuccessful cases were female (recall that 10 out of 11 therapists were female), suggesting that there may have been a gender pairing effect.

In addition, we did not define "R/S issues" for therapists, which may have led to a broader range of R/S issues than desired. However, we did not want to constrict their examples or impose our own meanings onto their words (Hill, 2012). In addition, the RCI-10 has not been validated with Jewish samples and may not have appropriately captured R/S within a Jewish context. We developed the other single-item measure that we used for assessing religious commitment, and single-item measures are problematic in terms of reliability. Finally, both measures of R/S commitment were self-report and not specific to Judaism.

Additionally, because this was a descriptive field study, we cannot make any causal claims that how therapists worked with R/S concerns influenced outcome. Fortunately, our goal was not to establish causality, but rather, to provide a rich description and acquire a deeper understanding of R/S in psychotherapy from the therapist's perspective.

Another strength/limitation involves using interviews, which are useful for collecting rich

recollections about complex topics, but also are subject to bias. Therapists were retrospectively recalling details of their experiences, and given the limitation of human memory, may not have been completely "accurate." Moreover, participants had to be aware of and willing to discuss concerns. Social desirability could have influenced the interviews, especially with therapists picking cases that could cast them in a positive light or restricting themselves when discussing the unsuccessful case examples. Furthermore, having only one interviewer may have introduced bias, although it allowed for consistency and uniformity across interviews. Since we only interviewed therapists, we also do not know how clients perceived these therapy experiences.

Lastly, many of the undergraduate students on the research team had minimal clinical experience, and some of the graduate students lacked a strong knowledge of Judaism. Although this diversity allowed for multiple perspectives, we note that it sometimes caused confusion around understanding clinical issues and Judaism. To address these potential issues, we carefully constructed the smaller teams to have equal representation of undergraduate and graduate students, those with and without clinical experience, and those with and without knowledge about Judaism. Furthermore, we discussed and recorded our biases and expectations at the outset of the study and continued to review them throughout the coding process. Finally, an auditor checked the analyses, providing more credibility for the results.

Implications for Practice

Given that religion and spirituality are integral for many Jewish clients in terms of identity, meaning in life, and coping, these results suggest that therapists should address R/S concerns as they emerge in therapy. Being able to discuss R/S concerns would of course require that therapists gain adequate training so that they can competently address R/S concerns. Theorists and therapists could also develop clinical approaches that are more sensitive to the R/S

concerns of Jewish clients (Shafranske, 2013). These recommendations fit with the APA guideline that psychologists should integrate research with clinical expertise in the context of patient characteristics, culture, and preferences (APA Task Force, 2006).

The results of this study suggest that in addition to focusing on common factors of successful therapy processes (e.g., strong therapeutic relationship, clear therapeutic boundaries, countertransference management, therapist qualities of openness and empathy), Jewish therapists should strive to understand their own R/S beliefs and values, acknowledge how these influence their therapeutic practice in general, and examine how they impact specific Jewish clients. Jewish therapists may benefit from explicitly discussing religious laws and practices with their R/S clients in an open and non-judgmental way, allowing clients to use the therapeutic space to explore all facets of their R/S identity. When deemed appropriate (i.e., for the benefit of the client and the therapeutic relationship), Jewish therapists might disclose about their R/S beliefs and practices to help Jewish clients feel more comfortable when discussing R/S concerns and strengthen the therapeutic relationship.

As Shafranske (2013) noted, clinicians should monitor the impact of their R/S interventions on the therapeutic relationship. The finding that it was detrimental when therapists tried to convince clients that they did not have to hold strict religious views suggests that therapists should be careful about their biases emerging. Trying to convince a client of anything is probably an unhealthy practice and may be harmful to the therapeutic relationship. In contrast, helping a client reflect on how their R/S views shape their relationships and their own self-concept could be beneficial to the client and the therapeutic process. The key here is a lack of judgment and an allowance for clients to safely explore their own beliefs. Relatedly, therapists might benefit from working within the client's R/S system. One therapist (5S) beautifully

articulated that she had been working from her own R/S value system. After the client called attention to this, the therapist switched gears and worked from within her client's R/S perspective.

