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Lauren Raymond
What's Faith Got to Do with It?
Clinicians' Experiences of Addressing
Issues of Religion and Spirituality in
Therapy

ABSTRACT

This exploratory, mixed-methods study was conducted to investigate the experiences of clinicians who have both been in personal therapy and practice with clients, to consider the nature of addressing issues pertaining to religion and spirituality, both in the role of client and as clinician. The study sought to explore whether there was any evident correlation between clinicians' experiences in therapy or one's personal spiritual affiliation, or lack thereof, and if and how they approached the discussion of these topics with clients.

The research was carried out via an online survey that was distributed to practicing clinicians via direct as well as NASW list serve appeals. Participants were eligible for this study if they were clinicians, holding at least provisional licensure and a master's or higher degree in social work, psychology, or a related therapeutic discipline, and 60 of the respondents proved eligible. The survey asked participants to answer an array of quantitative and qualitative questions that initially focused on their experiences as clients in their own therapy and then followed with inquiry on their experiences as therapists working with clients.

Findings suggest that the more respondents consider themselves to be spiritual, the more spirituality was discussed, both in their personal therapies and in their work as therapists, with the reverse is also being true--- the less spiritual respondents perceive themselves to be, the less apt they are to discuss these matters. Religiosity, however, and the value individuals place upon their own faith increased the likelihood that participants would discuss these matters in their own therapy, but not in their work with clients. Additionally, findings indicate that those who had a positive experience addressing religious and spiritual issue with their own therapists were apt to

carry on these conversations with clients, intentionally incorporating techniques modeled by their personal therapists. Most notable, and perhaps worrisome, is the discrepancy between the high importance therapists attribute to religion and spirituality in therapy and the limited frequency and depth with which these issues are being addressed. Though participants stated that they felt comfortable having these discussions, many seemed to be inhibited by a perceived difference of beliefs between client and therapist. Since religion and spirituality can be a significant component of personal identity and how one shapes one's worldview, building therapist competence in addressing these areas, in spite of difference, is vital to effective and ethical social work practice.

**WHAT'S FAITH GOT TO DO WITH IT?
AN EXPLORATORY MIXED-METHODS STUDY INVESTIGATING EXPERIENCES
OF CLINICIANS ADDRESSING SPIRITUAL ISSUES IN THERAPY**

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

Lauren Raymond
2015

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ACKNOWLEDGMENTS

This thesis could not have been accomplished without the input from all of those who participated in the survey and the individuals and agencies who distributed it. I would also like to thank my thesis adviser, Dr. Gael McCarthy, for her relentless patience and encouragement, even when the process was painful for both of us.

Additionally I would like to dedicate this thesis to my grandfather, George C. West: he was an inspiration for me throughout graduate school; though, sorrowfully, he passed away before seeing its completion. Despite not graduating from high school himself, he was a strong advocate in the education of each of his grandchildren and supported us emotionally and financially throughout all of our schooling.

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CHAPTER I

Introduction

This study was conducted to explore the personal experiences of clinicians to investigate if and how spiritual issues are viewed and approached in therapy. For many people, religion and spirituality are integral to identity. Faith can shape one's worldview, guide meaning making, and provide hope. Yet, historically, there has been a divide between religion and social work and a discrepancy in incorporating conversations of these matters into therapy. However, if providing hope and assisting in meaning making is part of the role of the therapist, then isn't it in the best interest of clients to meet them where they're at and explore the ways they are already finding support, even if this may be through religion and spirituality? It seems it would be a disservice to clients to ignore these topics. For the purposes of this study, unless otherwise noted, the words *religion* and *spirituality* will be used interchangeably. Nevertheless, it is widely recognized that there is a distinction and therefore if the words are intended to be used for a specific purpose, they will adopt the following operational definitions from Griffith & Griffith (2002). *Religion* "represents a cultural codification of important spiritual metaphors, narratives, beliefs, rituals, social practices, and forms of community among a particular people that provides methods for attaining spirituality" while *spirituality* is "a commitment to choose, as the primary context for understanding and acting, one's relatedness with all that is" (p. 15&17).

In a country where over 83% of the population claims a religious affiliation, it seems that addressing issues of religion and spirituality in therapy is vital (Pew Forum, 2008). And yet with such a large portion of the general population claiming a spiritual

practice and 85% of those surveyed describing religion as fairly or very important, only 52% of psychologists rated it as such (Delaney, Miller, & Bisono, 2013). Delaney et al., go on to explore the numerous studies that point to American psychotherapists as considerably less religious in terms of their beliefs, values, affiliations, and church attendance than their clients. This then raises concern as to whether therapists' unfamiliarity and lack of emphasis on religion may have a negative impact on the outcome of psychotherapy, especially when working with a spiritually affiliated client. And, are these clinicians, if they do not personally view religion and spirituality as significant, prepared to discuss these matters with their patients? Sheridan's study (1992) indicates that many clinicians do fail to effectively address issues of religion and spirituality in therapy. Additionally Sheridan's study points out the paucity of literature that focuses on spirituality in social work. Holloway (2007) and Canda, Nakashima, and Furman (2004), postulate that this omission—both in therapy and in literature-- is due to a lack of training and competency for individual clinicians, a fear of crossing ethical boundaries, and uncertainty in defining the line between therapy and ministry. Yet these studies each indicate a need for more in-depth research with clarification from clients and clinicians on what promotes and inhibits conversations of this nature.

With regard to what promotes these discussions, recent studies have indicated that there is a distinct correlation between therapists' personal religion and spirituality and a favorable integration of these topics with clients in therapy (Cummings, Ivan, Carson, Stanley, & Pargament, 2014). Likewise, therapists with a personal faith felt increased confidence in addressing these matters with clients. Therefore, this study seeks to explore the specific influence that one's personal experience with religion and spirituality

has on how these issues are addressed with clients. Additionally it sets out to investigate an aspect that previous studies have not considered-- what impact one's experience of incorporating religious and spiritual elements into one's own personal therapy may have on one's attitude towards integrating these elements with clients?

