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CLIENT PERCEPTIONS ON THERAPEUTIC QUALITY OF CARE WHEN DISCLOSING SPIRITUAL AND RELIGIOUS BELIEFS OR EXPERIENCES: A MIXED METHODS STUDY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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August 2015

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Client Perceptions
on Therapeutic Quality
of Care when Disclosing
Spiritual and Religious
Beliefs or Experiences:
A Mixed Methods Study

ABSTRACT

The spiritual and religious life of clients is an important clinical factor in therapy; it holds significant meaning and may support therapeutic outcome. This study explored client perceptions of the quality of care they received in therapy when disclosing their spiritual/religious life to their therapists as well as the factors that might contribute to their perceptions of care and disclosure. A total of 75 respondents participated in an online survey tool composed of quantitative and qualitative questions. Qualitative responses were coded and data was analyzed using descriptive statistics. Findings showed that most clients (73%) shared some or all of their beliefs; in contrast only 40% shared their spiritual or religious experiences. Almost all clients (80-90%) have had a significant spiritual/religious experience, most often describing a feeling of interconnection and well-being, a loss, gain, or change of faith, high intuition, and/or a sensory experience (auditory, visual, or tactile.) Fifty percent of clients who shared their beliefs with their therapists were satisfied or very satisfied with the care they received; 23% were somewhat satisfied or unsatisfied. Of clients who shared their experiences 38% were satisfied and less than 10% were somewhat satisfied or unsatisfied. A poor working alliance, misattuned responses, lack of engagement, and the therapist's lack of knowledge on the subject were reasons for low levels of satisfaction. The study concludes with suggestions on how to improve the therapeutic quality of care for spiritual or religious clients.

DEDICATION

"O Thou Whose face is the object of my adoration
Whose beauty is my sanctuary
Whose habitation is my goal
Whose praise is my hope
Whose providence is my companion
Whose love is the cause of my being
Whose mention is my solace
Whose nearness is my desire
Whose presence is my dearest wish and highest aspiration…"

(Bahá'u'lláh)

To the treasure of my life and the best of my friends
To the dark blue moon rising with the lotus-eyed jewel
To that One who has saved me, who does not forsake me:
I dedicate my life and my work.

And to my father, George Nikitovich,
whose pride, astonishment, and delight
have fueled my academic endeavors since I first began.

ACKNOWLEDGEMENTS

Thank you to all those who have loved me in my life, especially my mother, granny, and those who have supported me throughout— "animating" me and reminding me of my own worth and the value of this work.

And to the participants of this study, to Poor Magazine, and to all those who have shared themselves with me, expected much from me, and taught me. I hope this research will help those who navigate the mental health system receive what they truly need, influence academic institutions in training professionals within the mental health system, and enable the providers of care to offer services that entirely support the happiness and health of all.

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CHAPTER I

Introduction

The purpose of this study is to determine and explore: client perceptions of the quality of care they receive in therapy when disclosing spiritual/religious beliefs or experiences, as well as explore what factors contribute to their perceptions of care and disclosure in general. The research questions I intend to answer are: do clients who endorse spiritual/religious beliefs or experiences discuss these with their therapists? What do they think about the quality of care they receive in therapy after disclosure, and are they satisfied with it? What factors affect their perception of the quality of their care in this regard?

Spiritual and religious considerations are integral aspects of human life, individual identity, and personal worldview (Helminiak, 1996, Hay & Socha, 2005). Such factors will either be present or conspicuously absent within every therapeutic relationship (Coyle, 2001). Whether present or absent, a client's spiritual/religious beliefs or non-beliefs could have a significant effect on their daily lives and inner world; they may be pertinent to the individual through encounters with, for example, generational religious trauma, early childhood experiences and object relations with significant caretakers, or daily life experiences, possibly prejudicial, with family members, friends, media, and beyond (Shafranske, 2005; O'Rourke, 2010; Wesselmann & Graziano, 2010). Studies have indicated that spirituality and religion, as well as their absence, can significantly bolster wellbeing or lead to distress; Bonelli & Koenig (2013) suggest that spiritual/religious identification may ultimately be associated with better mental

health (Coyle, 2001; Mitchell & Roberts, 2009; Bonelli & Koenig, 2013). Additionally, extreme states that resemble mystic or transcendental experiences can be an integral aspect of spiritual/religious based practice and are culturally contextual; these same states can often occur, or be co-related with, what is typically termed psychotic or dissociative episodes experienced within multiple DSM diagnoses (Lukoff, 1988; Moreira-Almeida & Koss-Chioino, 2009; Phillips III, Lukoff, & Stone, 2009; Menezes Jr. & Moreira-Almeida, 2010; Gale, Robson, & Rapsomatioti, 2014). These issues must therefore be regarded as important clinical social work concerns and as such demand significant research.

Despite having a strong presence within the theoretical works of psychologists throughout history, who each held varying opinions on the matter, the role of spirituality and religion within psychotherapy has only recently been a focus of academic research (Coyle, 2001; Nicholi Jr., 2002; Fuller, 2008; Wiggins, 2009; Hathaway, 2013; Bonelli & Koenig, 2013). Some research has been done on the topic of therapist attitudes towards spirituality and religion in therapy, as well as studies that delineate types of spiritual interventions used, but there have been few if any studies that focus on client needs or attitudes during or after therapy. Given that 75% of the adult population in the United States endorses some form of religious identification, and perhaps more, this thesis topic has high relevance in the field of social work (Baker, 1997; Gallup, 2014). If roughly three out of every four adults in the United States have some sort of spiritual or religious belief then it is ethically sound to train therapists who are competent in supporting and aiding those clients, particularly when clinicians show a greater variety in religious identification and belief as compared to others on average (Josephson, Nicholi Jr., & Tasman, 2010; Rosmarin, Green, Pirutinsky, & McKay, 2013; Cummings, Ivan, Carson, Stanley

& Pargament, 2014). Research has shown a lack of educational training in this field, with greater efforts in the last decade to formulate new curriculum for clinicians and future clinicians (Puchalski, Larson, & Lu, 2001; Coyle, 2001; McCarthy & Peteet, 2003; Dwyer, 2010; Hathaway, 2013).

Religious prejudice and stigma remain realities today, for those who identify with a faith tradition and for those who do not, and as such spiritual/religious based training is an important aspect of culturally competent clinicians who come from myriad religious and ethnic backgrounds working with clients who range similarly. The topic of stigma and best practice methods is of paramount importance to those who are at highest risk for maltreatment from the medical establishment through traumatic experiences with forced hospitalization or over-medication, something survivor-led movements attest is a substantial reality (Morrison, 2003; Icarus Project, 2013). Is it ethical, therefore, for a person who has been given a diagnosis of schizophrenia, bipolar disorder, borderline personality disorder, or psychosis to live in fear of disclosing to mental health professionals what they perceive to be meaningful spiritual experiences or conclusions (Mitchell & Roberts, 2009)? What is the line differentiating a state labeled psychosis, “delusion,” or “inappropriate religious preoccupation” that could need immediate attention, and an experience of religious transcendence? It is the responsibility of clinicians to give this matter due diligence. This study, using client-centered research data, could therefore illuminate important considerations in the future of social work, specifically what is and is not useful to spiritually/religiously oriented clients who seek therapy, and may offer specific ways to aid clients who experience the most stigma and trauma within and by the mental health system.

This mixed methods study utilized purposive snowball sampling, receiving data through an online survey tool comprised of quantitative and qualitative questions. Participants were recruited through email and online participation within social networking sites. This report is organized into five chapters: introduction, literature review, methodology, findings, and discussion. The literature review discusses pertinent research providing foundational information on the topic of spirituality and religion within psychotherapy and social work, concluding with a summary of a client-centered study in the Netherlands that is most similar to the study I have conducted. The methodology section details the procedure of data collection and analysis as well as design, participant information, and recruitment. The findings chapter presents an overview of the data using descriptive statistical analysis. The discussion chapter synthesizes these results into pertinent clinical relevance and provides a direction for future research. References and appendices conclude this report.

CHAPTER II

Literature Review

Lack of Relevant Research

There have been no studies done in the United States that determine clients' own perceptions of quality of care after disclosure and discussion of spiritual/religious worldview or concerns. To highlight this lack of research a systematic review of relevant quantitative studies on therapist and client religious and spiritual belief was undertaken in 2014 (Cummings, et al., 2014.) The inclusion criteria were: original empirical research, publication in a peer-reviewed journal, total $n > 10$, therapist religion/spirituality was measured and varied, the relationship between therapist religion/spirituality and therapeutic alliance, outcome, or interventions was examined, participants were adults, and the study was published in the English language (Cummings et al., 2014). Out of 560 articles only 29 articles matched inclusion criteria for the review.

The review done by Cummings, et al. (2014) revealed multiple correlations and themes that offer greater breadth and background on the complexities of studies regarding spirituality and religion within clinical practice. Cummings, et al. (2014) revealed themes such as but not limited to: the effect of religious belief on client attitudes towards therapy (Pecnik & Epperson, 1985), showing that more spiritual or religious clients believed less in the helping potential of secular therapists, and that clients without a faith believed less in the helping potential of religious therapists; the relationship between therapist religious/spiritual orientation and

outcomes with clients of similar or different orientations (Martinez, 1991), showing that clinicians' spiritual/religious orientation affects how clinicians view a client's progress; the use of religious or spiritual interventions in treatment and its relationship to positive outcome (Propst, Ostrom, atkins, Dean, & Mashburn, 1992), showing that therapeutic improvement with Christian clients is often dependent on spiritual or religious interventions in session; and discussions of whether therapists' religious/spiritual values are related to their theoretical orientation (Cummings, et al. 2014). Other studies have determined the cultural meaning of spirituality within mental health (Verhagen, Praag, Lopez-Ibor Jr., Cox, & Moussaoui, 2010; Moreira-Almeida & Koss-Chioino, 2009; Wesselmann & Graziano, 2010), the benefits and distress related to spiritual/religious identities (Lukoff, 1988; Coyle, 2001), and the relationship of spiritual/religious identification on theoretical frameworks and client's choice of therapy (Rosmarin, et al. 2013). Most studies recommend a full research study on clients with diverse spiritual religious backgrounds, race, ethnicities, genders, and socioeconomic status.

Social Work Research on Spirituality/Religion in Mental Healthcare

Some studies have determined social workers use of and response to spiritually-based interventions in therapy, such as Sheridan, Bullis, Adcock, Berlin, & Miller, (1992), Hodge & Boddie (2007), and Dwyer (2010). Dwyer (2010), for example, studied the relationship between social workers' attitudes about spirituality within clinical practice and the history of their education regarding these matters. She found that less than half of licensed social worker participants reported learning about spirituality and religion in their masters program, and only a small number of participants (4.5%) reported taking a class on these topics for their clinical

degree. The demographics of the participants were skewed towards a majority of white, cisgendered female identified social workers predominately of a Christian faith.

Dywer had recreated studies preformed by Sheridan & Amato-Von Hemert (1990) and Sheridan (2004). These studies surveyed social workers level of agreement and use of spiritually based interventions in a clinical setting. Dwyer's studies replicated Sheridan et al.'s (1992) findings, but as a whole Dwyer discovered that the trend of usage of spiritual or religious interventions in clinical practice slightly decreased, as did social workers level of agreement and comfort with using these interventions (such as meditating or praying with a client, involving clergy members in session, or reading spiritual texts). This implies that social workers are less likely to use spiritual intervention in therapy, and if they do, they are more likely to be uncomfortable with it (Dywer, 2010). This could affect clients in the future, perhaps by not offering spiritually based interventions when necessary, or creating a palpable inter-subjective anxiety in session if the clinician does not feel comfortable with the work done.

Hodge & Boddie (2007) revealed that the level of spiritual motivation or orthodox belief have only a minor effect on whether or not social workers use spiritually based interventions in therapy, suggesting that other factors are more important, such as education in spiritual or religious clinical competency, empathic attunement, or ability to work within clients' worldview, all possible factors that are more important than a clinician's personal spirituality or religion. Hodge & Boddie note a concerning trend that clinicians who declared they had no faith were more likely to believe that spirituality and religion are one in the same, potentially doing a disservice to clients by being unable to identify differences in meaning and behavior, possibly preventing them from working within spiritually or religiously oriented client's worldviews in a

fully empathic way. Hodge & Boddie state that "working within the parameters of a clients' worldview" is the foundation of "spiritually competent practice" (Hodge & Boddie, 2007).

Patients' Views in the Netherlands: Patients' Views today

As mentioned earlier, I have not found research from the United States geared towards spiritual/religious clients' attitudes and opinions regarding their own mental health care when discussing spiritual/religious worldview or concerns, though modern research recommends actively engaging clients on the topic (Sheridan, Bullis, Adcock, Berlin, & Miller, 1992; Stewart, Koeske, & Koeske, 2008; Dwyer, 2010). Researchers in the Netherlands, Joseph Pieper and Marinus van Uden, have conducted one major study specifically on clients' opinions of the role of religion and spirituality in their mental health care.

In their book, *Religion and Coping in Mental Health Care,* Joseph Pieper and Marinus van Uden write, "religion and worldview could and should have a prominent place in many psychotherapeutic interventions. The physical, emotional, behavioural [sic] and social problems that the client brings in are often related to their systems of meaning and their religious attitudes…At the same time psychotherapists are being accused of neglecting this dimension" (Pieper & van Uden, 2005, p.145). To determine what kind of care is actually received by clients in the Netherlands, as well as to determine clients' attitudes on spirituality/religion within treatment, Pieper & van Uden conducted a non-purposive sampling studying in 1992, using a questionnaire to interview a total of 755 clients based at two mental health agencies within the Riagg district of the Netherlands. Their participants were homogenous, all white Christian adults of varying ages. Nonetheless, this study is particularly useful in that it provides some insight into potential relationships between care received and client response, and serves as an example

of empirical research into the topic despite the differences in country and setting. A summary of the Pieper & van Uden study follows. Because percentage responses of these two groups differ only slightly, for sake of clarity they will be summarized here as one. For a more detailed discussion of this study's results, please see the chapter on patients' views in *Religion and Coping in Mental Health Care* (Pieper & van Uden, 2005).

The entirety of this study's participants identified as some denomination within Christianity. Pieper & van Uden asked questions concerning three topics: clients' opinions of the relationship between worldview, religion, and mental health; whether their therapists discussed or neglected religion and worldview in session; and clients' wishes and concerns regarding the role that religion and worldview should play in therapy.

Pieper & van Uden discovered that a significant number of participants believed that their mental health problems were related to their spiritual/religious worldview, paradoxically considering it to sometimes exacerbate their problems yet to also provide considerable support for those same problems. Only about half of the participants stated they received questions in intake about their worldviews, and at least one quarter of participants expected to receive "no help at all" regarding spiritual/religious questions of concerns. On the results concerning clinical care Pieper & van Uden explain,

> How can these figures be understood? Firstly, it appears that it has been possible for clients to talk about religious/worldview issues related to their problems. About 60-70% of clients are satisfied in this respect. A client said: "My therapist is open to my outlook on life and she also respects it, although she doesn't have the same worldview. She admits that she isn't sure whether my point of view is right or wrong. But she is using my worldview in therapy".

> Secondly, usually therapists did understand the client's point of view concerning the religious/worldview aspects of the problems. Three out of five of the clients with religious/worldview questions were content with the situation.
>
> Thirdly, at the same time only one out of three was satisfied with the way in which treatment fitted the religious/worldview aspects of their problems. It seems that therapists could, and also wanted to listen to the religious/worldview aspects of the problems, but that they failed to endeavor concrete initiatives in this domain in their therapy. A client stated: "I could talk about the way religion helped me with my problems, but there was no reaction because she wasn't familiar with my religion. I feel very unhappy about that." In this context we can add that most respondents who saw a relation between religion/worldview and their problems replied that their religious background had been discussed only to some degree. (Pieper & van Uden, 2005)

Most participants did not know the religious affiliation of their clinician. A minority (usually of an older age group) considered it very important that a clinician share their worldview, while about half of the participants stated it did not matter if client and clinician shared religious affiliation. The majority of participants believed a therapist must learn to deal with spiritual/religious problems during their training. Out of those with religious concerns, almost half believed outside intervention within their tradition was a necessity in their mental health, with some not trusting the clinician to be able to help as well as a pastor could help. At least half desired spiritual/religious concerns and worldview to be discussed.