In addition, therapists might also benefit from focusing on understanding and managing their R/S countertransference. An understanding of their own R/S beliefs and experiences, as well as how they relate to their specific clients' R/S concerns, might aid the therapeutic process. Relatedly, Pargament (2007) identified spiritual intolerance (i.e., believing that spirituality is inherently problematic, harboring faulty assumptions about the client's spiritual beliefs) and spiritual illiteracy (i.e., lack of knowledge about R/S and its relevance to clinical practice) as two particularly dangerous therapeutic qualities.

In regard to relationship factors, therapists might try to use their shared R/S identity to help clients feel more comfortable. In contrast, they might attempt to overcome tension raised by R/S differences. Importantly, therapists should not assume R/S commonality and overlook the clients' unique R/S perspectives (Shafranske, 2013). Rather, therapists should maintain an openness to differences, an interest and curiosity in their clients' beliefs and practices, and an explicit attempt to repair ruptures in the therapeutic relationship (Safran, Muran, & Eubanks-Carter, 2011).

This study also highlights specific Jewish R/S issues that therapists should be aware may arise in therapy. Presenting concerns of family and community seemed particularly prominent in this study, which fits with the concept that Judaism is more than a religion; it is a civilization, cultural group, and ultimately, a family (Zedek, 1998). Jews understand that they are connected to each other no matter where they physically live, believe that they are responsible for one

another (*kol yisrael areivim ze laze*), and beyond that, responsible for ensuring justice for all people (repairing the world, *tikkun olam*).

Other general issues that may arise in the treatment of R/S Jewish clients include potential collaboration with clergy, stigma of seeking help, and understanding of Judaism as a minority community (Zedek, 1998). Given the respect for authority figures within Judaism (e.g., Rabbis, clergy members), some R/S Jewish clients might respond well to a collaboration between their clergy and therapist. In the current study, shame often prevented clients from consenting to this collaboration; however, it is reasonable to expect that other clients may benefit from a team of mental health professionals and clergy members. In addition, therapists should be aware of the stigma that might prevent potential clients from seeking treatment or might accompany clients into therapy. In this study, several clients expressed concern about stigma in their religious communities and breaches of confidentiality, and given the intimate nature of many of these communities, it is important to consider this factor and find ways to make Jewish clients feel comfortable in therapy. Lastly, Jews are a minority in the United States (approximately 2%, Gallup & Lindsay, 1999; Lipka, 2013). Specific issues relevant to all Jews (including but not limited to the Holocaust, antisemitism, and relationship to Israel) may arise in therapy.

In addition, therapists should be aware that different R/S issues might emerge for different types of Jews (Meyerstein, 2006). Orthodox Jews believe that the Torah is of divine origin and the teachings of the Torah and Talmud apply to all aspects of daily life (Milevsky & Eisenberg, 2012). Conservative Jews believe that the Torah is divinely inspired, but emphasize the need to adapt Jewish law within the context of modern society (Schlosser, 2006). Reform Jews appreciate the role of Jewish law (*halachah*), but more strongly embrace personal

autonomy (Zedek, 1998). Therapists working with Jewish populations could benefit from understanding the differences between members of various denominations of Judaism.

Implications for Research

This study should be replicated with different denominations within Judaism. It is possible that different results might emerge with different therapist-client pairings (e.g., an ultra-Orthodox therapist with an ultra-Orthodox client compared to an ultra-Orthodox therapist with a Reform client). Replications are also needed with non-Jewish samples (e.g., Baptists) to see if there are specific R/S concerns and interventions for different religious groups. Studies of R/S therapists paired with non-R/S clients, as well as non-R/S therapists working with R/S clients, would also further illuminate the role of R/S in therapy.

It would also be interesting to simultaneously explore the client and therapist perspective, especially to study their alignment. It would also be helpful to have observers watch recorded therapy sessions to determine and evaluate interventions used when clients raise R/S concerns. Additionally, because R/S is just one identity factor, it might be interesting to study the intersection of R/S and other identity factors such as gender (especially because Judaism has patriarchal roots and expressions of religious faith, in general, differ between genders, McCullough & Larson, 1998). Furthermore, it would be interesting to compare the process of psychotherapy for R/S concerns with the process of psychotherapy for other salient topics (e.g., meaning in life).