While studies have been done in the past to explore clients' perceptions of openness in discussing issues of spirituality (Mayers, 2007) and others have investigated the impact of the therapist's own spirituality on the work (Adams, 2011), little research has been done in comparing the experiences of those who have been both clients and clinicians and how this dual role impacts their work. It is because of this dual matrix that the clinicians recruited for this study were required to both have been in their own therapy and worked with clients. Additionally, this study recruited a wide range of participants, including those who align with a particular spiritual practice and those who do not, in order to compare their comfort levels and approaches in addressing these issues, both with their respective clients and in their experiences with their own therapists. As previously noted, this study sought to explore whether one's personal views on spirituality as well as one's experience in discussing spirituality with a therapist will have any correlation with one's tendency to address these issues with patients of one's own, how such topics are navigated by those who do and those who do not espouse a religious/spiritual orientation, and what the participants report about the impacts of these various perspectives and discussions on the clinical outcomes they are familiar with.

In order to explore and identify these relationships, participants completed a survey inquiring first about their experiences in therapy and secondly, using parallel

questioning, about their experiences working with clients. As this was a mixed methods study, the survey contained a combination of quantitative and qualitative questions in order to derive the most accurate and through depiction of their experiences.

Additionally, each question provided space for comments and it is through the added narrative information that participants were able to offer more detail about their experiences both as clients and as therapists.

The hope is that this study, as it explores elements that have not yet been considered regarding spirituality and social work, will provide a more nuanced perspective for those who wish to offer culturally competent and sensitive practice to clients. It seeks to address questions and incite self-reflection pertaining to therapists who are affiliated with a particular spiritual practice – or with none -- to work with a patient who is deeply religious. The hope is that considering these topics will contribute to greater therapist self-awareness, as well as to the above-mentioned culturally competent, sensitive practice.

CHAPTER II

Literature Review

Historically there has been a divide between social work and spirituality, in spite of the relevance and importance these matters bear on the lives of many individuals. It is significant to note, however, that in the past two decades, there has been a move towards greater emphasis on religion and spirituality and its value in therapy. Mayers et al., state, “spirituality is a human need, it is too important to be misunderstood, avoided, or viewed as regressive, neurotic, or pathological in nature (2007, p. 181). Gilligan and Furness (2006) also conclude that clinicians need to place a greater emphasis on religious and spiritual issues, as culturally sensitive service depends on an understanding of faith in the lives of clients for whom religion is central. According to the literature, clinicians themselves are also beginning to see greater value in addressing religion and spirituality, both in their own lives and incorporating these elements into therapy. The percentage of psychologists who identify with a religious practice has risen from 70% 1990 to 84% in 2003; and similarly, even if psychologists do not have a personal religious or spiritual belief, 82% of psychologists state that “being religious is beneficial to mental health” (Delaney et al., 2013). The majority of the literature for this research project will focus on studies that have surveyed clinicians and clients on their perception of religious and spiritual issues in order to guide the focus of this project specifically to clinicians who have been both the therapist and the client to compare their experiences of discussing religious and spirituality issues in therapy.

Cummings, Ivan, Carson, Stanley, and Pargament (2014) conducted a systematic review of studies that examined the relationship between psychotherapists’ religion and

spirituality and any of the following: therapy attitudes and behaviors, the therapeutic relationship, and treatment outcomes. Their overall finding was that therapists' personal religion and spirituality positively correlate with "favorably integrating religion and spirituality into therapy and confidence in one's ability to do so" (Cummings et al., 2014, p. 116). This idea will be further explored through this study in hopes of identifying additional correlations with therapy outcomes. However, themes identified by this review did not indicate that *similarity* of beliefs was correlated to the therapeutic relationship or treatment outcomes; the emphasis was more on adhering to a spiritual practice in general---which should provide greater freedom and ease for clinicians if they do not have to be aligned with the particular practice of their clients. Those therapists who rated themselves as less religious or spiritual were more inclined to overlook these elements in the work with clients by avoiding them altogether or diminishing the value and priority given to these issues. In recognizing that clinicians' personal system of beliefs, or lack thereof, affect how they handle religious and spiritual matters, then, as Cummings et al. (2014), emphasize, "we need to know *how*" (p.117).

If individuals hold strongly to spiritual beliefs, it is likely that this shapes their world view and affects meaning making. One's religion and spirituality can be a resource and an effective way of coping with difficult circumstances. Also, Sermabeikian (1994) builds on Jungian theory to argue that spiritual and transcendental values can aid the therapeutic process by helping people to resolve painful issues, enabling them to recover, heal, and grow (p. 181). Therefore, it would seem vital to bring this aspect of identity into the therapy room, especially if the role of therapists is to help guide personal discovery and meaning-making. Walker, Gorsuch, and Tan (2004) carried

out a meta-analysis to explore therapists' integration of incorporating religion and spirituality into counseling. They noted that addressing these issues is indeed an issue of cultural competence, similar to exploring the dynamics of more general multicultural counseling attitudes and therefore is important for therapists to cultivate this element of multicultural competency. To this point, studies have shown that clients generally find discussing religion and spirituality in therapy as appropriate and have a desire to do so (Rose, Westfield, & Ansley, 2001; Mayers et al., 2007). Therefore it seems necessary for clinicians feel competent and comfortable in integrating these elements.