Based on their results Pieper & van Uden recommend certain practices within mental health care. They recommend that: psychotherapists discuss amongst themselves questions on religion, worldview, and meaning of life, and create workshops catered to these topics as it

pertains to clinical care and mental health; the fields of clergy based counseling and mental health care should continue to build and support a relationship of referral with each other; religious specialist clinicians must be placed at each agency with enough budget to allow; religious/spiritual education must continue and increase for all psychotherapists; empirical and evidence based data must be the basis in treating and understanding the relationship between spiritual/religious coping and mental health, and such data must be continued within agencies, particularly clinician inventories of experiences regarding interventions in the treatment of religious clients; such individualized care must be nationalized, therefore initiatives for funding need to continue (Pieper & van Uden, 2005).

The Netherlands' study is promising, and gives us some insight into what some clients in America may also believe and desire, considering that the majority of Americans identify as a Christian denomination. The demographic of clients in the United States is more diverse than that of the Netherlands, however, and generalizability is currently impossible. It is important that empirical data is continually maintained to provide evidence for best practices.

Current Study

My study uses purposive sampling survey data with questions on clients' spiritual/religious identification, practices in spirituality/religion, personal descriptions of beliefs and spiritual or religious experiences, clients' level of comfort in discussing these topics with their therapist, whether clients are satisfied with their therapists' response towards them regarding spiritual/religious dimensions, and opinions on most helpful and least helpful therapist interaction, with the aim of including a diverse population in all aspects of identity, particularly within spiritual/religious identities. The data and methods of the Pieper & van Uden study are

relevant to this current work as their study is similar to mine both in subject matter and mixed methodology. My study, however, focuses in detail on the relationship within the therapeutic dyad through the eyes of clients, specifically clients' comfort in discussing the topic with their therapists, client satisfaction of therapist response after disclosure, and opinions on best practices for therapists working with spiritual and religious clients in therapy. My study does not, therefore, replicate the data sought by Pieper & van Uden, such as opinions on the relationship of mental health and religion, expectations of care, or opinions on therapists before and after treatment.

Their results present relevant data for my own study, in that it may be possible to compare and contrast some of my data with those of Pieper & van Uden. For example, would the majority of my sample mention the importance of spiritual and religious training within clinical education? Would they mention their desire to discuss the topic in sessions? Or bring up the necessity of outside care within their religious tradition alongside traditional psychotherapy? Even though the questions of my survey do not ask about these exact topics, if the topics do represent a common need they may be written about regardless within the qualitative questions provided for further elaboration in my survey.

It is my hope that this study will provide more information about clients in the United States with various identities, discover common threads in this research field in order to formulate future research directions, and offer additional detail on client attitudes and opinions regarding the role of spirituality and religion in their mental health care.

Summary

There is insufficient research, particularly empirical research with diverse participants, on

the relationships between religion, spirituality, mental health, and clinical practice. Research that has been undertaken shows that religious/spiritual identity, or lack thereof, in both clients and clinicians can affect therapy and outcome; research additionally provides evidence that there is a need for improved education and clinical training for social workers as well as other mental health providers (Puchalski, et al. 2001; Dywer, 2010). Excluding Pieper & van Uden's work, I have been unable to find studies that concentrate primarily on spiritual/religious client perceptions, attitudes, or needs within their current therapy programs or that ask these clients to reflect on their mental health service experiences in the past. This study thus has the potential to serve as a starting point for this kind of work in the future; mental health services exist for clients, not for providers—it is therefore imperative we strive to hear, understand, and let them speak for themselves.

CHAPTER III

Methodology

Research Design

The study consisted of an online mixed methods survey tool created through Survey Monkey containing quantitative and qualitative questions (see Appendix A: Survey Tool.) A mixed methods exploratory design was chosen in order to provide a more nuanced view of the topic and to allow for clients to share their subjective experiences and obtain a voice within academic literature, while simultaneously retaining empirical data. The realm of spirituality and religion is generally highly personal. A strict empirical model would have been useful to pinpoint and summarize trends with confidence, however such a model would have prevented the accumulation of potentially significant or influential data gathered from participants' subjectivity and freedom of expression.

Participants

The specific requirements for participation were: participants had to be over the age of 18, consider themselves religious or spiritually oriented, and have been in therapy with the same licensed social worker for at least six months during the last ten years, 2004-2014. Adult participants must not need a legal guardian, must be able to participate in an online-based survey, and must be able to read, write, and speak English.

Participants who had been in therapy less than six months or who had changed therapists within that period were excluded based on the need for client-therapist dyads to have had a quantitatively significant amount of time to develop a relationship with each other. Adult

participants who had a legal guardian, or who were unable to respond to the survey, were excluded due to the time constraints necessary in order to receive viable data before April 2015.

Recruitment

Through non-probability purposive snowball and convenience sampling, I recruited participants primarily through email, website forums, and my personal Facebook page using personally created recruitment advertisements (see Appendix B: Recruitment Flyer). I emailed this advertisement to personal and professional acquaintances, asking them to either participate in the survey themselves or share it with those they knew. I also posted the recruitment advertisement on my personal Facebook page and to multiple Facebook "groups," such as a Smith College School for Social Work students group, the Icarus Project group, the CrazyWise documentary group, a group for individuals interested in Shamanism, a Spiritual Emergencies group, an Edgar Cayce/ARE group, and two Baha'i Faith groups. I posted the same recruitment information and a link to the survey on the Icarus Project website forum and The Center for Clinical Excellence website forum.

There were 216 respondents who began the survey and answered the screening questions; 116 of those respondents were eligible to participate in the survey, however not all of them filled out the entirety of the survey. After accounting for missing responses and eligibility, total determined sample size was 75 participants (N=75).

Data Collection

The online survey was available from February 23rd, 2015 to April 6th, 2015. Participants who were interested in the study proceeded directly to the link of the survey. After reaching the survey, they were prompted with the screening questions. If they passed the screening questions

they were directed to the informed consent page and had to click “I Agree” before continuing with the survey. The questions to be answered by the survey include: How do participants identify regarding their spirituality/religion? Have they discussed religious/spiritual topics with their therapist, why or why not? What response did they receive from their therapist? Were clients satisfied, why or why not? What do participants believe is most and least helpful in therapy when discussing spiritual/religious beliefs, experiences, or concerns? What is the demographic of the participants?

The survey begins with quantitative and qualitative questions related to the participant’s spiritual/religious life and identification, such as affiliation, practices, experiences, beliefs, and personally defined importance of spirituality and religion. Qualitative sections included comment boxes in which participants could either embellish on answers or respond to entirely qualitative questions. Quantitative questions were multiple-choice questions or likert scales. The second part of the survey asks questions related to the participants’ experiences discussing or not discussing this information with their therapists. This section concludes with questions about client satisfaction of therapeutic response, if relevant, and personal opinions on most and least helpful possible responses from therapists. The final section of the survey consists of demographic questions related to region, gender, income, race/ethnicity, age, ability, and mental health. The survey concludes with a message thanking participants for participation, and offering additional information concerning mental health resources available to them.

Data Analysis

All data was analyzed using SPSS to determine frequencies and comparisons. N was analyzed in which N = number of respondents answering individual questions compared to the

total N of 75. Because many questions asked respondents to choose all that applied, and percentages were rounded as given to me by the data analyst, it is possible that the total percentage of data groups described is over or under 100%. Some participants skipped questions, and the frequency and percentage of missing respondents was calculated. Due to individuals skipping questions, the N for particular questions ranged in number.

Respondents' narrative comments were analyzed for common themes using respondents' own words. Qualitative coding occurred as follows: using an excel spreadsheet participants were given an identifying number for each qualitative response. These responses were classified into the smallest number of possible content themes. In excel, responses were classified using "1" if theme was present and "0" if theme was absent. Final averages for all themes were taken, and percentage was found using N=total number of respondents per question (see Appendix C: Qualitative Coding Example).

Ethics and Safeguards

Before implementing the survey tool, the study was approved by the Smith College Human Subjects Review Board (please see Appendix D: HSR Approval Letter.) A change in protocol request was made due to minute differences in syntax and question placement on the final survey tool used, and this request was approved (see Appendix E: Protocol Change Request and Appendix F: Protocol Change Approval). Benefits to participants included an opportunity to share their experiences and contemplate such experiences within their lives, and to provide important information to the academic field of Social Work through the sharing of their experiences and opinions, which may help improve the field in the future. Clients were briefed that survey questions could provoke distressing emotions or memories, and were offered mental

health resources both in the beginning and end of the survey. Participants had to agree to an informed consent page before proceeding with the survey, and were told of anonymity and confidentiality in data collection and data storage at that time (see Appendix G: Informed Consent).

Limitations

I believe technical issues within Internet browsers or within the Survey Monkey website itself prevented some individuals from continuing with the entire survey for a brief period of time while the survey was open; either by choice or by technical difficulties some participants only completed the first half.

This study was limited due to the online nature of the survey tool, and the fact that all materials were given in English. Participants needed to be fluent in English, have the ability to answer questions typing on a computer, and have access to a computer, Internet, and a Facebook account to participate. This may have excluded a number of interested individuals. Potential technical difficulties may have prevented participants from filling out the entire survey. The survey tool itself was not tested for validity and reliability, as I had newly created it for this individual study. There is personal bias inherent in my participation as researcher given that I am a spiritual/religious identifying person. Therefore I may have exhibited bias within the study and survey tool towards those who identify similarly. For example, the particular questions I asked, or the wording of these questions, may suggest or imply my own thoughts or opinions, though I strove to remain as objective as possible. The qualitative comment sections served to alleviate such personal bias as much as possible.

The Findings of this survey are presented in the next Chapter.

CHAPTER IV

Findings

This chapter presents the findings of my survey. Findings are divided into four Sections. Section I describes the participants' demographics—who they were. Section II describes their religious and spiritual life; Section III describes their experience of therapy; and Section IV describes their opinions on most helpful/least helpful clinical care.

Section I: Participants (final N=75)

The Demographics of the participants were as follows:

Race: Sixty-eight percent identified as White/Caucasian, 5.3% identified as African-American/Black, 5.3% identified as Hispanic/Latino, 4.0% identified as American Indian/Alaskan Native, 2.7% identified as East Asian, 1.3% identified as Caribbean, and 1.3% identified as South Asian. Roughly ten percent of respondents stated they identified differently than the options listed, or wished to further specify their response. Participants were given the option to check more than one category.

Table 1:

Race/Ethnicity Demographic

Response	Frequency	Percent (N=75)
White/Caucasian	51	68
African-American/Black	4	5.3
Hispanic/Latino	4	5.3
American Indian/Alaskan Native	3	4
East Asian	2	2.7
Caribbean	1	1.3
South Asian	1	1.3
Other Identity/Further Specified	8	10.4
African	0	0
Middle-Eastern/Northern African	0	0
Native Hawaiian/Pacific Islander	0	0
Southeast Asian	0	0
Total	75	98.3

Gender: Sixty-one percent identified as female, 8.0% identified as male, 5.3% identified as gender fluid/non-conforming, 1.3% identified as transgender, 1.3% did not identify strongly with any gender, and 6.7% of individuals stated they identified differently than the options listed for gender identity or wished to further specify. 12 participants, or 16% of individuals, did not answer this question.

Table 2:

Gender Demographic

Response	Frequency	Percent (N=63)
I identify differently than the options listed	5	6.7
I identify as female	46	61.3
I identify as male	6	8.0
I identify as transgender	1	1.3
I don't identify strongly with any gender	1	1.3
I identify as fluid/gender nonconforming	4	5.3
Total	63	84.0
Missing	12	16.0
Total	75	100.0

Age: Roughly 43% percent were between ages 35-60, 28% were between ages 18-34, and 13.3% were above the age of 60.

Table 3:

Age Demographic

Response	Frequency	Percent (N=63)
18-34	21	28.0
35-60	32	42.7
60 and above	10	13.3
Total	63	84.0
Missing	12	16.0
Total	75	100.0

Disability: Roughly fifty-one percent identified as living without a disability, while 29.3% identified as living with a disability of some kind. 15 individuals, or 20%, did not answer this question. The most common disability was described as having some sort of mental health diagnosis.

Table 4:

Disability Demographic

Response	Frequency	Percent (N=60)
Yes	22	29.3
No	38	50.7
Total	60	80.0
Missing	15	20.0
Total	75	100.0

Income: Roughly 37% percent of respondents identified their income as between $20,000-$60,000, 17.3% as between $10,000-$20,000, 16% as greater than $60,000, and 12% as below $10,000; 13 participants, or 17.3%, did not answer this question.

Table 5:

Income Demographic

Response	Frequency	Percent (N=62)
Less than $10000	9	12.0
Between $10000 and 20000	13	17.3
Between $20000 and 60000	28	37.3
Greater than $60,000	12	16.0
Total	62	82.7
Missing	13	17.3
Total	75	100.0

Mental Health Diagnosis: A majority of participants, 62.7%, stated they had received a mental health diagnosis, while 17.3% stated they have not; 15 individuals, or 20%, did not answer this question. The most common diagnoses were types of depression, anxiety, and PTSD.

Table 6:

Diagnosis Demographic

Response	Frequency	Percent (N=60)
Yes	47	62.7
No	13	17.3
Total	60	80.0
Missing	15	20.0
Total	75	100.0

Location: Sixteen percent were from New York; 8% were from California, 6.7% were from Massachusetts; 4.0% were from Michigan; 4% were from Virginia, and 4% were from Ohio; 2.7% percent were from Maine; 2.7% from Colorado; 2.7% from Washington; 1.3% were each from Oregon, Hawaii, Louisiana, Illinois, Arizona, Minnesota, Nebraska, New Jersey, New Mexico, Indiana, Georgia, Oregon, Pennsylvania, South Dakota, Vermont, Arkansas, and Montana; and 10.4% of respondents lived outside the USA. Twenty-eight percent of respondents did not answer this question.

Table 7:

Geographic Location Demographic

Response	Frequency	Percent (N=54)
AZ	1	1.3
AR	1	1.3
CA	6	8.0
CO	2	2.7
GA	1	1.3
HI	1	1.3
IL	1	1.3
IN	1	1.3
LA	1	1.3
ME	2	2.7
MA	5	6.7
MI	3	4.0
MN	1	1.3
MT	1	1.3
NE	1	1.3
NJ	1	1.3
NM	1	1.3
NY	12	16.0
OH	3	4.0
OR	1	1.3
PA	1	1.3
SD	1	1.3
VT	1	1.3
VA	3	4.0
WA	2	2.7
Outside the US	8	10.4
Total	54	72.0
Missing	21	28.0
Total	75	100.0

Section I summary. The majority of participants identified as female, White/Caucasian, between the ages of 35-60, making $20,000-$60,000 a year, living without a disability but with a mental health diagnosis. Participants varied greatly within the United States, coming from a total of 26 different states and some from outside the U.S. The majority of participants were from New York State.

Section II: Spiritual/Religious Life

Religious traditions. Participants were asked to choose which religious traditions they identified with, and were given the option to choose more than one response as well as choose to further specify their religious identification, therefore total frequency portrays the fact that individuals within n=75 identified with many different traditions at once. Choices of tradition were based on knowledge of most populated religions in the world, but some were chosen *a priori* through personal experience. Twenty-seven respondents (36%) identified with Christianity, 11 (14.7%) with Buddhism, ten (13.3%) with Judaism, ten (13.3%) with the Baha'i Faith, ten (13.3%) with Interfaith, nine (12%) with New Age, seven (9.3%) with Indigenous Traditional Religion, seven (9.3%) with Paganism, seven (9.3%) with Mystic Tradition, seven (9.3%) with Folk Tradition, five (6.7%) with Wicca, four (5.3%) with Taoism, three (4%) with Islam, two (2.7%) with Mormonism, two (2.7%) with Celtic, two (2.7%) with Spiritism, one (1.3%) with Shinto, one (1.3%) with Hinduism, and one (1.3%) with Jainism. No one identified with Confucianism, Scientology, Satanism, Zoroastrianism, or Sikhism; 30 individuals, or 39%, chose to further specify their response or identified with a different tradition.