Given the specific findings regarding unresolved transference and countertransference in the R/S realm, these distortions in the context of R/S seem worthy of further research. Since transference and countertransference are rooted in conflicts and vulnerabilities related to earlier significant relationships, and R/S is typically learned and practiced within the context of early

significant relationships, it seems that the connections between these distortions and one's R/S background might be particularly fruitful. Researchers might thus try to replicate and extend Spero's (1981) findings about transference and countertransference issues specific to R/S therapists treating R/S clients, including "idiosyncratic" and "conflicting" differences based on different needs between therapists and clients. In addition, given that some therapists noted a lack of specific R/S training and some mentioned that they processed their R/S countertransference and clinical challenges in their personal psychotherapy or with peer consultation groups, further research is needed to examine the role of training, supervision, consultation, and personal therapy on the way R/S therapists conduct therapy with R/S clients.

Finally, it would be helpful for researchers to coalesce around a consensus definition of R/S so that they could develop measures with better psychometric properties, assess broad patterns across populations, and facilitate productive interactions with other related fields (e.g., philosophy, theology). The field could also benefit from having measures that have been validated on different religious groups (McCullough & Larson, 1998). Further research in this field, shaped by thoughtful design, methodology, and execution, will assist R/S therapists in working more effectively with R/S clients and R/S topics.

Table 1. Experiences of Religious/Spiritual Jewish Therapists Working with Religious/Spiritual Jewish Clients

Domain/Categories/Subcategories	Frequency		Meaningful Difference
	Successful Cases	Unsuccessful Cases	
Client Religious/Spiritual Concerns			
Internal Struggles with Jewish Identity and Beliefs			
Questioning theological beliefs and relationship with God	T (9, 82%)	T (7, 64%)	
Grappling with Jewish views of mortality, death, and grieving	V (4, 36%)	V (2, 18%)	
R/S Issues in Relationships			
Navigating R/S problems in family relationships	T (8, 73%)	T (7, 64%)	
Navigating R/S problems in romantic relationships	T (6, 55%)	T (7, 64%)	
Tension with Jewish Community			
Feeling anxiety as a result of deviating from Jewish community norms	V (5, 45%)	V (5, 45%)	
Feeling disillusioned with Judaism and the Jewish community	V (3, 27%)	V (2, 18%)	
Therapeutic Interventions for Religious/Spiritual Clients and Concerns			
R/S-Specific Interventions			
Discussed Jewish Laws/Beliefs/Practices/Customs	T (9, 82%)	V (5, 45%)	Yes
Self-Disclosed R/S Beliefs/Practices	V (4, 36%)	V (2, 18%)	
Non-R/S-Specific Interventions			
Facilitated Exploration and Provided Support	T (9, 82%)	T (8, 73%)	
Encouraged Action	V (5, 45%)	T (8, 73%)	
Challenged	V (4, 36%)	V (7, 64%)	
Provided Psychoeducation	V (3, 27%)	V (5, 45%)	
Facilitated Awareness or Insight	V (3, 27%)	V (4, 36%)	
Therapist Internal Reactions to Self and Client			
Countertransference Reactions			
R/S Countertransference	T (7, 64%)	T (6, 55%)	
Non-R/S Countertransference	V (2, 18%)	V (2, 18%)	
Negative Reactions toward Client	T (7, 64%)	T (9, 82%)	
Positive Reactions toward Client	T (6, 55%)	V (4, 36%)	
Uncertainty and Regret about Clinical Decisions	– (1, 9%)	T (8, 73%)	Yes
Consequences of Therapeutic Interventions for Religious/Spiritual Clients and Concerns			