Walker et al. (2004) explore previous literature that expounds upon explicit integration versus implicit incorporation versus interpersonal integration of these matters. Explicit would be an overt approach such as actually praying with a client, referring to religious services, or reading spiritual texts; whereas implicit integration is more covert where therapists use their own spiritual beliefs to shape their therapeutic values and approaches. Lastly interpersonal integration would look like a therapist using their personal spiritual experiences in therapy, such as praying for a client during a counseling session. Birnbaum and Birnbaum (2008) emphasize the explicit integration mentioned above, directly through the focus of mindfulness. They have shown that mindfulness practices can be especially beneficial for clients in helping with acceptance, being in the moment, letting go, and maintaining a non-judgmental attitude. While they focus on mindfulness as primary spiritual integration, they note "Accepting the possibility of such a metaphysical reality invites social workers to remain open to diverse non-rational experiences in their clients and in themselves" (p.88). This is both encouragement and admonition for the therapist to delve into spiritual matters as presented by clients and to

allow themselves to be open to experiences that they may have otherwise missed or denied the client. Many other therapists, especially those with a personal spiritual affiliation, but not working in a pastoral counseling setting, feel more comfortable with incorporating their faith in a way that is personal to them, whether implicitly or interpersonally. However, is the client reaping the full benefit of exploring spiritual issues if they are not directly addressed?

Throughout the literature it is reiterated that in both the medical and mental health fields, lack of formal training on addressing issues of religion and spirituality with clients is considered to be one of the most significant impediments to having these conversations. Studies have shown that patients are open to this kind of inquiry and yet the prevalence of these conversations, even when they would be beneficial for the client, is very low (Walker, D.F., Gorsuch, R.L., & Tan, S., 2004). Walker et al. additionally conduct a study that concludes physicians who self-identify as spiritual and/or religious are more apt to address clients' spiritual and religious needs and likewise tend to have a positive attitude toward the role these issues have in healthcare. The present study hypothesizes that similar findings will be established when surveying mental health workers as discovered in assessing medical professionals' thoughts on these matters. Yet even if one has a strong personal spiritual belief, the dearth of training or guidance can prove detrimental for the therapist as he or she may overstep ethical boundaries by not knowing how to separate personal beliefs from effective therapy. Likewise, for the therapist who does not affiliate spiritually, he or she may have difficulty recognizing and addressing these issues with a client for whom they are important. Therefore, if religion

and spirituality is a foundation for certain clients, it is remiss on the part of the therapist to not consider such a central aspect of the clients' identities.

CHAPTER III

Methodology

This exploratory, mixed methods study was designed to discover more about therapists' personal experiences of integration of religious and spiritual matters into therapy. The investigation sought to explore whether there is any correlation between the personal value an individual therapist places on these issues and if and how the issues are addressed with clients, as well as whether the experiences therapists have had in discussing religious and spiritual matters in their own therapy affects raising these topics with clients. Though past studies have examined a single component of this matrix, they have not considered the therapist both as client and as clinician; and so further investigation of this matter could increase cultural competency and guide clinicians in future practice.

Past quantitative studies that have investigated spirituality and therapy indicate the need for further in-depth questioning of participants and more qualitative responses where the clinician is able to share his or her own encounters in handling issues of religion and spirituality (Gilligan & Furness, 2006; Canda et al., 2004). Therefore, this study was chosen to be exploratory in nature in order to carry out more inductive research where participants had opportunity to share personal experience, thus providing a richer understanding of individual views regarding integrating spirituality and therapy. Since this study relies on subjectivity, a mixed-methods approach was chosen in order to draw from a larger population while still eliciting personal, qualitative responses. Quantitative survey questions, which in this study primarily rely on participants ranking their opinions using a Likert scale, as well as purely qualitative questions that ask clinicians to share

personal and case examples, provided space to explore perspectives on spirituality as directly experienced by the participants, versus aligning responses specifically to categories prescribed by the researcher (Engle & Schutt, 2013).

The goal of this study was not to support an already derived hypothesis, but rather to delve deeper into a wide range of clinicians' anecdotes regarding their own views of spirituality and the impact their views and experiences may have had on integrating these topics into practice. In doing so, the hope was to draw correlations based upon these findings in order to develop an expanded notion of what may provide for future explanation (Engle & Schutt, 2013). Ideally this will assist therapists, regardless of personal spiritual alignment, in considering the impact that discussing or not discussing these issues may have on their clients.

Sample

Participants were eligible for this study if they were clinicians, holding at least provisional licensure and a master's or higher degree in social work, psychology, or a related therapeutic discipline. (This includes, though is not limited to, psychologists, social workers, and licensed clinical professional counselors). The second criterion for eligibility was that these clinicians must have had experience both in engaging in their own personal therapy as well as in working with individual clients. Clinicians needed not be in therapy presently, though they must have undergone their own therapy at some time. This survey was open to both those who identified with a particular religious or spiritual affiliation as well as those who did not, with the hope that both groups would be represented in order to draw comparisons between the two. Likewise, this survey sought

to recruit those who have addressed religious and spiritual issues in therapy alongside those who have not.

In order to reach a large pool of clinicians who adhered to varying spiritual beliefs and who have both been in practice and in personal therapy, this study relied on availability sampling to explore new questions and attempt to attain a sense of prevailing attitudes towards incorporating spirituality into therapy (Engle & Schutt, 2013).

Availability sampling also allowed for and encouraged greater diversity in the population, not only with regard to religion, but also varying theoretical orientations, age, race, ethnicity, gender, sexual orientation, socioeconomic class, and ability. In order to reach the minimum number of participants, the study relied on snowball sampling in addition to availability sampling so that those who participated were able to then share the survey with others whom they knew to be eligible.