Table 8:

Faith Tradition Demographic

Response	Frequency	Percent (N=75)
Christianity	27	36
Buddhism	11	14.7
Judaism	10	13.3
Baha'i Faith	10	13.3
Interfaith	10	13.3
New Age	9	12
Indigenous Traditional Religion	7	9.3
Paganism	7	9.3
Mystic Tradition	7	9.3
Folk Tradition	7	9.3
Wicca	5	6.7
Taoism	4	5.3
Islam	3	4.0
Mormonism	2	2.7
Celtic	2	2.7
Spiritism	2	2.7
Shinto	1	1.3
Hinduism	1	1.3
Jainism	1	1.3
Confucianism	0	0
Scientology	0	0
Satanism	0	0
Zoroastrianism	0	0
Sikhism	0	0

Some of the further specifying responses included:

"Atheistic Humanism"

"Catholic"

"Asatru"

"Agnostic"

"Reclaiming Witch"

"I consider myself to just be 'spiritual' belonging to no specific faith"

"I have my own sense of spirituality that certainly has connections to Buddhism but does not follow many of the specifics. Also, my spiritually is not connected to any community."

"Lucumi and Palo Mayombe"

"European Traditional Witchcraft. Not to be confused with Wicca."

"Progressive Muslim also participating in a Unitarian Universalist congregation."

Religious beliefs. Respondents were asked to describe some of the most important spiritual or religious beliefs they hold. I identified 14 major themes within each description, which were: to discuss one or more guiding principles they follow in life (79.1%, N=67), to describe themselves in relationship to a divinity, deity, or spirituality that is personal or impersonal (61.2%), to describe their belief through a specific spiritual practice (26.9%), to state something all-inclusive such as "all people are good" (55.2%), to mention cosmology or how reality is structured metaphysically (46.3%), to describe how they relate to other human beings (41.8%), to describe traditional religious tenets (35.8%), to describe their beliefs by discussing time or the idea of an afterlife (31.3%), to mention important historical spiritual or religious figures (28.4%), to mention the ideas of determinism (16.4%) or non-determinism (4.4%), to describe their beliefs by comparing it to common religious ideas in society in a positive or negative way (where they hold the belief or they do not) (16.4%), and to discuss their relationship to nature and the earth (13.4%).

Table 9 provides data on what were the most common and least common categories described by participants in the qualitative data of this question.

Table 9:

Content of Beliefs

Response	Frequency	Percent (N=67, missing 9)
Guiding Life Principle	53	79.1
Defined in Relationship to Divinity/Spiritual World	41	61.2
All-Inclusive Statement	37	55.2
Defined in Relationship to Cosmology/Structure of Reality	31	46.3
Defined in Relationship to Human Beings	28	41.8
Traditional Tenets of identified Faith	24	35.8
Defined in Relationship to Time/After-Life	21	31.3
Defined in Relationship to Historical Spiritual Figures	19	28.4
Defined in Relationship to Specific Spiritual Practice	18	26.9
Defined in Relationship to Common Views of Religion	11	16.4
Determinism	11	16.4
Defined in Relationship to Nature	9	13.4
Non-Determinism	3	4.4

Some of the varied responses include:

"I believe in one God. I believe in a multiplicity of prophets, some chronicled in the books of the Judeo-Christian-Islamic traditions (e.g. Muhammad, Jesus, Moses, Abraham), some not. I believe that

religion requires both belief and action. I believe that religion is both personal and community-based. I believe that working for social justice is a fundamental part of religion."

"The path of the witch is land based. It focuses on the inherent sacredness of the environment in which he or she dwells. A witch's primary devotion is to the spirit world and forming alliances with the unseen forces that occupy it. A witch does not concern themselves with gods and goddesses (although we do not deny their existence) but rather with the spirit of place and our personal familiar. Witchcraft is not concerned with belief but rather with an experiential congress with unseen realms. Sorcery and freedom from religious tyranny are core values as well."

"As a Christian, I believe in the Trinity and that Jesus is the way to get to heaven."

"I do not believe in a personal god. I believe that we need to uphold the qualities of the old gods to live a life that appreciates self and other."

"I believe that we go through life learning and experiencing, and that we tend to encounter the lessons we most need to learn. I don't believe in reincarnation per se or heaven/hell, but I do think when we die a part of us does get recycled into the universe."

"I pray to several Goddess deities. I worship the earth and the universe. When I die, I will become worm food and that is ok. I do my best to not 'sin' because I don't believe in getting a free pass on that shit. Karma is the law of spiritual realization."

"I believe in reincarnation. I believe in an afterlife and that there are different levels of awareness and knowingness to this afterlife. I believe we are spiritual beings having a human experience - that the body is purely the vessel that the soul occupies during this lifetime on Earth. I believe we each have a 'Spiritual Team' that consists of Guardian Angels, Archangels, Spirit Guides, and our loved ones who have crossed over."

“Time and space are infinite. There is absolutely no evidence to suggest the existence of any God(s). May all beings be peaceful, happy, and free from suffering.”

“I believe in the power of the soul discovering the illusion of the mind over matter.”

“All living things contain a spark of divine energy that connects us to The Divine Goddess/God & to each other. We can & should explore & develop this connection to help ourselves & each other live our highest & greatest good. We are spiritual beings having a human experience during our time here on Earth & our spirits will continue to exist after our physical bodies do not.”

“I believe that there is only one Creator of the universe Who guides us be selecting Manifestations to bring a message to us when mankind needs assistance, that the Creator has guided us for as long ago as we were able to understand during our evolution until the present time and will do so for as long as we are here. I believe that Baha'u'llah is the latest of these Manifestations and before Him, the Bab, Muhammad, Christ, Buddha, Krishna, Moses, Abraham, Zoroaster and Others who have been forgotten have brought us guidance. Baha'u'llah teaches that we all belong to the same human family. There is only one Creator. There is only one religion that is progressive. Woman and men are equal, Science and religion must agree, there should be a universal language, script, and monetary system developed. There must be a world government. There will be world peace. All children must be educated. Baha'u'llah brought a new administrative order whereby the peoples of the world can unite and work together to bring peace on this planet.”

“The guiding principle of my spirituality comes from Christian tradition: "Whoever oppresses the poor shows contempt for their Maker, but whoever is kind to the needy honors God." And, "When did we see You sick, or in prison, and come to You?' "The King will answer and say to them, 'Truly I say to you, to the extent that you did it to one of these brothers of Mine, even the least of them, you did it to Me.'”

> "I believe that all good things come from God and I believing in being thankful for your blessings. I believe that everyone has their own path to their God, and as long as your religion's message speaks of being good and fair to one another, it's okay by me."

> "I believe in God. I believe that faith is comforting. I believe in the power of community, and the support system it can provide. I believe in an afterlife. I believe that Judaism holds a special place in the history of the world."

> "I believe in different planes of consciousness. I don't believe in heaven or hell."

> "I believe that God is the prime mover of the universe and all that lies within it. From time to time God sends messengers that renew the eternal spiritual truths and brings laws that are appropriate to the current and future stages of development of humanity."

Religious practices. Respondents were then given a list of common religious practices and asked to check all that apply. There were 18 defined response choices: 69.3% of respondents participated in prayer, 64% practiced meditation, 56% participated in religious holidays or traditions, 54.7% read scriptural, sacred, or spiritual texts, 46.7% participated in spiritual/religious group meetings or events, 44% participated in private devotional worship, 42.7% identified with the idea of service, 41.3% practiced a form of yoga, 37.3% participated in a house of worship, 33.3% interacted with spiritual/religious teachers, 32% interacted with professional members of religious institutions, 25.3% practiced chanting, 24% interacted with healers, 22.7% interacted with psychics, mediums, or astrologers, 16% had a specific diet for spiritual/religious reasons, 9.3% prayed with a rosary, and 8% interacted monks or nuns. Roughly 19% of individuals chose to embellish further and identified other spiritual practices, such as: listening to music, periods of silence, studying science, journaling, exercise, tarot card,

teaching others, working for peace and justice, prayer beads, confession, art, ritual or ceremony, fasting, crystals and spells.

Table 10:

Spiritual/Religious Practices

Response	Frequency	Percent (N=75)
Prayer	52	69
Meditation	48	64
Religious Holidays/Traditions	42	56
Reading Scriptural, Sacred, Spiritual Texts	41	54.7
Group Meetings of Events	35	46.7
Private Devotional Worship	33	44
Service	32	42.7
Yoga	31	41.3
Participation in a House of Worship	28	37.3
Interaction with Spiritual or Religious Teachers	25	33.3
Interaction with Professional Members of Religious Institutions	24	32
Chanting	19	25.3
Interactions with Healers	18	24
Interactions with Psychics, Mediums, or Astrologers	17	22.7
Diet for Spiritual/Religious Reasons	12	16
Rosary	7	9.3
Interactions with Monks or Nuns	6	8

Importance of religion and spirituality. Participants were asked to fill out likert scales and multiple-choice questions. The first question was "how important is religion to you?" Thirty two percent stated that religion was very important; 21.3% stated it was moderately importance; 14% said it was not at all important to them; 13.3% said it was of little importance; and 12% stated it was important; 2.7% of individuals did not respond to this question.

Table 11:

Importance of Religion

Response	Frequency	Percent (N=73)
Very important	24	32.0
Important	9	12.0
Moderately important	16	21.3
Of little importance	10	13.3
Not at all	14	18.7
Total	73	97.3
Missing	2	2.7
Total	75	100.0

The second question was "how important is spirituality to you?" The majority of respondents, 62.7%, chose that spirituality was very important; 18.7% chose important; 12% chose moderately important; 1.3% stated spirituality was of little importance to them; and 2.7% said there was no difference to spirituality and religion; 2.7% of individuals did not respond to this question. I realize now that I did not include "Not At All important" as an option, likely exhibiting personal bias.

Table 12:

Importance of Spirituality

Response	Frequency	Percent (N=73)
Very important	47	62.7
Important	14	18.7
Moderately important	9	12.0
Of little importance	1	1.3
There is no difference between spirituality and religion	2	2.7
Total	73	97.3
Missing	2	2.7
Total	75	100.0

Religious and spiritual experiences. This section of the survey focused on religious and spiritual experiences. Participants were asked if they have ever had a spiritual/religious experience. An overwhelming number (80%) said yes; 8% said no; and 9% said they were not sure; 2.7% did not answer this question.

Table 13:

Number of Respondents with Spiritual/Religious Experiences

Response	Frequency	Percent (N=73)
Yes	60	80
No	6	8.0
I'm not sure	7	9.3
Total	73	97.3
Missing	2	2.7
Total	75	100

Participants were asked to describe these spiritual/religious experiences in detail. When analyzed I noted 12 separate themes as follows: they felt a part of an interconnected relationship (with others, nature, or divine/spiritual world, sometimes recognized by a physical manifestation

or strong coincidence) (44.2%, N=61), they described strong feelings (positive or negative, often resulting in a sense of well-being or peace) (34.2%), they recognized an identified result after a spiritual practice (34.2%), they experienced consciousness raising leading to mental, emotional, spiritual understanding and growth (31.3%), they had a sensory experience in which the participant did not explicitly state a dramatic life change resulting from sensory experience (31.1%) or a life-altering sensory experience, including near death experiences (27.9%), they described pre-cognitive parapsychic phenomena (27.9%), they had vivid or spiritually significant dreams (18%), they were unable to describe it or noted very many experiences (13.1%), they experienced consciousness raising leading to a sense of healing (12.9%), or consciousness raising leading to new life direction (8.2%), and one respondent felt a dissolution of a sense of "self" (1.6%).

Table 14 provides data on what were the most common and least common categories described by participants in the qualitative data of this question. When considering together the categories of life-altering sensory experience and non-altering sensory experience, more than half of all spiritual/religious experiences described by respondents contain some kind of sensory-perception experience, including seeing visions of spiritual beings, light, or loved ones who have passed on; these sensory phenomena experiences were often described as significantly life-altering. A little more than a quarter of respondents mentioned pre-cognitive parapsychic phenomena, such as knowing aspects of the future through intuition, dreams, or visions.

Table 14:

Content of Spiritual/Religious Experiences

Response	Frequency	Percent (N=61, missing 14)
Sense of Interconnection	27	44.2
Strong Feelings	21	34.2
Identified Result after Spiritual Practice	21	34.2
Non-Altering Sensory Perception	19	31.1
Consciousness Raising leading to mental/emotional/spiritual understanding or growth	19	31.1
Life-Altering Sensory Perception	17	27.9
Pre-Cognitive Parapsychic Phenomena	17	27.9
Vivid or Spiritually Significant Dreams	11	18
Consciousness Raising leading to sense of healing	8	12.9
Unable to Describe/Too Many	6	13.1
Consciousness Raising leading to new life direction	5	8.2
Dissolution of sense of "self"	1	1.6

Some of the qualitative responses include:

"Many, in guided meditations, where I experienced a direct relationship with God-Goddess-All That Is, my higher self, other 'unseen friends'. These were very emotional experiences, revealing parts of myself that have been invaluable to know."

"As a young child, I saw The Great Spirit in the clouds & spoke to & understood birds (carriers of Spirit's messages). I have also met Spirits of the deceased."

“I have had visions of & with Jesus Christ, I also believe I had a visit with Jesus this past summer.”

“I went to a Native American ritual and was healed from emotional distress and peace entered my body. I also receive regular Reiki that has alleviated mental blocks in my mind.”

“I've had a few, through experiences with group or extended meditation, and an ayahuasca ceremony with a shaman. All involved a very strong sense of connectedness, and seeing different visions. The closest I can describe it is as a dissolution of myself, where I forgot for a time who and what I am, polished off those bits and pieces, and put them back together. I have also experienced some pretty intense group meditation sessions where people would find themselves spontaneously using pretty similar imagery.”

“I have had a number of them. The most profound was during prayer after fasting at a fundamentalist church when I experienced an overwhelming sense of sorrow and regret for how I'd lived my life to that point, followed by a sense of joy and excitement I'd not previously known once I let those feelings wash over me. I found myself speaking in another language (it seemed to me - I knew what I was trying to say but it didn't come out in English) even though I was new to that sort of church and didn't understand what 'speaking in tongues' meant. Everything was brighter after that - clearer, visually. It was the most amazing experience. I also heard a distinct voice one time state "leave him alone" in response to prayer about a certain love interest of mine. Quite unsettling, to say the least!”

“I fell asleep driving. I heard someone yell very loud in the car my name, right in my ear. I woke right before going thru a red light at an intersection. I was watching TV. I looked and saw a woman type spirit/angel on the steps. I watched her/it walk up the steps. A minute or so after my dad died, I saw a mist of water like beads come out of him, like from his diaphragm. The mist was gigantic it filled the room. Almost like a vapor of some type.”

“I have seen an angel. I feel beings around me often.”

“Multiple spirit guide experiences…The earliest one I can remember is from when I was about 12 -- I had an out of body experience where I saw myself sleeping on the bed while I floated above. I've also felt (while in the presence of a woo friend) a goblin spirit who wanted to help me and my creativity. I also felt (while in the presence of another friend) spirits try to speak to us on a made-up ouija board.”

“I had a dream where 'Abdu'l-Baha, the son of Baha'u'llah, the founder of the Baha'i Faith, told me in no uncertain terms to "get out of the city." I moved to a rural area shortly after. I also recovered from anxiety, depression and PTSD from extreme childhood abuse, by reading the Baha'i Writings, following the instructions; and sharing them with others.”

“I find a sense of inner peace when I meditate or discuss Buddhism.”

“Visions of beings of light; visions of departed loved ones; physical sensations; sense of connection to divine; intuition.”