Client's Initial Response to Therapeutic Intervention			
Client responded well	G (10, 91%)	V (3, 27%)	Yes
Client did not respond well	– (1, 9%)	T (7, 64%)	Yes
Changes in Therapy			
Therapeutic process improved	T (8, 73%)	V (2, 18%)	Yes
Therapeutic process deteriorated	– (0, 0%)	T (9, 82%)	Yes
Client's Functioning and Well-being Improved	G (11, 100%)	V (4, 36%)	Yes
Factors Associated with Success			
Therapeutic Relationship Factors			
R/S-Therapeutic Relationship Factors			
Shared R/S identity between therapist and client was helpful	T (8, 73%)	– (1, 9%)	Yes
Ability to overcome tension raised by R/S differences in beliefs and practices	T (6, 55%)	– (1, 9%)	Yes
Non-R/S-Therapeutic Relationship Factors			
Strong therapeutic relationship	G (10, 91%)	V (3, 27%)	Yes
Clear therapeutic boundaries	V (5, 45%)	V (2, 18%)	
Therapist Factors			
Managed countertransference	T (8, 73%)	V (3, 27%)	Yes
Demonstrated a supportive, open, and non-judgmental stance	T (8, 73%)	– (0, 0%)	Yes
Client Factors			
Exhibited openness, flexibility, stability, strength, and/or motivation	T (8, 73%)	– (0, 0%)	Yes
Factors Associated with Lack of Success			
Therapeutic Relationship Factors			
R/S-Therapeutic Relationship Challenges			
Therapist's R/S identity impeded the therapeutic work	V (3, 27%)	V (4, 36%)	
Client-therapist mismatch in R/S identity	V (2, 18%)	V (5, 45%)	
Client negatively judged therapist based on therapist's R/S beliefs and practices	V (2, 18%)	V (4, 36%)	
Non-R/S-Therapeutic Relationship Challenges			
Weak therapeutic relationship	– (0, 0%)	V (5, 45%)	Yes
Unresolved transference	– (0, 0%)	V (3, 27%)	
Therapist Factors			
Lacked empathy and understanding of client's R/S beliefs and practices	– (0, 0%)	T (8, 73%)	Yes
Inability to manage countertransference	– (0, 0%)	V (5, 45%)	Yes
Lacked experience, training, and awareness	– (0, 0%)	V (3, 27%)	

Client Factors			
Presented with challenging problems	– (0, 0%)	T (8, 73%)	Yes
Low motivation for therapy	– (0, 0%)	V (3, 27%)	

Note. N = 11; General (G) categories = 10-11 cases; Typical (T) categories = 6-9 cases; Variant (V) categories = 2-5 cases; Bold = Domain; Nonbold = Category or Subcategory. Categories were considered meaningfully different if the frequency differences exceeded 30%.

Appendices

Appendix A
Demographic Form

Age: _____

Gender: _____

Race/ethnicity (check as many as apply):

- White American
- African American
- Asian American
- Hispanic American
- Native American
- Middle Eastern
- Multiethnic _____
- International _____
- Other: _____

Degree in psychology (ex: PhD, PsyD, etc.): _____

Year attained degree: _____

Year(s) of post-degree clinical experience (ex: 1, 5, 20, etc.): _____

Religious denomination:

- Jewish: Ultra-Orthodox
- Jewish: Orthodox
- Jewish: Modern Orthodox
- Jewish: Conservative
- Jewish: Reconstructionist
- Jewish: Reform
- Jewish: Renewal
- Jewish: Non/Post-Denominational
- Jewish: Secular
- Jewish: Other _____
- Not Jewish: _____

Please read the following questions carefully and indicate where you place yourself on the scale:

How important is your religious/spiritual identity to you?

1 = Not Important, 2 = Slightly Important, 3 = Moderately Important, 4 = Important, 5 = Very Important

How much do you believe in and adhere to the techniques of psychodynamic/psychoanalytic therapy?

1 = Not at all, 2 = Slightly, 3 = Moderately, 4 = Mostly, 5 = Completely

How much do you believe in and adhere to the techniques of humanistic/experiential/existential therapy?

1 = Not at all, 2 = Slightly, 3 = Moderately, 4 = Mostly, 5 = Completely

How much do you believe in and adhere to the techniques of cognitive/behavioral therapy?

1 = Not at all, 2 = Slightly, 3 = Moderately, 4 = Mostly, 5 = Completely

Appendix B
Religious Commitment Inventory (RCI-10)

Not at all	**Somewhat**	**Moderately**	**Mostly**	**Totally**
True of me	true of me	true of me	true of me	true of me
1	2	3	4	5

1) I often read books and magazines about my faith.
2) I make financial contributions to my religious/spiritual organization.
3) I spend time trying to grow in understanding of my faith.
4) Religion/spirituality is especially important to me because it answers many questions about the meaning of life.
5) My religious/spiritual beliefs lie behind my whole approach to life.
6) I enjoy spending time with others of my religious/spiritual affiliation.
7) Religious/spiritual beliefs influence all my dealings in life.
8) It is important to me to spend periods of time in private religious/spiritual thought and reflection.
9) I enjoy working in the activities of my religious/spiritual affiliation.
10) I keep well informed about my local religious/spiritual group and have some influence in its decisions.