As part of initial recruitment, I sought out licensed clinicians, asking them to forward the study description and survey link to colleagues whom they thought might be interested, willing, and eligible to participate. In addition, I contacted 27 state NASW chapters asking for permission to distribute the survey. Two states assisted in this via emailing the survey and study description to all of their members. Others posted on their state websites or allowed me to post directly on state chapter Facebook pages. Still other, numerous chapters offered the purchase of mailing address labels to share the study via post, but I did not pursue this option as it didn't seem conducive to an online survey. In addition, many states declared that they were prohibited from sharing the survey in anyway. Although only two states were open to sharing the survey, the greatest number of responses came from this approach.

Ethics and Safeguards

This study was approved by the Smith College Human Subjects Review Committee (See Appendix A). No vulnerable populations were targeted in this study as it sought responses from clinicians; in that vein, it was expected that clinicians have access to necessary resources should any element of the survey cause distress. Participants were provided informed consent prior to beginning the survey. In order to protect participants' confidentiality, the survey was completely anonymous and I as the researcher had no direct contact with any of the participants. These surveys were electronically managed through SurveyMonkey and both quantitative and qualitative information thus collected will be stored in a secure physical location or a password protected computer file for three years according to federal regulations for research involving human subjects. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. Data may be used in future publications and possibly secondary analyses beyond the thesis; however, if so, anonymity will still be maintained in the secure manner just described.

There were no foreseen risks to the participants, short of any distress that may have been caused by recalling how particular issues of religion and spirituality were or were not handled, both in personal therapy and in their own practice--- for which it is assumed these licensed clinicians would be able to obtain adequate support. There was no financial compensation provided for this study; yet it has the potential benefit, both for the participant and the field as a whole, to encourage self-examination, as well as greater training for clinicians regarding addressing issues of spirituality in therapy. From engaging in the study, participants may gain a reflection of their own experiences in

incorporating these elements and a consideration of how their personal stance may affect their ability and willingness to address religion and spirituality with clients in order to guide future practice.

Data Collection

This study was conducted using a survey instrument created via SurveyMonkey (See Appendix B for a copy of the eligibility screening questions and Informed Consent content, and Appendix D for the complete survey). The survey contained 29 questions in total. The first half of the survey focused on the participants' experiences as *clients* in their own personal therapy and sought to explore whether or not issues of religion and spirituality were raised as well as the ease, comfort, and benefit---or lack thereof---of discussing these topics. There were 16 questions in this section: five of which were qualitative and 11 were multiple choice or ratings on a Likert scale. The second half of the survey focused on the participants' experiences as *therapists* and inquired about the experience of discussing issues of religion and spirituality with clients in order to discover whether or not these topics are brought up and, if they are, how they are initiated and what the reported nature and impact of the conversations are. Here there were 13 parallel questions where the clinician responded from the perspective of therapist---- four of these were qualitative. In addition to the qualitative responses, each of the quantitative questions also included a textbox for participants to elaborate on their Likert scale rating as they saw fit. Following this were four questions where participants could indicate whether or not they have a personal religious or spiritual affiliation. Additionally, the survey contained simple questions pertaining to demographics which had no bearing on

how the data are analyzed, but which may illuminate correlations between aspects of respondents' personal characteristics and patterns in the responses they gave.

Data Analysis

As this survey contained both qualitative and quantitative responses, each was analyzed separately and parallel themes were examined. The advantage of using a mixed-methods approach for this study allowed a larger data pool, both objective and subjective measures, drawing personal meaning as well as that which is more quantifiable, and making distinctions as well as describing things as they are (Engle & Schutt, 2013). The qualitative components were analyzed using open coding to determine similar and diverse recurrent themes in the responses. The goal in analyzing these qualitative data was to move beyond seeing participants' responses as just numbers and instead focus on their in-depth, lived personal experiences in order to illuminate patterns pertaining to incorporating spirituality into therapy. Since this is inductive research, I created categories within the data in order to discern relationships, specifically between therapists' own spiritual affiliations or non-affiliations and their likelihood of addressing spiritual issues, either in personal therapy or work with their clients, as well as whether their experiences of discussing these topics with their own therapists seemed to have affected their probability and process of having similar conversations with clients. In analyzing the qualitative responses, therapists' experiences as client were compared against their experiences in the role of therapist to identify common themes and direct correlations. This thematic analysis was applied to both the open-ended questions and the provided comment boxes following each Likert scale question. These were manually

coded and analyzed in the findings chapter, with pertinent data entered into separate table texts.

A similar process of organizing data into readable tables was conducted with the quantitative data and since the Likert scale questions used the same rating scale, the responses on parallel questions were directly compared to explore similarities and differences between the respondents' experiences as client and as therapist. Using SurveyMonkey and Excel, frequencies were drawn from the data and compiled into table form in order to create a side-by-side contrast between the two experiences.

Thirdly, inferential statistics were used to seek out correlations between demographic information, including how respondents viewed their own faith and spirituality, and the questions pertaining to frequency and comfort level on how these issues were addressed in therapy. Due to the size of the sample, I was unable to run parametric tests, but was able to conduct non-parametric tests using Spearman's rho to examine these relationships. In addition, paired t-tests were run to explore differences in respondents' answers to parallel questions pertaining to their experience in personal therapy as opposed to that in work with clients. These paired questions were answered both from the point of the view of the therapist and the client regarding the following: the extent discussion of religion or spirituality entered therapy, the comfort level discussing these matters, and personal opinion on incorporating discussion of religion and spirituality. Marjorie Postal, Smith's statistical consultant, provided the analysis support for these statistics. Strengths and limitations of the methods used in this thesis project will be discussed further in the final chapter of this report, Chapter V: DISCUSSION.