“I've had a numerous instances of heightened emotion that I interpret as awareness of God's presence, and personal understanding that seemed to arrive to me (rather than emerging from a rational process of thought). I also had a number of religious dreams (some of which may have been visions, depending on the definition of that term), when I was in my 20s. In one, I had a very intense and realistic dream about what Muslims call ‘sirat al-mustaqeem’, which is crossed on the day of judgment, before I actually knew what that meant.”

“A young woman I vaguely remember meeting years ago called me one day asking to pray with me. In her prayer she literally (and I mean literally) started asking God for help to deal with specific things that I was actually battling at the time. Then she started giving me advice in detail...full detail things that I never spoke with anyone about, negative thoughts I was battling, worries I had, and issues I was dealing with that I never told anyone much less this young woman about. It was so specifi it was almost scary. I've also had moments of extreme intuition where something stopped me from doing something only to find out that something bad happened.”

“Altered states of consciousness, medical intuitions, acknowledgment by others that something strange/mystical has happened in my presence....”

“Experiences of heightened or mystical ecstatic awareness. Precognitive dreams. Strong intuitive awareness at times to somewhat telepathic experience.”

“Feelings of Peace when pray. Dream shortly before my husband's unexpected death that a golden angel emerged from him. Actually seeing shortly before husband's death uncanny number of deer in foggy woods during 3 hour trip along highway. Also at husband's death my sister felt presence of large protective wings over him and that night said he heard choral music coming from house.”

“When looking at the stars in the Milky Way, I felt a great sense of awe. I'm an astronomer, so that's my work, but there was something very moving and encouraging in looking up at the sky and feeling a sense of oneness with the universe - seeing and feeling myself to be part of the entirety of the universe, without any judgment on smallness or any sense of importance/humility, only observing the world as it is...”

“After praying intensely I met my present husband. I feel God answered my prayers.”

“Wow, so many. Predicted my son’s car accident. Helped to remove a legendary curse from a location with a shaman. I have always had a heightened sense of emotion. When you hang with witches, this stuff happens all the time. I am descended from one of the witches murdered in Salem...so when I am there, lots of energy is in the air.”

“Feeling of oneness, boundless acceptance.”

“Expanded consciousness, visualizations of spiritual connectedness to the Divine & to Earth/Gaia. Visitation & connection to Angels during deep meditation/hypnosis, visitations from family who

have crossed over, & dynamic powerful changes in health & lifestyle through working with spiritual healing power."

"As a reiki practitioner, I experience monthly visions during meditation regarding my connection to the collective unconscious and the sprites/fairies that watch over me and mine."

"My ex wife who died came to me several times."

Respondents were given a list of common spiritual experiences defined by Christina and Stanislav Grof in their work on spiritual emergencies, and participants were to check all that apply. There were 25 choices to choose from. The most common experiences were a loss, gain, or change of faith, heightened intuition, spiritual awakenings, déjà vu, lucid dreams/out-of-body experiences, existential crises, spiritual emergencies, and psychic experiences. See Table 15 on the next page.

Table 15:

Spiritual/Religious Experience Categories

Response	Frequency	Percent (N=75)
Loss, gain, or change of faith	55	73.3
Heightened intuition	37	49.3
Spiritual Awakening	36	48
Déjà vu	33	44
Lucid Dreams/out-of-body experience	32	42.7
Existential Crisis	26	34.7
Spiritual Emergency	23	30.7
Psychic experience	22	29.3
Mystical Experience	21	28
Visions	20	26.7
Dark night of the soul	19	25.3
Divine experiences	18	24
Knowing the future	17	22.7
Near Death Experience	16	21.3
Past Lives	15	20
Shamanic issues	13	17.3
Unitive Consciousness	13	17.3
Reading minds	12	16
Kundalini	11	14.7
Rebirth/Renewal	10	13.3
Drug Induced Experience	10	13.3
Prana/Chi intensity	6	8
Void experience	5	6.7
Possession	4	5.3
ET/UFO	3	4
Psychokinesis	2	2.7

Respondents described other experiences including: astral projection, seeing auras, having significant emotional effects on others, knowing the divine is present, prophetic dreams and experiences, and accuracy in tarot readings.

Spiritual experiences: Negative emotions. I specified with participants on whether they had felt negative emotions during spiritual experiences; the majority of participants, 40%, stated they had not had a spiritual experience in which they felt negative emotions while 38.7% of participants stated they have had a spiritual/religious experience in which they felt negative emotions; 13.3% were not sure, 4% chose “N/A” suggesting they have never had what they would consider a spiritual/religious experience, and 4% did not answer this question.

Table 16:

Number of Respondents' Spiritual/Religious Experiences with Negative Emotions

Response	Frequency	Percent (N=73)
Yes I have had a spiritual/religious experience in which I felt negative emotions	29	38.7
No I have not had a spiritual/religious experience in which I felt negative emotions	30	40.0
I am not sure	10	13.3
NA	3	4.0
Total	72	96.0
Missing	3	4.0
Total	75	100.0

Participants were asked to describe these experiences in detail, and I identified 12 common themes for negative spiritual/religious experiences as follows: purpose/value was found in the negative experience (47.8%, N=32) the experience was a result of their spiritual/religious life (47.8%), there were strong negative emotions (47.8%), there was discomfort in religious settings or activities (25%), a disturbing sensory perception or parapsychic phenomenon (25%), a

negative effect caused by others and felt by the self (25%), painful memories (15.6%), a crisis or doubt of faith (12.5%), dreams (12.5%), a disturbing thought (12.5%), a disturbing belief (12.5%), and physical discomfort (9.4%). The most common and least common qualitative content of negative spiritual/religious experiences can be seen in Table 17.

Table 17:

Content of Spiritual/Religious Experiences with Negative Emotions

Response	Frequency	Percent (N=32, missing 43)
Strong Negative Emotion	14	47.8
Negative Emotion Considered Result of Spirituality or Practice	14	47.8
Purpose/Value Found in Negative Experience	9	28.1
Negative Effect of Others	8	25
Disturbing Sensory Perception or Parapsychic Phenomenon	8	25
Discomfort in Religious Setting or Activity	8	25
Painful Memory	5	15.6
Crisis or Doubt of Faith	4	12.5
Dream	4	12.5
Disturbing Thought	4	12.5
Disturbing Belief	4	12.5
Physical Discomfort	3	9.4

Some examples of how participants described these experiences are as follows:

> "I have been attacked by spiritual forces on more than one occasion. Also have survived a pretty serious hex."

“Sometimes at Sangha we discuss difficult topics and my negative emotions about the topic show through.”

“I had a drug-induced experience pertaining to content of my religious upbringing in which I experienced negative emotions.”

“Now that I am no longer Roman Catholic, I have felt extremely uncomfortable in Catholic church services--to the point of almost feeling panicky about being there.”

“Part of breaking down the illusions of self and world can put you face to face with your own darkness. Hopelessness, questioning of self worth, anger, depression have also accompanied very spiritual spaces for me. Sometimes the unknown can be terrifying and it brings all of this to the surface.”

“I have felt negative emotions which I believe are appropriate for the situation. The situations were when I felt very convicted of sin in my life and I was grieved in my spirit. But, I confessed it to God and received peace through His forgiveness. I have also felt negative emotions during great suffering, but knew to whom to turn, and found relief eventually.”

“My parents were part of a satanic cult; and the activities they participated in were a perversion of religion.”

“I've had negative emotions come when I went to a religious activity, but wasn't in the spirit, so I felt I was trespassing on the faith of others. One time I felt the presence of God, I suppose, telling me not to go to another town for a weekend with a brother and his family; I ignored it even though the feeling of disobeying God went on for the entire weekend, and later on when I got home eventually I had some traumatic thoughts and emotions afterwards, which have in a sense plagued ever since.”

“I felt I was wrestling with the Devil, who was telling me to kill my Mother.”

"I sometimes have experiences of being 'convicted,' as Quakers say, about a fault, failing, or bad habit of mine. When I was 7 or 8 I went to a church not my own, out of curiosity. During the service a woman began weeping loudly and otherwise displaying very strong emotion. I had no idea why, and found it very upsetting. I fainted or nearly so, and couldn't explain what was wrong with me or why I didn't feel well."

"The profound sense of sadness and regret were certainly not positive emotions, however they were followed by intense joy (which is the part I most remember). "

"I saw something holding my ankles and for a moment I felt fear. I kicked it off. It fled. It looked black."

Spiritual experiences: Positive emotions. When asked whether they had ever felt positive emotions during spiritual/religious experience, a huge majority, 88%, stated they have had a spiritual/religious experience in which they have felt positive emotions; 4% were not sure; 2.7% said they had not had a spiritual/religious experience with positive emotions; 1.3% chose "N/A;" and 4% of respondents did not answer this question.

Table 18:

Number of Respondents' Spiritual/Religious Experiences with Positive Emotions

Response	Frequency	Percent (N=72)
Yes I have had a spiritual/religious experience in which I felt positive emotions	66	88.0
No I have not had a spiritual/religious experience in which I felt positive emotions	2	2.7
I am not sure	3	4.0
NA	1	1.3
Total	72	96.0
Missing	3	4.0
Total	75	100.0

When asked to describe these experiences, I identified 19 common themes: participants noted feelings of well-being using words like peace, bliss, clarity, joy, etc. (75.4%, N=57), their experiences resulted from personal spiritual practice (49.1%), they spoke about relationships with others, nature, or divinity/spiritual world (40.4%), they spoke of confirmations or the creation of faith, which included seeing results, gaining understanding, or receiving answers to spiritual needs or requests (36.8%), they felt a sense of belonging, connection, or purpose (31.6%), they felt a sense of love (28.1%), they described sensory experiences like auditory, visual, or tactile experiences (26.3%), they had experiences through community activities (21.1%), or through helping others/receiving help (17.5%), they felt a sense or emotional, mental, or physical relief/healing (17.5%), and a sense of being cared for or protected (17.5%), they had experiences through reading, hearing, or studying the written word (12.3%), they felt a sense of gratitude, blessings, or luck (especially after dangerous situations) (10.5%), they felt a sense of hope (5.3%), they had experiences through music (7%), they were unable to describe

these experiences or noted too many (5.3%), they spoke about the natural world/the earth (3.5%), one noted significant dreams (1.8%), and one had an experience during pilgrimage (1.8%). The most common and least common qualitative content of positive spiritual/religious experiences can be seen in Table 19.

Table 19:

Content of Spiritual/Religious Experiences with Positive Emotions

Response	Frequency	Percent (N=57, Missing 18)
Feeling of Well-Being	43	75.4
Personal Spiritual Practice	28	49.1
Relationship (with others, nature, or divinity/spiritual world)	23	40.4
Confirmations of Faith	21	36.8
Sense of Belonging, Connection, or Purpose	18	31.6
Sense of Love	16	28.1
Sensory Experiences	15	26.3
Community Activity	12	21.1
Feeling Cared For or Protected	10	17.5
Helping Others / Receiving Help	10	17.5
Emotional, Mental, or Physical Relief/Healing	10	17.5
The Written Word (hearing, studying, listening, or reading)	7	12.3
Sense of Gratitude, Blessings, or Luck	6	10.5
Music	4	7
Unable to Describe/Too Many	3	5.3
Sense of Hope	3	5.3
The Natural World	2	3.5
Dreams	1	1.8
Pilgrimage	1	1.8

Examples of positive experiences include:

> "Experiencing The Holy Spirit inside me gave me a particular feeling I have never experienced before - warm, loving, calm, on fire (for Jesus)."

> "Most of the spiritual experiences I've had have left me feeling optimistic, supported, empowered, and generally at-ease."

> "The first time I connected with an Angel was during deep hypnosis with guided imagery & meditation. The meditation & imagery wasn't intended to specifically connect to Angels & it was not my Will or intention to have the experience or vision that I did but when the Angel appeared, I wept because I was overwhelmed with joy, the beauty of the Angel & the energy that came into me when I saw the Angel."

> "After praying or meditating I always feel more energetic, calm, and unburdened. My depression if I have had one is lifted if I pray a long time."

> "Most of my religious experiences have been positive. I like church, and I love having a relationship with God. I also really like singing in church. Once I came to terms (though lots of reading) with God not hating me because I'm gay, I was good."

> "Most of my religious experiences have been positive emotions, or have had positive, strengthening, uniting results for me, though difficult, or intense/violent to go through. I would say that both my negative and positive experiences have all ultimately led me somewhere I needed to be."

> "When I studied the Baha'i Writings on forgiveness; and learned how to do it; I felt myself becoming lighter and lighter; and for the first time ever, I smiled for no reason and I could honestly say ' I love my life; and am grateful for everything that happened to me.'"

"It is wonderful to be able to 'summon' unusual help for people, or to feel that one has received it oneself; or sometimes it is just a moment of piercing, extraordinary joy."

"At El Escorial, shortly after my sudden recognition that I loved God, a small group of us (Smith Chamber Singers) were up in the organ loft as the church organist showed the instrument to our own organist. Then he let her play it; she started playing Bach, and after a bit she switched to one of the pieces we were singing. By that time we had it memorized and all started singing along. The chapel organist pulled out stop after stop until we were utterly immersed in and pervaded by sound throughout our whole bodies. I felt tears coming and felt embarrassed until I saw that every one of us was weeping. It was a physical and emotional, but definitely also spiritual experience. Sometimes God says very deep and unexpected things to me, especially in Quaker Meeting."

"Finding The Great Spirit was still with me & accessible after years of feeling abandoned was cathartic. And daily prayer-meditation-contact brings a beautiful feeling of peace, calm & connectedness over me."

"I feel like when I prayed to God to save and forgive me I felt a warmth and light flow through my body and knew that he would."

Section II summary. Most participants identified with Christianity (36%) and Buddhism (14%), mentioning specific guiding life principles and a relationship to divinity/the spiritual world when asked to specify their beliefs. The majority of them practiced prayer and meditation, and felt religion and spirituality were very important in their lives. A large majority, 80% of participants, stated they had had a spiritual experience, the most common consisting of strong feelings, usually of wellbeing, combined with a sense of interconnectedness. A majority of participants described sensory-perceptions, such as hearing voices or seeing visions of angels or spirits. When asked to specify experiences, most respondents had experienced a loss, gain, or

change of faith and heightened intuition. When participants had spiritual experiences where they felt negative emotions, participants recognized that this was a natural consequence of spirituality and spiritual practice, often finding meaning and value through these feelings. When participants had positive spiritual experiences, about half related it to consistent spiritual practices. Almost all participants with positive experiences noted profound feelings of wellbeing.

Section III: Client Experiences in Therapy

Client disclosure of belief. Participants were asked to rate their comfort level in talking with a therapist about their religions and spiritual life; 28% were somewhat comfortable discussing this information; 24% were very comfortable; 18.7% were comfortable; 8% were not comfortable at all; and 21.3% of people did not answer this question.

Table 20:

Comfort Disclosing to Therapists

Response	Frequency	Percent (N=59)
I am not comfortable at all	6	8.0
I am somewhat comfortable	21	28.0
I am comfortable	14	18.7
I am very comfortable	18	24.0
Total	59	78.7
Missing	16	21.3
Total	75	100.0

Participants were then asked if they have ever spoke with their therapist about their spiritual/religious beliefs; 52% stated that have shared some beliefs; 21.3% shared all of their beliefs; 8% shared none of them; and 18.7% of people did not answer this question.

Table 21:

Disclosure of Beliefs

Response	Frequency	Percent
Yes, about ALL my beliefs	16	21.3
Yes, about SOME of my beliefs	39	52.0
No, about NONE of my beliefs	6	8.0
Total	61	81.3
Missing	14	18.7
Total	75	100.0

For the qualitative responses of this section, I have not included additional tables due to the longer descriptions. Percentage and sample size are given here in descending order. Participants were asked to describe why they shared their beliefs in the manner they did. The eight common identified themes for those who shared *all* their beliefs included: the client considered spirituality/religion to be highly significant in their life or sense of self (47.6%, N=21), participants shared as a result of connection, attunement, disclosure, and/or trust in dyad (38.1%), to provide therapist with context for client's inner world/motivations (28.6%), to receive feedback (19.5%), sharing was a method of measuring therapist's competence for client (19.5), to build a sincere relationship with their therapist (19%), clients shared as a result of the therapist's initiative or interest (14.3%), and in order to incorporate it directly into treatment/interventions (14.3%).