Appendix C
Interview Protocol

Successful Event

We are going to start with a specific religious/spiritual event (a discrete moment bounded within one session) that went well (had a successful outcome) in your work with one Jewish, adult client.

1. Tell me a little bit about the client to start.
    a. (Tell me about the client's demographics and religious/spiritual identity.)
    b. (Tell me briefly about their presenting concerns and course of treatment.)
    c. (How far along in the therapy were you? (Ex: session 3 out of 12))
2. What was the client's specific R/S concern?
3. How did this concern come up before and how did you deal with it?
4. What was going on immediately before the event during that session?
5. Walk me through the event from start to finish including what the client did and what you did.
6. What, if any, transference* reactions emerged?
7. What, if any, countertransference** reactions emerged?
8. What do you think made the event successful?
9. What were the immediate consequences of the event in that session?
10. What were the delayed consequences of the event after that session?

Unsuccessful Event

Now we will transition to a specific religious/spiritual event (a discrete moment bounded within one session) that did not go well (did not have a successful outcome) in your work with a different Jewish, adult client.

1. Again, start by telling me a little bit about the client.
    a. (Tell me about the client's demographics and religious/spiritual identity.)
    b. (Tell me briefly about their presenting concerns and course of treatment.)
    c. (How far along in the therapy were you? (Ex: session 3 out of 12))
2. What was the client's specific R/S concern?
3. How did this concern come up before and how did you deal with it?
4. What was going on immediately before the event during that session?
5. Walk me through the event from start to finish including what the client did and what you did.
6. What, if any, transference* reactions emerged?
7. What, if any, countertransference** reactions emerged?
8. What do you think made the event unsuccessful?
9. What were the immediate consequences of the event in that session?
10. What were the delayed consequences of the event after that session?

Therapist's R/S Identity

To conclude, I am curious to hear about your own religious/spiritual identity and how you integrate it into your work.

1. What are the positive aspects and struggles of integrating religion/spirituality into your therapeutic work?
    a. (How would you describe your religious/spiritual identity?)

*Transference: "The patient's experience and perceptions of the therapist that are shaped by the patient's own psychological structures and past, involving carryover from and displacement onto the therapist of feelings, attitudes, and behaviors belonging rightfully to and in earlier significant relationships."

Gelso, C. J., & Bhatia, A. (2012). Crossing theoretical lines: the role and effect of transference in nonanalytic psychotherapies. *Psychotherapy, 49*(3), 384-390. doi: 10.1037/a0028802

**Countertransference: "The therapist's internal and external reactions that are shaped by the therapist's past and present emotional conflicts and vulnerabilities."

Gelso, C. J., & Hayes, J. A. (2007). *Countertransference and the therapist's inner experience: Perils and possibilities*. Mahwah, NJ: Erlbaum.

Appendix D
Recruitment Email Version A
Potential Participants Researcher Knows

Subject: Religious/Spiritual Concerns in Psychotherapy

Dear [Name],

I hope you are doing well. I am reaching out to you because you might be interested in participating in my qualitative study on how Jewish therapists actually work with Jewish clients' religious/spiritual concerns in psychotherapy.

I would really appreciate your help with this study because it is so important to have more in-depth information about this understudied topic.

If you consent to be a participant and are eligible for the study, I would interview you for one hour by phone, with the possibility of a thirty-minute follow-up interview.

The criteria for the study are as follows:

1) Identify as a religious/spiritual Jew
2) Have recently worked with adult, religious/spiritual Jewish clients
2) Conduct individual psychotherapy in private practice as a licensed therapist
4) Be at least five years post graduate school
5) Be psychodynamic or humanistic (not strictly cognitive/behavioral) in your theoretical orientation

This is an exciting opportunity to learn more about the intersection of religion/spirituality and psychotherapy. I hope you will be interested in participating.

After you have had a chance to think about participating, I will contact you again. If interested, I will send you a link to the consent form, a brief standardized measure to assess your religious/spiritual commitment, and a demographics form. Once you have returned these completed forms, I will call you to set up a time for the interview. I will also send you a copy of the interview protocol in advance so that you can prepare for the interview.