CHAPTER IV:

Findings

This study investigated attitudes of therapists, both as client and clinician, towards the role of religion and spirituality in therapy. Clinicians were surveyed using a mixed methods research design that combined ratings on a Likert scale with qualitative responses in order to develop an in-depth representation of the experiences these clinicians have had with regard to discussing spiritual matters, both with their clients and with their own therapists. Seventy participants opened this survey; however, approximately half of these respondents followed the allowance provided in the Informed Consent and skipped whichever questions they did not wish to answer. Since the decline in responses occurred early on in the survey, it is likely that some respondents opened the survey in error or realized that it was something they were either not interested in or not eligible to participate in. The decline in responses may have also been attributed to discomfort with a particular question or the sheer number of questions as well as their repetitive nature. This will be further examined in the discussion chapter.

Demographics of Participant Sample

Seventy people accessed this survey, though when faced with the screening questions, six were ineligible based on lack of academic degree and four denied being in personal therapy. These screening questions eliminated 10 respondents in total, leaving a total N of 60 to continue with the survey. Of those who were licensed, 52 reported being a licensed clinical social worker (LCSW). However, since each state varies in its terminology, this is not necessarily indicative of level of experience. Based on the times at which responses came in, most were likely social workers in the state of Maine, as the

NASW state chapter graciously shared this study with its list-serve. If the majority of respondents were indeed from the state of Maine, then holding an LCSW would mean that they held the highest level of licensing, which is an independent clinical license. Likewise, there were nine licensed master's social workers (LMSW), a nonclinical license in Maine--- yet out of these nine, eight had the addition of "CC" which means they are master's graduates engaged in clinical work under supervision. However, clearly not all respondents were from Maine as three indicated that there were certified social workers (CSW) and one a licensed independent clinical social worker (LICSW). Since the primary means of recruitment was reaching out to state NASW chapters, it is not surprising that all of the respondents were trained as social workers (as opposed to other mental health professions). However, in addition to holding an LCSW, one also noted earning a PhD, two were certified alcohol and drug counselors (CADC), one a licensed alcohol and drug counselor (LADC), one Advanced Certified Hospice and Palliative Social Worker (ACHP-SW), and one an Academy Certified Social Worker (ACSW).

Thirty-three participants completed the entire survey and the demographic questions that followed. From those respondents, the ages ranged from 25 to 82 with an average of 50 years of age. The median was 55 while the mode was 33. Out of these, only one participant was male; the rest identified as female, which, while somewhat reflective of the field of social work, is limited in its representation. From the 32 who responded with their race, 30 self-identified as white/Caucasian, one as black, and one as Filipino.

Participants held a wide range of spiritual beliefs and practices. There is a contrast between those who described themselves as spiritual as opposed to religious and it would be interesting to know how each participant defined these terms. As previously noted, there is a distinction between these terms as religion can be defined as “an organized, structured set of beliefs and practices shared by a community, related to spirituality” and spirituality as involving “the search for meaning, purpose, and morally fulfilling relations with self, other people, the encompassing universe and ultimate reality” (Canda et al., 2004). Participants may have held a similar or differing view of these definitions; however, for the purposes of this study, the words “religious” and “spiritual” were used interchangeably. It is striking that only 33% of those surveyed considered themselves somewhat or very religious whereas 94% considered themselves somewhat or very spiritual. It is likely that for these participants, in accordance with the literature, spirituality is a more all-encompassing term allowing for personal expression whereas religious may connote affiliations with particular denominations and practices. It is also noteworthy that 72% of the participants stated that their faith was either somewhat or very much an important part of their life. This small sample stands in contrast to the research indicating that only half of mental health professionals consider faith to be important in their own lives. When 258 psychologists and other mental health practitioners were asked, “how important is religion in your life?” only 52% stated that it was either very important or fairly important with 48% saying it was not very important at all (Delaney, Miller, & Bisono, 2013).

The differences in responses from the current study may be attributed to its small sample size or possibly the type of practitioner, as most in the Delaney study were

psychologists and most in the current study were social workers. There is also the challenge of directly comparing the results of these two surveys due to terminology. Though the Delaney study also used religion and spirituality interchangeably, the wording on this question says “religion” and the wording in the current study asks about importance of “faith.” Since, as previously noted, the way one defines “religion” versus “spirituality” may be vastly different, it may have dramatically reduced the number of participants who denied any personal importance of religion; and, perhaps if the word had been faith or “spiritual,” answers would have been different. It is also true that regardless of the provided definition of these terms, they tend not to be universally understood and could never be “fully inclusive and all-encompassing.” Therefore this definitional ambiguity leads to limitations in conceptualization (Elkonin, Brown, & Naicker, 2014, p. 123).

However, the sample from this study was more in line with the general census of faith amongst Americans though still falls significantly short of it as 82% of the American population does profess a spiritual affiliation (Pew Research, 2012). Though the numbers have been significantly increasing over the past decade, as of 2012, only 18% of the United States population describe themselves as having no religious affiliation (Pew Forum, 2012). This is significantly less than the unaffiliated in this survey (6% spiritual, 42% religious). Since this surveyed population may not be representative of social workers as a whole, it raises the question of whether or not people chose to participate (and complete) the survey based on their own vested interest in this area. Perhaps the title and description of the survey was more apt to catch the attention of

those who do affiliate spiritually and simultaneously to be overlooked by those who do not.