Fourteen separate themes were identified as to why clients only shared only *some* of their beliefs. The client shared only what was relevant to their identified concerns (51.4%, N=37), clients considered it irrelevant or unnecessary to treatment (27%), they shared as an initial introduction or a brief explanation (27%), they shared as a means to illustrate a point (27%), the

client considers the topic as personal, private, special, or sacred (16.2%), the client did not feel beliefs were respected, acknowledged, or understood by the therapist (16%), the client did not want to "explain" their faith to their therapist (16%), the client had negative experiences with others previously when they shared their beliefs (13.5%), the client considered their beliefs to be unusual (10.8%), the client recognizes there is not enough time to share all beliefs (10.8%), the therapist never initiated a discussion on the topic (8.1%), the client believes their spiritual/religious life to be separate from the psychological realm (8.1%), clients were fearful or wanted to avoid therapist reaction (5.4%), and the client's beliefs were still in development (2.7%).

For participants who shared none of their beliefs I identified six common themes for why they did not share. Clients did not share any of their beliefs because: the client considered them out of the scope of therapy (66.7%, N=6), the therapist never asked or engaged with the topic (33.3%) the client was fearful or wanted to avoid a possible response (33.3%), the client mistrusted the therapist (33.3%), the client was not spiritual or religious at the time of therapy (33.3%), and the client feared that sharing would diminish the value of their faith (16.7%).

Therapist response to beliefs and client satisfaction. For those clients who did share their beliefs with their therapist, they were asked to describe the therapist's response to this information. The 13 identified themes discovered were: the client received what they considered to be an attuned response from their therapist (66.7%, N=54), the subject was referenced later for a therapeutic purpose (53.7%), therapists responded by engaging with the subject, lead by client or therapist, in a beneficial, therapeutic manner that was very satisfying or led to increased insight, healing, or significant positive change (46.7%,), the client perceived a satisfactory,

neutral, or somewhat satisfactory response (44.4%), the therapist disclosed personal beliefs or opinions which were helpful or neutral (31.5%), engagement was minor or lacking (on part of either client or therapist) (27.8%), the therapist incorporated spirituality or spirituality-based interventions in therapy in a helpful or neutral way (25.6%), the client received what they felt was a misattuned response from their therapist (20.4%), the therapist did not integrate the client's spirituality into therapy (16.7%), the therapist did not disclose or discuss personal beliefs and/or opinions (12.9%), the therapist discussed various practices or faith as an important means for psychological coping but did not discuss the client's faith in depth (11.1%), the therapist incorporated spirituality or spirituality-based interventions in therapy in an unhelpful way (3.7%), and the therapist disclosed personal beliefs or opinions that were unhelpful (1.9%).

Clients were then asked to rate their level of satisfaction and explain why they were or were not satisfied. Generally, those who shared with their therapist their beliefs were satisfied; 18.7% of respondents did not answer this question.

Table 22:

Satisfaction with Therapeutic Response to Belief Disclosure

Response	Frequency	Percent (N=61)
I was very satisfied	21	28.0
I was satisfied	17	22.7
I was somewhat satisfied	14	18.7
I was not satisfied at all	4	5.3
I did not share my Beliefs with my therapist	5	6.7
Total	61	81.3
Missing	14	18.7
Total	75	100.0

I identified 15 themes as to why clients were or were not satisfied with their therapist's response: the response from the therapist was satisfactory for the client's identified need at the time (61.5%, N=52), the therapist created a respectful, nonjudgmental space (46.2%), the client perceived the response was highly attuned (42.3%), the satisfaction level was related to level of rapport and trust in dyad (21.2%), the client sometimes desired more (17.1%), less (1.9%), or a different response (23.1%), the therapist was ignorant to the client's faith (17.3%), the therapist was of a different faith (15.4%), the therapist was of a similar faith (13.8%), the therapist was misattuned to their needs (13.5%), the therapist did not engage with the client further on the subject (11.5%), the therapist had in-depth discussions that led to increased healing, insight, or significant positive change (11.5%), the client took responsibility for their level of satisfaction (11.5%), and the therapist integrated spirituality into treatment (3.8%). These themes were described as reasons why clients were satisfied or unsatisfied, thus they have either positive or negative connotations specific to the client.

Client disclosure of experience. Clients were then asked whether they shared their spiritual/religious experiences with their therapists. The majority of individuals, 40%, shared none of their experiences; 32% shared some; 8% shared all; and 1.3% stated they had never had a spiritual/religious experience; 18.7% of participants did not answer this question.

Table 23:

Disclosure of Experiences

Response	Frequency	Percent (N=61)
Yes, about ALL my experiences	6	8.0
Yes about SOME of my experiences	24	32.0
No about NONE of my experiences	30	40.0
I have never had spiritual/religious experiences	1	1.3
Total	61	81.3
Missing	14	18.7
Total	75	100.0

For clients who shared all their experiences, the five common identified themes were that the client considered them therapeutically relevant (33.3%, n=9), the client feels it important to share everything possible with therapist (33.3%), there was good rapport and previous attuned responses in the dyad (33.3%), the client wanted to receive specific feedback from the therapist (22.2%), and the client states their spiritual/religious experiences are a part of their identified faith (22.2%).

Describing their reasons for sharing some of their responses, there were seven common identified themes: the client shared only what was relevant to their identified concerns (57.1%, N=21), the client considered it irrelevant or unnecessary to share them (38.1%), the client feels the topic is too special, private, personal, or sacred (14.3%), the client was afraid of a specific response from the therapist (9.5%), the client felt their experiences were unusual (4.8%), and the dyad consisted of mistrust, was poor, or exhibited misattuned responses previously (4.8%).

For clients who shared none of their experiences, the themes described were similar as above. The client considered it irrelevant or unnecessary (48%, N=25), the dyad consisted of mistrust, was poor, or the therapist had exhibited misattuned responses previously (20%), the therapist never asked or engaged (20%), clients feared a specific therapist reaction (16%, n=25), the client felt the topic is too special, private, personal, or sacred (12%), and the client felt their spiritual/religious life was separate from the psychological realm (12%).

Therapist response to experiences and client satisfaction. Therapist responses to this information varied. I used the same themes found when clients shared their beliefs as I did not determine any additional therapeutic responses. After disclosure the client perceived an attuned response from the therapist (73.3%, N=30), the response by the therapist was considered satisfactory to client's identified needs (23.3%), the topic was discussed, lead by client or therapist, in a beneficial, therapeutic manner that was very satisfying or led to increased insight, healing, or significant positive change (20%), the subject was referenced later for a therapeutic purpose (20%), the client perceived a satisfactory, neutral, or somewhat satisfactory response (13.3%), there was a brief acknowledgement by the therapist in the moment (10%), the client perceived a misattuned response from the therapist (10%), the therapist was ignorant of client's faith (10%), the therapist disclosed personal beliefs or opinions which were helpful or neutral (10%), there was a lack of or minor engagement after disclosure (on part of client or therapist) (6.7%), the therapist did not disclose or discuss personal beliefs and/or opinions (6.7%), the therapist did not integrate client's spirituality into therapy (6.7%), the therapist incorporated spirituality or spirituality-based interventions in therapy in a helpful or neutral way (6.7%), the therapist asked questions (3.3%), the therapist disclosed personal beliefs or opinions that were

unhelpful (0%), the therapist incorporated spirituality or spiritually-based interventions in therapy in an unhelpful way (0%), and the therapist discussed various practices or faith as important means for psychological coping but did not discuss the client's faith in depth (0%).

When asked if they were satisfied with their therapist's response after disclosure of spiritual/religious experiences, the majority of individuals (30.7%) did not speak with their therapist about their spiritual/religious experiences; 22.7% were very satisfied with the therapist's response; 16% were satisfied; 6.7% were somewhat satisfied; 1.3% were not satisfied at all; and 22.7% of participants did not answer this question.

Table 24.

Satisfaction with Therapeutic Response to Experience Disclosure

Response	Frequency	Percent (N=58)
I was very satisfied	17	22.7
I was satisfied	12	16.0
I was somewhat satisfied	5	6.7
I was not satisfied at all	1	1.3
I did not speak with my therapist about spiritual or religious experiences	23	30.7
Total	58	77.3
Missing	17	22.7
Total	75	100.0

The reasons for client satisfaction after sharing their experiences were generally the same themes as previously described when clients share their beliefs: the response from the therapist was satisfactory for the client's identified need at the time (66.7%, N=30), the client perceived the response was highly attuned (66.7%), the therapist created a respectful, nonjudgmental space (36.7%), the satisfaction level was related to level of rapport and trust in dyad (16.7%), the client sometimes desired more from their therapist (16.7%) or a different response (13.3%), the

therapist provided space for repeated discussions that led to increased healing, insight, or significant positive change (13.3%), the therapist integrated spirituality into treatment (13.3%), the therapist was of a different faith (10%), the therapist was misattuned to their needs (10%), the therapist was ignorant to the client's faith (6.7%), the therapist did not engage with the client further on the subject (6.7%), the client took responsibility for their level of satisfaction (6.7%), and the therapist was of a similar faith (3.3%).

Section III summary. Results within client experiences in therapy were more variable than results within the spiritual and religious life of participants. Roughly an even amount of participants were either very comfortable (28%) or only somewhat comfortable (24%) sharing their beliefs with their therapists. Most had shared some beliefs with their therapist, and a small minority shared none. When clients did share all their beliefs, generally it was because they considered their beliefs to be highly significant in their life or in their sense of self. When clients only shared some of their beliefs, it was because they spoke about identified concerns in which beliefs were related. For those who shared none of their beliefs, the majority did not share because they believed it was irrelevant or outside the scope of therapy. When clients shared their beliefs, the majority of clients felt they received an attuned response, and noted therapists referenced it for a therapeutic purpose. Clients described their satisfaction levels, and most clients were satisfied due to a perceived attuned response and stated the therapist created a nonjudgmental, therapeutic space in which to discuss their beliefs.

Interestingly, and unlike when clients shared belief, the majority of participants (40%) disclosed none of their spiritual or religious experiences; 32% shared some. For the small minority who shared all of their experiences (n=9), they did so because of positive rapport, the

client felt they were therapeutically relevant, and clients desired to share everything, or as much as possible, with their therapist. For those who shared only some of their experiences, they shared based on identified therapeutic concerns related to the experience, otherwise they considered them to be irrelevant to the therapeutic purpose. For those who shared none of their experiences, most did not share because they did not consider the information relevant (48%). If coding categories are taken together, a majority did not share because of a poor relationship with their therapist (20%) or because the therapist never inquired (20%).

Therapist response to client disclosure of spiritual or religious experiences was positive. For the clients who shared, the majority reported a response that they believed was highly attuned (73.3%). Clients were generally satisfied because the therapist fulfilled their identified needs in an attuned way.

Section IV: Client Perceptions on Most Helpful/Least Helpful Clinical Care

The final questions of the survey asked clients to share their opinions on what they believed would be the most helpful and least helpful way a therapist can response to clients who disclose information about their spiritual or religious life. Themes for what clients considered to be the most helpful ways to respond to disclosure of spiritual/religious beliefs or experiences were: to create a positive therapeutic space (72.7%, n=55), to utilize and reference material to client's context and identified needs (37.5%), to support and encourage a client's self-determination (34.5%), to look for meaning and purpose within the client's world (21.8%), to gather knowledge and cultural competency for a wide variety of faiths and increase such competence when necessary outside of treatment (16.4%), to re-frame, challenge, or provide clinical interpretations with awareness and sensitivity (9.1%), to clarify and use mutually

understood language (9.1%), to provide referrals and recommendations after self-assessment of clinical competency (7.3%), to provide strong initial and sustained engagement (37.5%), and to recognize and emphasize growth and progress in a client (3.6%).

Themes for what clients considered to be the least helpful ways to respond to spiritual/religious disclosure were: unprofessional judgments (77.8%, n=54), unprofessional manipulations through intervention or interpretation (57.4%), unawareness of countertransference or bias (13%), inappropriate self-disclosure (13%), and clinical narcissism such as focusing on yourself or blatantly ignoring particular content in the client's sharing (14.8%).

Section IV summary. Clients were asked to describe what they considered to be the most and least helpful ways therapists could respond to clients who disclose information about their spiritual or religious life. The majority of participants described that the most helpful thing a therapist could do is create a positive, nonjudgmental and therapeutic space in which the client felt safe to discuss these concerns. Clients stated that any unprofessional judgment, such as bias, inappropriate diagnoses or labels, likely due to countertransference issues or ignorance, would be the least helpful way to respond to spiritual/religious clients in therapy. I concluded the survey with a question asking clients to tell me if anything was missing from this survey study. This information I did not code but I believe it is extremely important to consider; all findings and their implications for Clinical Social Work are discussed in the next Chapter.

Findings Chapter Summary

Participant demographics were not exceptionally diverse; the most diverse demographic sections were participants' religious tradition and geographic location. The majority of

participants had had a spiritual/religious experience at some point in their lives; most described this as a state of wellbeing and connection and many noted coinciding sensory perceptions such as auditory, visual, or tactile sensations. When asked to categorize their experiences, a large majority of participants stated they had experienced a loss, gain, or change of faith.

Most participants were comfortable sharing their religious/spiritual life with their therapist, however a greater number of clients shared their beliefs but kept their experiences private. When they did disclose spiritual/religious information to their therapist, participants were satisfied in the way their therapist had responded to them. When asked why they did not share, usually the respondent did not consider disclosure pertinent to therapy, though a significant number noted a poor therapeutic alliance as well as therapist non-engagement as reasons for why they did not disclose more.

Therapist responses varied greatly, but were generally described as attuned and satisfactory to participants' identified needs; many respondents remarked that engagement with the material in a clinically relevant way was particularly useful. Respondents recommend that the most helpful way a therapist can respond to spiritual/religious content in therapy is to create a nonjudgmental, therapeutic space in order to foster a client's comfort in sharing this information and thus facilitate discussion. Unprofessional judgment, such as bias, inappropriate diagnoses or labels, likely due to countertransference issues or ignorance, that in any way was harmful or infringed on the clients rights to self-determination were determined by participants to be the least helpful way a clinician could respond to spiritual/religious clients.

CHAPTER V

Discussion

This chapter discusses the findings of my study and the implications for clinical social work. It compares results to the Pieper & van Uden study, then discusses the data results as it relates to clinical implications, concluding with limitations and recommendations for future research.

Pieper & van Uden Study

Despite differences in methodology and demographics, my findings are similar to findings found within Joseph Pieper and Marinus van Uden's study on spiritual/religious clients' views of therapeutic care, suggesting there may be common responses in mental health care when treating spiritual/religious clients both across nations and identity; generalizability is not determinable, however, due to the small sample size of my study. Like Pieper & van Uden, the majority of participants in my study have spoken about their spiritual/religious life with their therapists, and the majority of them were satisfied with the therapeutic response. Some participants mentioned a lack of engagement and initiative during intake and later sessions, as well as a lack of training, ignorance, and poor cultural competency on the part of their therapist regarding spiritual/religious needs or concerns. Data also showed trends that suggest participants in my study believe negative emotions can result from spiritual/religious faith but consider these experiences valuable and recognize their faith as significantly supportive to their problems nonetheless; Pieper & van Uden had specified this query as whether or not client faith

exacerbated or supported mental health concerns, but results are comparable. Finally, like Pieper & van Uden, my data shows that clients shared their beliefs only when they considered it necessary or important; roughly half of participants who shared some or none of their beliefs, for example, did not feel it necessary to discuss this area of their lives in therapy and thus did not desire it. The half who desired to discuss it did so or kept the information private nonetheless. It is possible, therefore, that engaging with clients about what it means to share this kind of information in session could help clients feel more comfortable in sharing or not sharing this information during therapy as the work goes on. This may be especially helpful to clients who have the desire to discuss the topic but remain ambivalent.