If you would like to get started with the forms now, you can follow this link: [link to Qualtrics]

Unfortunately, I cannot offer you any monetary incentive. I do hope that the interview will be a meaningful opportunity for you to reflect on your practice (participants often say that such interviews are almost a form of self-supervision). Additionally, you will be helping me as a doctoral student complete my research requirements on a topic for which I am passionate. You should know that I am Jewish and value my Jewish religion and spirituality as a major part of my identity.

Thank you for considering. I will follow up with you shortly.

Sincerely,

Judith Gerstenblith, Doctoral student in counseling psychology

Clara E. Hill, PhD, Advisor

Appendix E
Recruitment Email Version B
Potential Participants Recommended to Researcher

Subject: Religious/Spiritual Concerns in Psychotherapy

Dear [Name],

I received your name and contact information from [Name], who recommended I reach out to you because you might be interested in participating in my qualitative study on how Jewish therapists actually work with Jewish clients' religious/spiritual concerns in psychotherapy.

I would really appreciate your help with this study because it is so important to have more in-depth information about this understudied topic.

If you consent to be a participant and are eligible for the study, I would interview you for one hour by phone, with the possibility of a thirty-minute follow-up interview.

The criteria for the study are as follows:

1) Identify as a religious/spiritual Jew
2) Have recently worked with adult, religious/spiritual Jewish clients
2) Conduct individual psychotherapy in private practice as a licensed therapist
4) Be at least five years post graduate school
5) Be psychodynamic or humanistic (not strictly cognitive/behavioral) in your theoretical orientation

This is an exciting opportunity to learn more about the intersection of religion/spirituality and psychotherapy. I hope you will be interested in participating.

After you have had a chance to think about participating, I will contact you again. If interested, I will send you a link to the consent form, a brief standardized measure to assess your religious/spiritual commitment, and a demographics form. Once you have returned these completed forms, I will call you to set up a time for the interview. I will also send you a copy of the interview protocol in advance so that you can prepare for the interview.

If you would like to get started with the forms, you can follow this link: [link to Qualtrics]

Unfortunately, I cannot offer you any monetary incentive. I do hope that the interview will be a meaningful opportunity for you to reflect on your practice (participants often say that such interviews are almost a form of self-supervision). Additionally, you will be helping me as a doctoral student complete my research requirements on a topic for which I am passionate. You should know that I am Jewish and value my Jewish religion and spirituality as a major part of my identity.

Thank you for considering. I will follow up with you shortly.

Sincerely,

Judith Gerstenblith, doctoral student in counseling psychology

Clara E. Hill, PhD., Advisor

Appendix F
Recruitment Email Version C
Potential Participants Not Directly Recommended to Researcher

Subject: Religious/Spiritual Concerns in Psychotherapy

I am reaching out to you because you might be interested in participating in my qualitative study on how Jewish therapists actually work with Jewish clients' religious/spiritual concerns in psychotherapy.

I would really appreciate your help with this study because it is so important to have more in-depth information about this understudied topic.

If you consent to be a participant and are eligible for the study, I would interview you for one hour by phone, with the possibility of a thirty-minute follow-up interview.

The criteria for the study are as follows:

1) Identify as a religious/spiritual Jew
2) Have recently worked with adult, religious/spiritual Jewish clients
2) Conduct individual psychotherapy in private practice as a licensed therapist
4) Be at least five years post graduate school
5) Be psychodynamic or humanistic (not strictly cognitive/behavioral) in your theoretical orientation

This is an exciting opportunity to learn more about the intersection of religion/spirituality and psychotherapy. I hope you will be interested in participating.

After you have had a chance to think about participating, I will contact you again. If interested, I will send you a link to the consent form, a brief standardized measure to assess your religious/spiritual commitment, and a demographics form. Once you have returned these completed forms, I will call you to set up a time for the interview. I will also send you a copy of the interview protocol in advance so that you can prepare for the interview.

If you would like to get started with the forms, you can follow this link: [link to Qualtrics]

Unfortunately, I cannot offer you any monetary incentive. I do hope that the interview will be a meaningful opportunity for you to reflect on your practice (participants often say that such interviews are almost a form of self-supervision). Additionally, you will be helping me as a doctoral student complete my research requirements on a topic for which I am passionate. You should know that I am Jewish and value my Jewish religion and spirituality as a major part of my identity.

Thank you for considering. I will follow up with you shortly.

Sincerely,

Judith Gerstenblith, doctoral student in counseling psychology

Clara E. Hill, PhD., Advisor

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