Table 1: Perception of Personal Religion/Spirituality

	Very untrue of me	Somewhat untrue of me	Neutral	Somewhat true of me	Very true of me
I consider myself to be religious	27.27%	15.15%	24.24 %	21.21%	12.12%
I consider myself to be spiritual	3.03%	0%	3.03%	36.36%	57.58%
My faith is an important part of my life	3.13%	3.13%	21.88%	25%	46.88%

However, though most participants may have a spiritual affiliation, in looking at the descriptive responses, it is clear that respondents have a vast array of beliefs and practices (see Table 2 for verbatim answers to this question). The responses reflected a trend where respondents may have been raised with a particular religious affiliation, but now either do not affiliate, or have broadened their beliefs to be “accepting of all religions” or “open” or those things that are all encompassing, such as “nature,” “the universe” or a “metaphysical view.” Yet some did affiliate with a particular religion--- one was of the Church of Latter Day Saints, one wiccan, two Protestant Christian, one Episcopal, one Catholic, one Pagan, two Buddhist, and one Jewish. In spite of 94% of respondents describing themselves as spiritual, four out of the 25 who provided qualitative responses stated that they do not affiliate with any religion or spirituality. This again raises the question then of how participants define spirituality and further exploration of this topic would be beneficial for future practice. A unique and particularly interesting response ended with the statement, “I wish sometimes I could be

religious/spiritual; those people have answers for everything!” Though the individual does not personally affiliate, he or she seems to see value in religion and spirituality. This is particularly noteworthy as often those who do not have a personal spirituality are also less likely to identify spirituality as beneficial or attach appreciation to it. Perhaps the respondent sees in his or her clients the strength and answers religion and spirituality may provide.

Table 2: Please use the Space Below to Further Describe Your Religion/Spirituality or to Indicate that You Do Not Affiliate with Any Particular Practice.

1.	I received Jesus in my life as my Lord and Savior when I was 16. I participated and continue to participate in bible studies, attending church regularly, involved in missions, mentoring others in their spiritual growth.
2.	Raised catholic and still practice lent but traded prayer for meditation Practice aspects of Buddhism beliefs in and out of my clinical practice such as meditation and yoga
3.	Over the years I have expanded my spiritual beliefs and am much more open to other people's feelings and thoughts about religion/spirituality.
4.	The higher being I identify with is the "universe."
5.	LDS
6.	I consider myself spiritual, but independent and not affiliated with a religion. My spiritual leanings are a combination of Buddhist beliefs, Pagan/Native American/naturalist beliefs, and belief in science and scientific process. I was raised Catholic.
7.	I am Wiccan and tend to be nature based in my spirituality
8.	I was raised Catholic but don't believe 100% of the teaching, i.e. abortion versus I believe woman have right to choose, I support gay marriage, etc. I do attend services but not on regular basis, I do pray and feel I have a strong connection to god/gives me support during difficult times.
9.	I was raised Catholic but do not practice anymore. Some of the concepts have stayed with me, but I embrace a more metaphysical view now.
10.	Pagan, Buddhist.
11.	I am a Protestant from a liberal tradition of a main line denomination - The United Church of Christ - which appreciates and nurtures diversity.
12.	I do not affiliate with any religion in particular, although I was raised Baptist. I believe in a universal spirituality that includes all species, that is a form of life energy that continues on in some form after one's physical self dies

Table 2 (Continued): Please use the Space Below to Further Describe Your Religion/Spirituality or to Indicate that You Do Not Affiliate with Any Particular Practice.	
13.	I have been involved for over about 20 years as a member of a Unitarian Universalist Church community. I was involved for many years in 12 step recovery (Alanon, and others); I have been trained in Polarity Therapy and have been receiving body energy healing sessions for over 20 years and this continues to inform my beliefs and keeps me open minded. Having grown up with no religious background (meaning not attending church or temple) in a way it makes me very accepting of all religions
14.	Episcopal
15.	I am half Jewish by blood, but do not affiliate with any religion. I was raised Catholic. I have my Bachelor's in religious studies, which only reflects my interest in the topic.
16.	Open but I find affinity with Buddhism and the Quaker faith.
17.	I do not attend Unitarian/Universalist churches regularly as an adult. My beliefs and knowledge are integrated in me. I enjoy going to churches/etc with others as I was taught to have a love of others' religions. Now I incorporate whatever beliefs I choose from various religions. I do not consider myself Christian. But was brought up in the Christian tradition in the Universalist church I attended. I did not believe in God (father agnostic, mother believed in God, but did not believe Jesus was the son of God). I became interested in Nature and its spiritual aspects. But no organized religions.
18.	I have faith in the scientific method. I believe that we are all part of a greater whole/ecosystem. I believe that human development is a process which continues throughout life, unless thwarted. I believe that people can create meaning which makes life worthwhile. I believe all life is precious. I wish sometimes I could be religious/spiritual; those people have an answer for everything!
19.	am affiliated
20.	Jewish
21.	Born and raised Jewish. More connected w/ beliefs of a higher power/something greater than myself.
22.	I am a meditator.
23.	I do not affiliate with any particular practice.
24.	I practice Buddhist meditation, and attend an interdenominational Christian church.
25.	I do not affiliate

Frequency of Spiritual Discussion

Both qualitative and quantitative data were examined in considering the frequency of spiritual discussion in one's personal therapy as well as one's work with clients. In response to question number five, which pertained to the frequency with which

discussion of religion or spiritual issues entered into one's personal therapy, the majority of those who responded stated that it was discussed only occasionally: 23% of respondents said the conversation rarely came up and 14% said these matters were never discussed. Only 17% combined said that these conversations had been brought up frequently or almost always. Out of those who elaborated with qualitative responses, most appeared to be the ones for whom these issues were discussed since their qualitative responses included comments such as "spirituality is my anchor and number one source" and "my spirituality/religious beliefs have always guided my decisions and life changes" or that they were in "pastoral counseling." For these respondents, clearly religion and spirituality was already a part of their lives, so it only seems natural that spirituality would be addressed in therapy. Others, however, wrote specifically that neither they nor the therapist "brought it up." It is interesting to note that one respondent states that these discussions were had more frequently as time went on. Perhaps this is indicative of an increased level of trust and rapport, making it therefore safer and more comfortable for clients to talk about.