Discussion and Results

The discussion of results will be categorized into the following sections: spiritual/religious life, spiritual/religious experiences, comfort and rate of disclosure, therapeutic response and client satisfaction, and client opinions on most and least helpful forms of care.

Spiritual and religious life. Demographic data is slightly more varied than previous studies within this field, however data summary shows participants were still overwhelmingly working/middle class, Christian identified, cisgendered white women. The sample is more diverse in religious identification, however; participants identified themselves within 19 separate traditions. Almost all participants identified with more than one religious tradition when given the option, and others defined their faith as something individualized, not related to commonly known traditions or communities. This religious diversity emphasizes the complex nature of spiritual and religious beliefs, and reinforces that fact that clients are unique, multifaceted individuals not easily confined to specific labels or tenets of faith.

When clients were asked to specify their beliefs, a huge majority spoke of their beliefs in terms of a guiding life principle and held a belief in or contemplated the existence of a spiritual nonmaterial divine world and/or personal spiritual figure(s) interacting with them. Some spoke of fate or free will, cycles of reincarnation, a lack of belief in an afterlife, or an all-pervading sense of goodness. Thus spiritual/religious clients live their lives according to worldviews that are intricately connected to nonmaterial senses of truth; many of their thoughts, feelings, actions, and responses will be connected with this part of their lives; much of their coping, in fact, may be dependent on it. A majority of them considered both religion and spirituality to be important or very important in their lives. Clinicians must therefore have an understanding of their clients' particular worldviews appropriately and recognize the substantial meaning found wherein. They must honor the fact that for many people their spirituality/religious is founded on intangible realities, on experience or faith rather than material evidence.

In my study most clients practiced prayer, meditation, reading of scriptural, sacred, or spiritual texts, and participated in religious traditions or holidays. Specific spiritual practices may represent ways that participants can and do put their faith into action, and could serve as important coping mechanisms. Pieper & van Uden mention a lack of concrete initiatives on the part of therapists when working with spiritual/religious clients (Pieper & van Uden, 2005). Having an improved understanding of what spiritual practices clients use consistently, or desire to use more consistently, could be beneficial in providing therapists with guidance in offering catered suggestions and intervention to their clients; open and engaged discussion on this topic may also prevent therapists from offering unhelpful alternatives that may rupture alliance or rapport.

Spiritual/religious experiences. Almost all participants in this study had what they consider to be a spiritual/religious experience. The most common features of these experiences were a sense of interconnection or relationship, strong positive emotions, auditory, tactile, or visual sensory perceptions, and the attainment of a particular result after a spiritual practice, often confirming their faith and devotion. One quarter of participants' qualitative descriptions mentioned pre-cognitive, paranormal or parapsychic content. When asked to categorize their experiences 20% of all respondents affirmed that they have had psychic experiences, visions, knowledge of the future, an ability to read minds, experience with psychokinesis, possession, and ET/UFOs. The most common specified spiritual experiences were a loss, gain, or change of faith and heightened intuition.

I believe this data has huge implications in social work, particularly clinical social work. It suggests that these kinds of experiences, particularly sensory perceptions, are normal for spiritual/religious people, and may not necessarily be related to mental health diagnoses; other research, such as Hay & Socha (2005) or Phillips III et al. (2009), suggest the same. Since most of these experiences are related to positive emotions, interconnection, and feelings of growth, understanding, or healing, clinically supporting these experiences may also support wellbeing, mental health, and therapeutic outcome. Positive spiritual experiences are usually co-related with feelings of relationship and consistent spiritual practice. Relationships and practices can be noted, discussed, and supported in therapy according to the client's context and personality.

When spiritual experiences are negative, which is less common but highly significant, most clients interpret them as natural consequences of their spiritual/religious life and find value in them afterwards, thus providing opportunities for therapists to explore meaning with clients.

Usually negative experiences consisted of the client being affected by others deleteriously, having feelings of discomfort in religious settings, or coincided with paranormal or parapsychic causes, which for some may be due to psychotic episodes. One client succinctly explained the nuances inherent in this issue, writing:

> "Keeping in mind that such experiences can be the beginning of psychosis or drug induced, I think it is important for a therapist to understand that there could be more to life and that the experience can be used to help the client figure out her situation. The therapist should recognize that the experience is likely to be there (whether a creation of her own mind or not) to assist in some way, and that the experience is not disconnected from what the client is going through."

The strong emotional content of these experiences provides evidence for the important meaning these events may have in clients' lives, and thus deserve clinical space for discussion according to client comfort and desire. Meaning making has been shown to have mental health benefits, particularly for clients with trauma history (Calhoun, Cann, Tedeschi, & McMillan, 2000). Providing such discussions safely, with the awareness of power dynamics within the therapeutic dyad and acknowledging the sensitive nature of this topic, is tantamount to successful clinical practice with spiritual/religious clients. Given that most participants have had a loss, gain, or change of faith, asking questions or leading discussions specifically on this topic may allow clients the room to share their stories, provide greater information on their spiritual/religious identity, and allow the dyad an opportunity to increase rapport and solidify a nonjudgmental, supportive therapeutic space. This itself can be of utmost importance, given the positive predictive factor the therapeutic working alliance (Constantine, 2007). Clinicians and

clients can then work together to determine whether further exploration of experiences is necessary or useful.

Client comfort and rate of disclosure. In this study clients were either somewhat comfortable or very comfortable sharing their spiritual/religious life with their therapist, and most had shared their beliefs. When participants shared their beliefs, they did so because they found it highly significant to their lives; they did not share if they did not believe it was relevant to their individual therapeutic needs. Sometimes they shared in order to provide context, explanation, or introduction. When taking data amounts together, almost half did not share beliefs due to deficiencies in relationship or a sense of stigma. Either participants reported negative experiences with their therapist previously or they had negative experiences with others in the past after instances of disclosure. Some clients considered their beliefs to be too unusual to share, and some felt burdened with the task of explaining their belief system to a therapist who lacked the knowledge or understanding to relate to it. A small amount feared a particular therapist response, stating they might be considered “crazy,” while others said their therapists never engaged with them on the topic. Knowing why clients do and do not disclosure aspects of their spiritual/religious life to their therapists is clinically valuable. If therapists understand common reasons for disclosure or lack thereof, they will be able to offer informative, comforting, and empathetic discourse more often and cater their interpretations or interventions appropriately.

Interestingly, while the majority of participants had shared at least some of their beliefs with their therapists, the majority did not share their spiritual experiences. Those who shared did so because the experience was therapeutically significant, they felt it was important to share as

much as possible with their therapist, and they had good rapport with their therapist already. The vast majority of participants did not share because they felt the topic was unnecessary to discuss in therapy. Some noted feelings of deficiency in the therapeutic relationship, fear, or sense of stigma. Highlighting the value of these spiritual/religious experiences, some did not share because the topic was too personal, sacred, or special to them and they did not want it devalued. When comparing percentages between disclosure of beliefs as compared to experiences, participants were slightly more likely to keep their experiences private because of a factor within the therapeutic relationship. Thus while most clients catered disclosure as to whether they considered the topic relevant or irrelevant to their therapeutic needs, many of them highlighted problems within the relationship as reasons for censorship. Discomfort in the relationship may also be indicative of a phenomenon that clients may intuit, which is that if clients mention religion in a certain way it might predispose their clinician to consider that they have a mental illness (Lukoff, Turner, & Lu 1992). Given that poor working alliance is correlated with poorer outcomes (Constantine, 2007) and better alliance with better outcomes, this suggests therapists must establish rapport and trust in their clinical relationships with spiritual/religious clients, checking in and repairing the relationship successfully when alliance is ruptured, while monitoring their own reactions and interpretations upon their clients' disclosure. This can lead to improved satisfaction, outcome, and communication in the dyad.

Therapeutic response and client satisfaction. In general therapists responded in a way that clients were satisfied with, most describing the therapeutic responses after disclosure of both beliefs and experiences to be attuned and satisfactory to identified needs. Therapists who were responding in an attuned manner often engaged the client in discussion in an accepting,

nonjudgmental manner and referenced the subject for a therapeutic purpose. Clients were not always pleased with the level of engagement both in discussion or intervention. Clients rarely if ever desired less engagement, instead they usually desired changes in response or greater engagement.

Some clients mentioned instances when the therapist offered their own disclosure of opinions or personal faith; generally this was perceived positively by clients, but there were some instances when clients felt alienated if the therapist shared negative opinions or shared a different faith than them, especially when they were unable to explicitly relate to the client's faith due to this difference. For example, one client mentioned that she had found answers using tarot cards, and the therapist responded with "you're smarter than that." The participant felt shocked and angry at this response, and understandably became more reticent to share with their therapist. Another client, who identified as a witch, felt it would be impossible to have a Christian therapist, particularly if they held fundamentalist views. She had also worked with therapists who had no understanding of what it meant to be a witch and thus cast spells or participate in rituals that led to auditory or visual sensory perceptions. She wrote, "some are actually so inexperienced that they say things like 'wow' or have this shocked look on their face when I tell them some of the stuff I have done. I thought 'I would have thought you heard a lot of this stuff before…'"

When clients shared their experiences, there was less variability in therapeutic response. This could be due to a smaller sample size for this question than the sample size of those who shared their beliefs. Therapists were more likely to respond in an attuned way, but there were less instances of engagement that led to significant growth or positive change and clients were

less likely to mention that their therapist included spiritual/religious interventions into therapy. These findings may be because of how clients are sharing this information in session, perhaps isolating it by offering it contextually as relevant in the moment but not necessarily in the future. It may also describe difficulties clinicians have in understanding and contextualizing spiritual/religious experiences therapeutically, i.e. not being able to utilize the information concretely in the session in which it was disclosed or in future sessions; it is possible some therapists believe that discussing these experiences could exacerbate psychosis, though multiple studies have shown this to be untrue (Phillips III, et al. 2009). Again, a clear understanding of how therapists respond to the disclosure of spiritual/religious topics, and the way clients interpret these responses generally, could serve clinicians in the future by increasing their knowledge and awareness about how this discourse manifests within the therapeutic dyad, objectively and subjectively. Because spirituality and religion may be correlated with better mental health, this aspect of clients' lives should, at the very least, be supported as empathically as possible (Bonelli & Koenig, 2013).

Client opinions on most and least helpful forms of care. Participants stated that the most helpful thing a therapist can do for a spiritual/religious client is to provide a safe therapeutic space that is first and foremost nonjudgmental and supportive of the client's right to self-determination. Active engagement is also important through intake discussions, questions, hearing and providing explanations, and receiving confirmations of what is helpful for the client in question and how they feel about the discussion as it develops. Clinicians must let the client talk, actively listen, and then use the information appropriately— in a way that preserves the client's dignity, safety, and self-determination while supporting wellbeing and growth. If

clinicians have a lack of experience or knowledge of the subject matter, clinicians must be willing to research and increase their knowledge outside of sessions, as some clients felt burdened to have to explain their beliefs, practices, or experiences.

The majority of participants stated that any kind of judgment, bias, or misuse of clinical power is the least helpful response and is potentially harmful. Clinicians must understand how to provide useful (i.e. healing and supportive) care to clients, and be able to discern and determine what is thus a helpful clinical judgment and what may be based on ignorance, bias, or countertransference. Improved training and education, as well as further empirical and qualitative research in the field of spirituality/religion in mental health, are paramount if we would like to improve the quality of care in social work, as is creating space for continual discourse amongst clinicians about spirituality, religion, mental healthcare, and the meaning of life. It is in this way that clinicians will be able to grasp their own countertransferential realities or competency deficits, and its relationship with the mental health system at large.

Summary: Implications for clinical social work. The results of this study offer future suggestions for improving the quality of care for spiritual/religious clients in therapy with social workers. In general, social workers are offering satisfactory care to spiritual/religious clients in therapy, but roughly a quarter of clients will be less than satisfied and consider their therapist to respond to them in misattuned ways. Social workers can use this study's results as starting points for engagement with clients, particularly by using concrete initiatives. Concrete initiatives could include: increased efforts during intake to discuss spirituality/religion using research-based questions or measurements, like RCOPE (Pargament, Feuille, & Burdzy, 2011); competency in the use of appropriate spiritual/religious interventions (Hefti, 2011); greater self-reflection to

recognize competency, bias, ignorance, or countertransference; efforts to support client safety and comfort in discussing this aspect of their lives; awareness of power differentials; empathic tact in clinical judgment and interpretation; fostering positive rapport and sustaining alliance through active engagement with empathic ruptures; continuous commitment to and knowledge of academic research and clinical praxis; increased relationship between mental health services and spiritual/religious institutions, resources, or referrals; providing a greater variety of resources for all types of faith traditions at inpatient and outpatient centers and working to improve these agencies; asking questions, actively listening, and following through with discussions on the topic; improved education training and continuing education; personal endeavors to increase cultural competency especially when uninformed; recognizing that this aspect of clients' lives is intimate, personal, and often sacred; and, perhaps most importantly, understanding that spiritual/religious experiences may be quite common, are often preternatural, and have the potential to be curative, long-lasting means of wellbeing, support, and connection.

Additionally, I support the conclusions of Pieper & van Uden, repeated here: psychotherapists must discuss amongst themselves questions on religion, worldview, and meaning of life, and create workshops catered to these topics as it pertains to clinical care and mental health; the fields of clergy based counseling and mental health care should continue to build and support a relationship of referral with each other; religious specialist clinicians must be placed at each agency with enough budget to allow; religious/spiritual education must continue and increase for all psychotherapists; empirical and evidence based data must be the basis in treating and understanding the relationship between spiritual/religious coping and mental health, and such data must be continued within agencies, particularly clinician inventories of

experiences regarding interventions in the treatment of religious clients; such individualized care must be nationalized, therefore initiatives for funding need to continue (Pieper & van Uden, 2005).

Client voices. To hear from clients in their own words is a necessity for competent care. What follows is what clients consider as least helpful clinically when working with spiritual/religious clients in therapy:

> "Trying to push or insert their own ideas or conclusions onto their clients. Steering the client in any way, or being unaware of the bias that they bring because of their own beliefs."

> "Insisting that the person use his or her religion to solve all his problems and not rely on modern therapy or meds to help the individual come to terms with his or her healing process or coping mechanism."

> "Trying to dismiss what you are saying as a sign of illness"

> "Ignoring that the experiences were actually real to the person experiencing them and attempting to psychoanalyze why the person may say they had those 'experiences.'"

> "To refuse to hear them, or react with skepticism or disagreement rather than nonjudgmental acceptance that this is what the client believes. I know that I inwardly shudder when a client tells me that a pastor or other religious authority has told them that their MH problems are from the devil, as I suspect most clinicians do, but even then I am careful to assess their own level of belief in such a thing, vs. impose my own views on the subject. Certainly no proselytizing, or other interference meant to provide the client with the "proper" values in the therapist's view."

> "Dismissing them, patronizing them, trying to talk the client out of them (unless they seemed dangerous, in which case it should be done respectfully and delicately)."

"Expressing judgment. Expressing unquestioned biases (which comes up a lot for Muslims because of the media representation of Muslims). Making declarative statements before ascertaining that they are in harmony with the client's own viewpoint. Assuming that all members of a religious group believe or behave in the same way. Ignoring intersections of identity (e.g. an African American Muslim who was part of a Black Muslim community and lived through the civil rights era, a young white woman who just converted, a Pakistani-American lesbian, a transgender Iranian seeking asylum, etc. may all have very different experiences of faith because of the other identities they hold)."

"Never asking about its role in my life and not defining a specific safe space to discuss it."

Here are some descriptions of what they consider to be most helpful clinically:

"Joining with the client, and aiding them in exploring the material - Not giving them the answers."

"Ask how they help and/or hinder my mental health."

"Total non-judgment and acceptance. The beliefs serve a purpose whether they are 'right' or 'wrong.'"

"I needed a therapist who understood the Baha'i Writings; and how to apply them in my situation - this would be very helpful for all members of the Baha'i Faith; as it's the latest guidance, direct from God; a source we can trust. A non-Baha'i therapist is working with outdated models of what it means to be human; and isn't really helpful for those who have accepted the authority of the Baha'i Faith."

"[My] therapist was not religious/spiritual. However, she encouraged me strongly through the few years we worked together to practice the spiritual things that helped me. She did not offer alternatives, such as "Have you tried thus and so?"…She never told me not to pray, read the Bible, or separate from my church friends. She encouraged me strongly. Even though she may not have practiced or believed as I do spiritually, it was a given that this was who I am, and is integral to my therapy. She could not advise me in spiritual matters, but did encourage me to do what helped… She didn't need to completely understand it, just understand that it is important to me, to listen, and care. If a therapist is not

comfortable with my spirituality, she can tell me in a diplomatic and caring way…Better yet, have some referrals."

"They either get it or they don't…I think they need to get out there and have some experiences themselves...Don't say 'wow' or look at the patient with your mouth gaping open in disbelief."

"Validating them as real and offering other experiences that also might be related and valid. Offer insight into why/how they could be a sign or proof of progress in recovery."

"Ideally, a therapist will communicate clearly about his/her knowledge and competency relating to that particular faith, as well as his/her comfort discussing religion. The therapist would seek out cultural competency resources (perhaps requesting recommendations from the client in addition to others) and also explore the client's own experience of his/her religion, including variations over time and family of origin. Ideally, if religion is an important part of the client's life, or important to those the client relates to often (e.g. partner, family of origin, work environment), at least one getting-to-know-you session early on would be spent covering this. Asking questions."

"I would have found it healthy as part of intake to explore how I practice or my level of comfort with certain spiritual terminology."

"Therapists need to be sure they are whole and healthy before trying to impart their knowledge, experience and wisdom unto others. Good therapists must have a broad tolerance and acceptance for different beliefs to be successful with a broad range of clients."

"With a measured concern and respect. With a freeing and friendly demeanor. With love and compassion. With a good background of religious study from all available practices. To determine what value and relationship this practice offers the client. Being ready to state they do not know… utilizing strategies to [anchor the] fragile psyche or to help control…freaks to learn the subtle beauty that is truth in human faith despite [the] reality of our complex society. To help the indoctrinated become individual first. To give a true believer [an] outlet for their obsession that may be more

> productive. To pull the introverted into society in a safe way. To expose the zealot to the damage they can cause in mass hysteria. To create a safe place to maybe contemplate and entertain their ideas against opposition and enhancement to make a person a critical thinker without destruction of the magnificence of our unknown universe about us all, etc...A multifaceted hat to presume to fill for anyone. Mostly a caution to the institution of learning that produced the graduate of psychiatry and psychology... that it too is a kind of religion. Based upon assumptions promoted by powerful men mostly [for] money and fear of shaming if their version of science is not swallowed hook line and sinker. Our society fluxes in a…mass illusion of good/evil and race to truth or… money [and] power... Religion is larger than congregations [with] tax exemption status based upon their acceptability to the power structure of society as a whole. Just a thought... that's all."

Limitations

Major limitations to this study were due to the methodology, particularly the structure of the survey. Giving participants the option to choose more than one response for many of the questions made it impossible to collect isolated independent variables, which are necessary for analyses that determine significant trends or correlates. Thus I can only hypothesize, through qualitative coding, the factors that influence clients' perceptions on the quality of their therapeutic care; I cannot make empirically supported conclusions. The study would have been improved had these more complex empirical analyses been done in addition to descriptive analysis. I believe the study would have also been improved had I received permission to include a greater number of client responses. Many first hand accounts representing the reality of client opinions and subjectivities could not be included in the final paper; this information would have been informative and valuable to readers.

The sample size of this study could have been larger, and the population could have been more demographically variegated. This limitation can be ameliorated in the future by more

rigorous recruitment, particularly through mental health agencies and within spiritual or religious communities. Because I used an online survey tool there were sometimes technical difficulties involved that prevented a small number of participants from completing the survey. The content of the survey could have been improved, perhaps with fewer questions; the large amount of data might suggest that certain data sections of this study could serve as entire research studies alone. For some questions clients stated that they did not understand what was being asked or had already provided relevant responses in previous questions, suggesting that they felt question content was being repeated. Personal bias may be at fault for this fact; questions may have been written in such a way to suggest a hypothesis or to elicit particular information despite efforts to the contrary. I tried to solve this as much as possible before implementing the survey, and therefore I changed the syntax and the order of questions to improve them, thus I requested a change in protocol from the Human Subjects Review at Smith College (see Appendix E: Protocol Change Request and Appendix F: Protocol Change Approval).

Recommendations for Future Research

Client-focused research, particularly empirical research, must be continued with populations of diverse intersectional identities. Providing space for client subjectivity in this research is tantamount to promoting ethically sound research, so as not to collude with voyeurism, oppression, and objectification within academia (Zucker, 2014). The findings of this study suggest that more in-depth analyses of the client-clinician dyad could be useful, particularly with before and after treatment considerations, in incidences of poor fit, and to determine specific trends when client and clinician are of similar or different faiths. Knowing what helps or hinders, and why, in a way that accounts for both context and generalizability, is

valuable for the clinical social work field, and is the beginning of spiritually competent care. This kind of research should be continued as it supports clinicians working within the client's worldview while taking into account macro-considerations (Hodge & Boddie, 2007). These understandings are particularly important when a client's religious identity might be inseparable from ego functioning; Maloney (2006) writes a detailed example of this in her article on best practice methods for working with Baha'i clients.

A greater understanding of clients' diagnoses, and how it might affect their relationship to their spiritual/religious life, and vice versa, may be another avenue of research (Anonymous, personal communication, March 2015). This could be determined by studies on client attitudes or perceptions regarding their spiritual/religious life in relation to their diagnoses and vice versa, studies on the relationship between a client's object relations and their theistic, nontheistic, or atheistic identities, and the role of trauma and memory on clients' spiritual/religious life. Finally, I would recommend more research on the relationship between macrosystems and mental health consumers, such as studying what the role of mental health institutions might be for clients who have spiritual/religious needs or concerns and whether these institutions are efficacious and in what ways. This would improve understanding, from a systems perspective, on what is being provided and what is lacking in these institutions in order to promote best outcomes for clients.

I'd like to conclude this section with the words of the participants as many of them offered additional insight into how this study could have been improved and suggested avenues of further research. In response to the question "is there anything relevant that is not covered in this survey?" participants wrote:

“I think it would be interesting to also examine questions of how identity intersections play a role. LGBTQ identity can be a significant question around religious experience *and* [sic] comfort in therapy, so looking at that together could be very interesting. (I identify as queer and trans.) Another area that could be an interesting one for further study would be the role of in-person vs. online religious community/practice. Among other things, I wonder if there is less discussion of therapy about aspects of life that the client experiences primarily online.”

“…your hypothesis streamlined it to gathering pertinent questions to support a preference. Be aware of this type of motivation as you create your presentation. Let it be open-ended as all things in nature are. Yet I hope it also contains food for thought to make open-minded opportunities to create a more encompassing field more inclusive and less threatening to access. Mostly... I did not see mention of drug use in therapeutic sense being compared/contrasted.”

“When I go inpatient, I have sometimes been offered Christian services. I have never had access to Buddhist services inpatient.”

“Doesn't deal with pastoral counseling by a qualified therapist. I specifically went to such a pastoral counseling center because of my religious background but it was more than ten years ago.”

“Many people with mental illness are well educated, deep, thoughtful thinkers with a ton of creative energy (I am an artist and dancer...) After being treated like a criminal at some facilities (having purse checked for weapons, forced med checks, just an atmosphere of mistrust) [I think] a lot of people who have been diagnosed as mentally ill would have been much better off if they were not stressed out all the time by people who have no diagnosis, but berate and put down the person...I would rather hang out with a few crazy people who are fun and exciting than to take meds to make me normal and like every other totally boring person…Also I have been on every drug out there, they don’t work...staying away from assholes is the best therapy for people who are suffering. I am doing a lot better since getting out of a job in the public school system (being a witch was not a popular thing there, let me

tell you.) and getting away from [certain] friends, co-workers, and family…(It literally changed my life).”

“Perhaps it would be useful for therapists to work within the faith community so that individuals would have a choice that perhaps betters suits their concerns and needs.”

“Suggestion for questions: Have you ever been helped by a spiritual experience with more success than in conventional therapy? Have you ever felt psychological assistance from a spiritual advisor? Do you believe that the psychological mind and the spiritual self are separate? Do you believe if you were psychologically healthy that it would strengthen your faith? Do you believe if you practiced your faith with more rigor, that your psychological health would benefit [sic]? Would you like to talk more about your faith and spirituality with your therapist?”

Conclusion

The dimension of spirituality and religion is a clinically significant factor in a client’s life, and can be relevant within the clinical dyad to varying degrees. For some clients this part of their lives remains separate from the clinical relationship and may not be considered relevant; for others, this part of their lives is a necessity and something they desire to discuss in therapy. This study has provided detailed information on what factors might be relevant within the relationship between a client’s spiritual/religious life and their experiences in therapy after disclosing or not disclosing this part of their lives to their therapist. Some clients take the lead on this process, and are able to tailor their therapy cooperatively in order to suit their needs. Other clients do not feel as comfortable doing so, and may benefit from increased skillful engagement by their therapist on the topic. In order to serve clients best more research in this field is necessary; this study has offered some concrete ways clinicians can begin.

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Appendix A:

Survey Tool

Welcome and Thank You!

To begin the survey you will be asked 3 questions to determine if you fulfill the requirements for participation. If you meet requirements you will be sent to an informed consent page. If you do not meet requirements, I sincerely thank you for your interest!

Screening Questions

***1. Are you 18 years or older?**

○ Yes

○ No

Screening Questions

***2. Are you an Adult with a Legal Guardian?**

○ Yes

○ No

Screening Questions

***3. Have you ever been in therapy with the same *licensed social worker* for at least 6 months within the last ten years?**

○ Yes

○ No

Informed Consent

Consent to Participate in a Research Study
Smith College School for Social Work
Northampton, MA 01063

Title of Study: Client Perceptions on Therapeutic Quality of Care When Disclosing Spiritual/Religious Beliefs or Experiences: A Mixed Methods Study

Investigator(s):
Maia Nikitovich
Smith College School for Social Work
(646) 397-2342

Introduction
· You are being asked to be in a research study regarding the quality of care received in therapy for clients who are spiritual or religious.
· You were selected as a possible participant because you are over the age of 18 and do not have a legal guardian, you identify as spiritual or religious, and you have been in therapy with the same licensed social worker for at least 6 months at any point in time during the last 10 years, 2004-2014.
· We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study
· The purpose of the study is to determine and explore client perceptions of the quality of care they receive in therapy when disclosing spiritual/religious beliefs or experiences, as well as explore what factors contribute to their perceptions of care and disclosure in general
· This study is being conducted as a research requirement for my master's in social work degree (MSW).
· Ultimately, this research may be published or presented at professional conferences Description of the Study Procedures
· If you agree to be in this study, you will be asked to do the following things: you will be asked to fill out a survey of about 25-45 questions, which should take anywhere between 15 minutes to 1 hour, but no longer than 1 hour and a half. Your participation will be required only once.
· The survey consists of 3 sections. In the first section you will be asked questions about your religious/spiritual identity, practices, beliefs, and experiences. In the second section you will be asked questions about your experiences discussing your religious/spiritual life with your therapist, and your opinion on how therapists do or should respond to this information. In the third and final section you will be asked demographic questions about yourself in order to describe participants as accurately as possible in the study.

Risks/Discomforts of Being in this Study
· The study has the following risk: the questions of the survey may remind a person of emotionally distressing memories. There are no other foreseeable risks. If you would like to receive follow-up support for this risk, please see the referral list at the end of this consent form.

Benefits of Being in the Study
· Participants have the possibility to gain insight into important experiences in their lives and the ability to share this information with the larger academic and professional world for the benefit of others in the future.
· Your participation in this study will help aid the field of social work in the following ways: the field of social work will gain a greater knowledge into how best to provide quality care for spiritually/religiously oriented clients. This study can provide similar information for other mental health professionals. This study could improve the quality of education for social workers and clinical social workers.

Confidentiality
· This study is entirely anonymous. We will not be collecting or retaining any identifying information about your identity.

Payments/gift
· You will not receive any payments or gift for participating in this survey.

Right to Refuse or Withdraw

· The decision to participate in this study is entirely up to you. You may refuse to take part in the study without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely, however you must do so before you click the "submit" button. Once you click the "submit" button at the end of the survey, you cannot withdraw, since it will then be impossible to find your information. After you click "submit" your information *will* be part of the thesis, dissertation, or final report.

· The last day to participate in the survey is April 10th, 2015.

Right to Ask Questions and Report Concerns

· You have the right to ask questions about this research study and to have those questions answered by me before, during, or after the research. If you have any further questions about the study, at any time feel free to contact me, Maia Nikitovich, at mnikitovich@smith.edu or by telephone at (646) 397-2342. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Referrals

Should you want to speak with somebody after completing the survey, the following websites provide resources for finding a mental health clinician.

1. http://www.naswdc.org/

· Under the "Resources" Tab, scroll down to "Find A Clinical Social Worker"

2. http://www.apa.org/

· Click on "Find A Psychologist" on the left side of the home-page. Enter your zip code to find a psychologist near you.

3. http://www.helpstartshere.org/find-a-social-worker

· There are several directories listed there to begin your search.

Consent

· Please use the "print" button on your browser to save a copy of this consent for your records.

· By clicking "I agree" you give your consent to be a participant in this study.

Thank you!

Maia Nikitovich
Smith College School for Social Work
mnikitovich@smith.edu
(646) 397-2342

***4. Do you agree to the above terms? By clicking "I agree" you consent that you are willing to answer the questions in this survey.**

- ◯ Yes, I agree
- ◯ No, I do NOT agree

Spiritual/Religious Life of Participants

In this section you will be asked questions about your religious/spiritual identity, practices, beliefs, and experiences.

5. What spiritual/religious tradition do you identify with? Please check all that apply.

- ☐ Judaism
- ☐ Christianity
- ☐ Islam
- ☐ Baha'i Faith
- ☐ Hinduism
- ☐ Taosim
- ☐ Buddhism
- ☐ Sikhism
- ☐ Mormonism
- ☐ Zoroastrianism
- ☐ Jainism
- ☐ Shinto
- ☐ Confucianism
- ☐ Indigenous Traditional Religion
- ☐ Wicca
- ☐ Paganism
- ☐ Celtic
- ☐ Folk Tradition
- ☐ New Age
- ☐ Spiritism
- ☐ Satanism
- ☐ Scientology
- ☐ Interfaith
- ☐ Mystic Tradition

I identify with something different or would like to specify my response (please specify)

6. Please share some of the most important spiritual/religious beliefs you hold. Some examples include: "I believe in heaven or hell," "I believe in reincarnation," or "I do not believe in a personal God." What are some of the most important spiritual/religious beliefs you hold?

7. Do you engage in any of the following? Please check all that apply.

- [ ] Prayer
- [ ] Meditation
- [ ] Yoga
- [ ] Chanting
- [ ] Rosary
- [ ] Reading scriptural, sacred, or spiritual texts
- [ ] Specific diet for spiritual/religious reasons
- [ ] Spiritual/religious group meetings or events
- [ ] Participation in a house of worship
- [ ] Interactions with professional members of religious institutions
- [ ] Interactions with monks or nuns
- [ ] Interactions with religious or spiritual healers
- [ ] Interactions with religious or spiritual teachers
- [ ] Interactions with psychics, mediums, or astrologers
- [ ] Religious holidays or traditions
- [ ] Private devotional worship
- [ ] Service

Other activity or activities (please specify)

8. How important is religion to you?

Very Important	Important	Moderately Important	Of Little Importance	Not At All
○	○	○	○	○

9. How important is spirituality to you?

Very Important	Important	Moderately Important	Of Little Importance	Not At All	There is no difference between Spirituality and Religion
○	○	○	○	○	○

10. Have you ever had a spiritual or religious experience? This could include (but is not limited to) a heightened sense of emotions, personal understanding, visions, miracles, or dreams.