It is interesting to note these findings in comparison to question twenty-one--- when respondents answered the question from the point of view of their roles as therapist, issues of religion and spirituality appear to be discussed with significantly higher frequency. Here, more than half of the respondents stated that these conversations were had frequently or almost always. None of the respondents said that they *never* had these conversations with clients and the scores for "rarely" dropped to 16%. In terms of the qualitative responses, numerous respondents noted that religion and spirituality were addressed at intake. There was not enough information to determine how often this

dialogue continued beyond the initial assessment. Some therapists noted that they worked with children, often in a school setting, and so felt all the more inhibited from raising these discussions. Still others took a strong client-centered view and said that they would only discuss these things if the client wanted to.

Table 3: To What Extent Did Discussion of Religion or Spirituality Enter into Therapy?

	Never	Rarely	Occasionally	Frequently	Almost Always	Answered	Skipped
As a client in personal therapy	14.29%	22.86%	45.71%	11.43%	5.715	35	35
As a therapist in work with clients	0%	16.13%	32.26%	41.94%	9.68%	31	39

In terms of the quantitative data, nonparametric tests were run using Spearman’s rho to assess the relationship between given variables, including demographics.

Regarding the frequency with which these discussions of religious and spiritual nature arose, no significant correlation was found between participants’ ages, years in practice, or years in therapy and the extent to which these conversations were had, either in their personal therapy or in their practice with clients.

However, while these demographic data did not directly correlate to the way in which respondents answered this question, their perception of their own religion and spirituality did. A significant, moderate correlation ($\rho = 0.524$, $p = 0.002$, two-tailed) was found between how religiously one defined oneself and the frequency with which one discussed these matters in one’s personal therapy. However, participants’ descriptions of how religious they perceived themselves to be had no bearing on the frequency with which they discussed these topics with clients. In terms of how

spiritually one defined oneself, there was a significant positive weak correlation between the frequency with which one discussed these matters both in one's own therapy ($\rho=.385$, $p=.027$, two-tailed) *and* in one's work with clients ($\rho= 0.373$, $p= 0.039$, two-tailed). The positive correlation suggests that the more respondents consider themselves to be spiritual, the more spirituality was discussed, both in their personal therapies and in their work as therapists. The reverse is also true--- the less spiritual respondents perceive themselves to be, the less apt they are to discuss these matters. In a similar vein, there was a significant positive weak correlation ($\rho=.376$, $p=.034$, two-tailed) between the importance of faith and the extent to which it was discussed in one's personal therapy. However, this correlation was insignificant for participants when in the role of therapist. This pattern is similar to the relationship noted between one's self-identified religion and how frequently these matters are discussed, both in personal therapy and as the therapist. Perhaps it is indicative of the respondents' raising these issues in their own therapy as they are significant to their own lives while also indicating that the therapist is capable of maintaining a neutral stance when working with clients, where they can be focused on the client's needs versus their own interests.

Nature of Spiritual Discussion

When respondents were asked who initiated the discussion about spirituality, in both the role of therapist and in the role of client, they noted that the client was more frequently the one who introduced the topic. However, it is interesting to note that the conversation was client-initiated significantly more when the respondent was answering from the point of view of the client (61%) than when answering as the therapist (32%). In the latter, the therapist took a more active role in initiating this discussion (26% as

opposed to 16%). Perhaps, as indicated by multiple qualitative responses, the conversation was initiated by the therapist as it was a required part of intake.

There was also an option for respondents to choose “other” in these two questions (six and twenty-two) and it seems, based on qualitative responses, that those who answered “other” for each of the two questions, did so because *both* the therapist *and* the client brought up the topic; it was not one-sided. Considering that there were 31 respondents for these questions, another possibility for the choice of “other” is perhaps these conversations did not come up at all and rather than skip the question, considering 31 answered, they simply checked “other” since neither “therapist” nor “client” would have been a suitable answer if these issues were never discussed. In future research, clearer delineations will be important for clearly identifying data.

Table 4: If this Discussion Entered into Therapy, Who Initiated It?

	Therapist	Client	Other
Role of Client	16.13%	61.29%	22.58%
Role of Therapist	25.81%	32.26%	41.94%

Following the above questions, respondents were asked *how* these discussions on spirituality were initiated and it is interesting to note the myriad of answers. In their own personal therapy, numerous respondents noted that the topic of spirituality came into the discussion as it was a source of strength and internal support. Sometimes this came in response to the question: “What helps/helped you?” Others seemed to broach the topic when “discussing supports and ways to find balance within the struggles of the field.” Similarly, multiple respondents stated that the conversation came up as they discussed their personal spiritual practice, such as regular meditation, or exploring whether incorporating such a practice might serve as a way of coping with life’s challenges. For

instance, one respondent said, “The first time I was in therapy, it was brought up as a form of thinking about an area of self-care that I was not familiar with” while another said the topic was addressed when “wondering if what my life was missing was some sort of spiritual practice.” Some participants responded that religion and spirituality came up when discussing one’s self-concept or sense of life purpose. For still others, the discussion was integrated into how the respondent handled various situations. “I would always bring up the issue of living as best I could according to my morals, ethics, and conscience.” And “I believe it came up in a discussion of personal issues and how spirituality impacted these.” Lastly these topics seemed to come up as they were pertinent to personal or family history or if it was the specific reason they were coming to therapy. For instance, one respondent referred to “anger at a priest who responded negatively to my seven-year-old daughter’s request to visit her brother in the hospital” while another said that it was “via discussion about interfaith relationship.” One individual said the areas that promoted this discussion were:

Issues around childhood and growing up in a particular faith (LDS). Issues regarding living with boyfriend outside of marriage. Issues of no longer identifying with the faith, yet family members are still very involved. Feeling like I disappointed my parents for no longer believing in the LDS faith. Issues around sexual orientation.