- ○ Yes
- ○ No
- ○ I'm not sure

11. (If you answered "NO" please skip to question 13) If you answered YES, please describe the experience(s) in the text box provided. All answers are confidential.

12. If you are not sure, please describe the experience(s) you are thinking of in the text box provided. All answers are confidential.

13. Have you ever experienced any of the following? Please check all that apply.

- [ ] Kundalini
- [ ] Spiritual Awakening
- [ ] Spiritual Emergency
- [ ] Unitive Consciousness
- [ ] Existential Crisis
- [ ] Near-Death Experience
- [ ] Loss, Gain, or Change of Faith
- [ ] Past Lives
- [ ] Lucid Dreams/Out-of-Body Experiences
- [ ] Divine Experiences
- [ ] Shamanic Issues
- [ ] Channel/Medium Experience
- [ ] Mystical Experience
- [ ] Dark Night of the Soul
- [ ] Visions
- [ ] Heightened Intuition
- [ ] Psychic Experience
- [ ] Knowing the Future
- [ ] Reading Minds
- [ ] Deja Vu
- [ ] Prana/Chi Intensity
- [ ] Void Experience
- [ ] Rebirth/Renewal
- [ ] Chemical or Drug Induced Experience (Entheogenic)
- [ ] ET/UFO

☐ Psychokinesis (using the mind to manipulate physical objects)

☐ Possession

Other (please specify)

14. Have you ever had a spiritual/religious experience in which you felt NEGATIVE emotions, or no?

- ◯ Yes, I have had a spiritual/religious experience in which I felt negative emotions.
- ◯ No, I have NOT had a spiritual/religious experience in which I felt negative emotions.
- ◯ I am not sure
- ◯ N/A

15. If you answered "yes" or "I am not sure" please describe this experience in the text box provided. All answers are confidential.

16. Have you ever had a spiritual/religious experience in which you felt POSITIVE emotions, or no?

- ◯ Yes, I have had a spiritual/religious experience in which I felt positive emotions.
- ◯ No, I have NOT had a spiritual/religious experience in which I felt positive emotions.
- ◯ I'm not sure
- ◯ N/A

17. If you answered "yes" or "I am not sure" please describe this experience in the text box provided. All answers are confidential.

II) Spirituality/Religion in Therapy

In this section you will be asked questions about your thoughts and experiences discussing or not discussing your spiritual/religious life with your therapist.

18. Please rate your level of comfort in talking with a therapist about your religious or spiritual life.

I am not comfortable at all	I am somewhat comfortable	I am comfortable	I am very comfortable
◯	◯	◯	◯

19. Have you ever spoken with your therapist about your spiritual/religious BELIEFS?

- ◯ Yes, about **all** of my beliefs
- ◯ Yes, about **some** of my beliefs
- ◯ No, about **none** of my beliefs.

20. If you answered YES for ALL, why did you share this information? Write N/A if this does not apply for you.

21. If you answered YES for SOME of your beliefs, why did you share some of your beliefs and not others? Write N/A if this does not apply.

22. If you answered NO, why didn't you share this information? Write N/A if this does not apply.

23. We have found that therapists' responses to this information can vary. Please describe how your therapist responded when you shared information about your spiritual/religious BELIEFS. For example, did you both speak about this topic again in later sessions? Did your therapist refer you to an outside service? Did your therapist integrate your religion or spirituality into therapy? Did they discuss their own faith with you? Write N/A if this does not apply.

24. How satisfied were you with your therapist's response?

I was very satisfied	I was satisfied	I was somewhat satisfied	I was not satisfied at all	I did not share my BELIEFS with my therapist.
◯	◯	◯	◯	◯

25. Please explain the reason for your level of satisfaction. If you were satisfied, why were you satisfied? If you were not satisfied, why were you not satisfied? Write N/A if this does not apply.

26. Have you ever spoken with your therapist about any spiritual/religious EXPERIENCES you have had?

- ◯ Yes, about **all** my experiences
- ◯ Yes, about **some** of my experiences
- ◯ No, about **none** of my experiences
- ◯ I have never had spiritual/religious experiences.

27. If you answered YES for ALL, why did you share this information? Write N/A if this does not apply.

28. If you answered YES for SOME, why did you share some of your experiences and not others? Write N/A if this does not apply.

29. If you answered NO, why didn't you share this information? Write N/A if this does not apply.

30. We have found that therapists' responses to this information can vary. Please describe how your therapist responded when you shared information about your spiritual/religious EXPERIENCES. Write N/A if this does not apply to you.

31. How satisfied were you with your therapist's response?

I was very satisfied	I was satisfied	I was somewhat satisfied	I was not satisfied at all	I did not speak to my therapist about spiritual/religious EXPERIENCES.
◯	◯	◯	◯	◯

32. Please explain in the text box provided the reason for your level of satisfaction. If you were satisfied, why were you satisfied? If you were not satisfied, why were you not satisfied? If you did not speak with your therapist about this topic please write N/A.

37. What race(s) and ethnicity (ies) do you identify as? Please check all that apply

- ☐ African (central, east, west, southern African)
- ☐ African-American/Black
- ☐ American Indian/Alaskan Native
- ☐ Caribbean
- ☐ Caucasian/White
- ☐ East Asian (including China, Taiwan, Japan, Korea, and Mongolia)
- ☐ Hispanic/Latino
- ☐ Middle-Eastern/Northern African
- ☐ Native Hawaiian/Pacific Islander
- ☐ South Asian (including Bangladesh, Bhutan, India, Maladives, Nepal, Pakistan, and Sri Lanka)
- ☐ Southeast Asian (including Burma, Thailand, Laos, Cambodia, Vietnam, Indonesia, Malaysia, Singapore, East Timor, Brunei, and the Philippines)
- ☐ I identify differently than the options mentioned here, or I wish to further specify my race/ethnicity (if you wish, please specify)

38. How old are you?

- ○ 18-34
- ○ 35-60
- ○ 60 and above

39. Do you identify as living with a disability of any kind?

- ○ Yes
- ○ No

If yes, please specify (all responses are confidential and anonymous)

40. What is your annual income, generally?

- ○ Less than $10,000
- ○ Between $10,000 and $20,000
- ○ Between $20,000 and $60,000
- ○ Greater than $60,000

41. Have you ever received a mental health diagnosis?

- ◯ Yes
- ◯ No

If yes, please specify (all responses are confidential and anonymous)

42. In what state or U.S. territory do you live?

- ◯ Alabama
- ◯ Alaska
- ◯ American Samoa
- ◯ Arizona
- ◯ Arkansas
- ◯ California
- ◯ Colorado
- ◯ Connecticut
- ◯ Delaware
- ◯ District of Columbia (DC)
- ◯ Florida
- ◯ Georgia
- ◯ Guam
- ◯ Hawaii
- ◯ Idaho
- ◯ Illinois
- ◯ Indiana
- ◯ Iowa
- ◯ Kansas
- ◯ Kentucky
- ◯ Louisiana
- ◯ Maine
- ◯ Maryland
- ◯ Massachusetts
- ◯ Michigan
- ◯ Minnesota
- ◯ Mississippi

- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Northern Marianas Islands
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Puerto Rico
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Virgin Islands
- Washington
- West Virginia
- Wisconsin
- Wyoming

I live outside of the US (please specify)

Appendix B:

Recruitment Flyer

"Do you identify as spiritual or religious?
Have you ever been in therapy with a licensed social worker?
Then this survey is for you!"

My name is Maia and I am a graduate student at the Smith College School for Social Work. This post is a request for participants for my MSW thesis. I am writing my thesis on what clients think about their quality of care in therapy when discussing spiritual/religious topics. For example, is your therapist helpful to you in these matters, why or why not? Do you feel comfortable speaking with your therapist about your spiritual/religious beliefs or experiences? Have you had any negative experiences with your therapist now or in the past?

If you are an adult and you consider yourself to be spiritual or religious, and you have had therapy for at least six months continuously with a licensed social worker at any point during the last ten years (2004-2014), please consider taking part in this survey. This will be an opportunity for you to share your lived experiences and help improve the quality of care for individuals in the mental health system everywhere. All information from this survey will be entirely anonymous.

The data collected from this study will be used to complete my Master's Thesis in Social Work (MSW), and the results of the study may also be used in publications and presentations. I have completed the Collaborative Institutional Training Initiative (CITI) on line training course prior to HSR approval. The certificate of completion is on file at Smith College SSW.

If you choose to participate, but for any reason would like to withdraw your information from the study, please make this choice BEFORE submitting the survey. Because the survey is entirely anonymous, if your answers to the survey are submitted I will be unable to go back and find your information. If submitted it will used as part of the final project.

(survey link here)

To receive pdf copy of the survey before you begin responding (some people prefer to know the questions and plan answers in advance) please email me at mnikitovich@smith.edu and I can send you a copy. The answers must still be filled out online using the link provided.

Thank you!
Maia Nikitovich

Appendix C:

Qualitative Coding Example

Therapist never asked or did not engage	Considered irrelevant, unnecessary, or out of scope of therapy	Fear of therapist response	Mistrust of therapist; possible poor relationship	Client did not have significant spirituality or religion at time of therapy	Fear subject could diminish in value after sharing	Response
1	1	0	0	0	0	I guess it didn't feel totally relevant to my treatment. It was never asked about
1	1	0	0	0	0	It never came up. Sometimes it also feels too heady or intellectual or abstract for therapy.
0	0	1	1	0	1	I felt she would not understand them or consider them "magical thinking". I felt her response would take something away from my experience of faith
0	1	0	0	1	0	I developed more of a spiritual practice years after seeing a therapist; it didn't seem particularly relevant at the time
0	0	1	1	0	0	I am afraid that my beliefs will not be taken seriously by my therapist
0	1	0	0	1	0	Seeing them mostly about gender issues. Spirituality didn't play a big part in my life at that point

0	0	1	1	0	1	I felt she would not understand them or consider them "magical thinking". I felt her response would take something away from my experience of faith
0	1	0	0	1	0	I developed more of a spiritual practice years after seeing a therapist; it didn't seem particularly relevant at the time
0	0	1	1	0	0	I am afraid that my beliefs will not be taken seriously by my therapist
0	1	0	0	1	0	Seeing them mostly about gender issues. Spirituality didn't play a big part in my life at that point
2	4	2	2	2	1	
33.3	66.7	33.3	33.3	33.3	16.7	
		N=6				

Appendix D:

HSR Approval Letter

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950   F (413) 585-7994

February 10, 2015
Maia Nikitovich

Dear Maia,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

Elaine Kersten, Ed.D.   Co-Chair, Human Subjects Review Committee
CC: Krishna Samantrai, Research Advisor

Appendix E:

Protocol Change Request

RESEARCH PROJECT CHANGE OF PROTOCOL FORM – School for Social Work

You are presently the researcher on the following *approved* research project by the Human Subjects Committee (HSR) of Smith College School for Social Work:

Client Perceptions on Therapeutic Quality of Care when Disclosing Spiritual or Religious Beliefs and Experiences: A Mixed Methods Study
Maia Nikitovich
Krishna Samantrai

……………………………………………………………………………………

I am requesting changes to the study protocols, as they were originally approved by the HSR Committee of Smith College School for Social Work. These changes are as follows:

1. Editing syntax and placement of questions on the survey tool

……………………………………………………………………………………

_x___I understand that these proposed changes in protocol will be reviewed by the Committee.
_____I also understand that any proposed changes in protocol being requested in this form cannot be implemented until they have been fully approved by the HSR Committee.
___I have discussed these changes with my Research Advisor and he/she has approved them.

Your signature below indicates that you have read and understood the information provided above.

Signature of Researcher: _Maia Nikitovich____

Name of Researcher (PLEASE PRINT): __Maia Nikitovich______________ Date: 3/12/15___________

PLEASE RETURN THIS SIGNED & COMPLETED FORM TO Laura Wyman at LWyman@smith.edu or to Lilly Hall Room 115.

****Include your Research Advisor/Doctoral Committee Chair in the 'cc'. Once the Advisor/Chair writes acknowledging and approving this change, the Committee review will be initiated.*

……………………………………………………………………………………

Updated: 9/25/13

Appendix F:

Protocol Change Approval

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 12, 2015

Maia Nikitovich

Dear Maia,

I have reviewed your amendment and it looks fine. This amendment to your study is therefore approved. Thank you and best of luck with your project.

Sincerely,

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Krishna Samantrai, Research Advisor

Appendix G:

Informed Consent

Consent to Participate in a Research Study
Smith College School for Social Work ● Northampton, MA

………………………………………………………………………………….

Title of Study: *Client Perceptions on Therapeutic Quality of Care When Disclosing Spiritual/Religious Beliefs or Experiences: A Mixed Methods Study*

Investigator(s): Maia Nikitovich

Smith College School for Social Work

………………………………………………………………………………….

Introduction

- You are being asked to be in a research study regarding the quality of care received in therapy for clients who are spiritual or religious.
- You were selected as a possible participant because you are over the age of 18 and do not have a legal guardian, you identify as spiritual or religious, and you have been in therapy with the same licensed social worker for at least 6 months at any point in time during the last 10 years, 2004-2014.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to determine and explore client perceptions of the quality of care they receive in therapy when disclosing spiritual/religious beliefs or experiences, as well as explore what factors contribute to their perceptions of care and disclosure in general
- This study is being conducted as a research requirement for *my master's in social work degree (MSW)*.
- Ultimately, this research may be published or presented at professional conferences

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: you will be asked to fill out a survey of about 21 questions, which should take anywhere between 15 minutes to 1 hour, but no longer than 1 hour and a half. Your participation will be required only once.
- The survey consists of 3 sections. In the first section you will be asked questions about your religious/spiritual identity, practices, beliefs, and experiences. In the second section you will be asked questions about your experiences discussing your religious/spiritual life with your therapist, and your opinion on how therapists do or should respond to this information. In the third and final section you will be asked demographic questions about yourself in order to describe participants as accurately as possible in the study.

Risks/Discomforts of Being in this Study

- The study has the following risk: the questions of the survey may remind a person of emotionally distressing memories. There are no other foreseeable risks. If you would like to receive follow-up support for this risk, please see the referral list at the end of this consent form.

Benefits of Being in the Study

- Participants have the possibility to gain insight into important experiences in their lives and the ability to share this information with the larger academic and professional world for the benefit of others in the future.
- Your participation in this study will help aid the field of social work in the following ways: the field of social work will gain a greater knowledge into how best to provide quality care for spiritually/religiously oriented clients. This study can provide similar information for other mental health professionals. This study could improve the quality of education for social workers and clinical social workers.

Confidentiality

- This study is entirely anonymous. We will not be collecting or retaining any identifying information about your identity.

Payments/gift

- You will not receive any payments or gift for participating in this survey.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely, however you **must do so before** you click the "submit" button. Once you click the "submit" button at the end of the survey, you cannot withdraw, since it will then be impossible to find your information as the survey is anonymoous. After you click "submit" your information **will** be part of the thesis, dissertation, or final report.
- The last day to participate in the survey is April 10th, 2015.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during, or after the research. If you have any further questions about the study, at any time feel free to contact me, Maia Nikitovich, at *mnikitovich*@smith.edu. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Referrals

Should you want to speak with somebody after completing the survey, the following websites provide resources for finding a mental health clinician.

1. http://www.naswdc.org/
    - Under the "Resources" Tab, scroll down to "Find A Clinical Social Worker"

2. http://www.apa.org/
    - Click on "Find A Psychologist" on the left side of the home-page. Enter your zip code to find a psychologist near you.

3. http://www.helpstartshere.org/find-a-social-worker
    - There are several directories listed there to begin your search.

Consent

- Please use the "print" button on your browser to save a copy of this consent for your records.
- By clicking "I agree" you give your consent to be a participant in this study.

[ ] I agree and provide my consent to participate in this research study.
[ ] I do NOT agree, and do not consent to participate in this research study

Thank you!
Maia Nikitovich
Smith College School for Social Work
mnikitovich@smith.edu