In contrast, the way in which respondents reported broaching this topic was different when answering from the point of view of clinician. Still, a vast number of respondents stated, as they did in the preceding question, that these conversations were initiated by the therapist upon intake. One striking finding, however, was that many therapists sought elaboration upon a client’s religion. This seems to contradict much of the literature which states that therapists tend to avoid the topic of religion and spirituality

and do not probe further beyond what is required for intake. Yet here, many noted that they would proceed by inquiring about the role and importance of their belief system on their lives. Therapists often did this through broad, open-ended questions such as, “Do you have or practice any type of spiritual beliefs? If so would you be willing to share how they impact your life?” or “Do you have a spiritual/religious belief system that is important to you? How do you practice it? How often?” Then there might be more questions, like “Is there family history behind it?” etc.” It is encouraging to note that in spite of the literature which states that most clinicians do not engage in these conversations even though they’ve been shown as beneficial, that the respondents in this study often did address this area. Yet still others responded more consistently with the current literature and would only acknowledge these topics if the client initiated them. One explicitly stated “A client would talk about their concerns; I would consider this a topic only if the client brought it up” and “I allow clients to discuss it and will only ask further questions with their initiation.” Others echoed this client-directed stance.

There were definite parallels between therapists’ experiences as both client and clinician regarding what sparked the conversation. For instance, it commonly came up as a source of support, strength, and pertinent to one’s values. Numerous therapists and clients alike noted spirituality as part of their identity. One respondent noted, “The client would usually start with a statement similar to ‘Well, you know I am ___ and this is how we are...’” type comments. Other times clients, just like the surveyed therapists, brought up issues of religion and spirituality as they were salient to the matter being discussed in therapy. For example, one respondent noted the discussion began with “a client telling me that they have not been going to church regularly since an ‘incident’ and they used to

go regularly” or that it was addressed because a client stated that she believed in Jesus, but didn’t feel loved by Him, or with regard to relationships and sexual orientation. These themes are common throughout and what seems to vary is how the therapist responds.

The importance of knowing whether the client and clinician had similar views regarding religion and spirituality varied among respondents. However, there did appear to be a positive correlation between those who self-identified as holding to a particular affiliation and the value they placed on knowing their therapists’ belief systems. This was evidenced especially by those who intentionally chose their therapist knowing that he or she held to a similar spirituality. Likely, since faith was of significant importance to these individuals, they sought out therapists who they knew in advance could address their presenting issues from a similar framework. This is consistent with studies that have shown that highly religious/spiritual clients tend to prefer clinicians who share their beliefs and, similarly, therapists appear to prefer clients who share their belief system (Cummings, Ivan, Carson, Stanley, & Pargament, 2014). Respondents’ answers in the current study are both indicative of the desire to work with someone who shares the same faith values as well as perhaps a fear that if the therapist does not share the same belief system, he or she may not address, respect, or understand the client’s spirituality.

The overwhelming percentage of respondents, from both the point of view of the therapist and that of the client, stated that they did not know whether the person they were working with shared their beliefs or not. This is understandable when the respondent is answering from the point of view of the client and some of the qualitative responses build upon this: “Therapist did not self-disclose” and “My therapist has

remained neutral when discussing spirituality.” It is expected that the client likely would not know the spiritual affiliation of her/his therapist, unless s/he had intentionally sought out someone with similar views, as therapists are less likely to reveal this information in the dyad. However, what is somewhat concerning is when the respondent answered from the point of view of the therapist and did not know whether or not the client shared her/his views. This is indicative of either the therapist not addressing religious and spiritual issues at all (meaning that they also declined to assess for this during intake) or that the therapist had not taken the time to figure out for her/himself what s/he believes. Some therapists even felt strongly that it did not matter whether or not they knew where the client was coming from spiritually. For instance, “I don’t know and it’s not relevant” and “I don’t relate my own beliefs to others’ views. It’s not applicable in my opinion.” All of these possibilities of omission may have been to the detriment of the client. While it may not be appropriate to relate one’s own belief to another’s, experience indicates that there is value in knowing and making space for the client’s beliefs, whether or not they are similar to the therapist’s.

When therapists were asked what factors inform whether or not they raise issues pertaining to religion and spirituality with clients, again an overwhelming number stated that they first address this on intake. Numerous therapists noted that they then use the answer to this question to shape if and how they bring up the topic again. Examples of their responses are:

- ...client’s level of interest and religious history/background as indicated at intake and initial sessions
- ...dependent upon previous discussions
- ...I will always go back to the intake question that deals with these topics, check their responses, and go from there.
- ...client’s response when I initially inquire about spirituality/religion in practice

Other therapists initiated conversation focusing on spirituality if it was pertinent to treatment---specifically if it was in conjunction with the therapist’s use of mindfulness, used as a “coping skill,” if perceived as a “support system” or ”strength” for client, in addressing ethical issues, especially as they relate to substance abuse, or around death and dying. One therapist made note that the client’s diagnosis and presenting symptoms would have a bearing on whether or not she raised these topics saying, “if a client is psychotic and expressing delusions based in religious beliefs, I would not initiate this topic at all until the client is stabilized.”

Four out of the 25 respondents to this question stated that they always assess and raise these issues with clients, including one response which read, “It is standard for me to include in my assessment process -- not optional.” Others let the client determine whether or not these issues were raised and addressed:

- ...only if the client brings it up
- ...Do they bring it up? Does it seem logical to bring it up?
- ...how the client presents and what they are indicating
- ...It is always based on the client and the treatment plan that is developed in conjunction with them
- ...go with the clients’ issues

In general, as was the trend throughout most of the survey, if the clinicians address these issues, it is usually in intake and then followed up with the client if deemed appropriate and pertinent to the work they are doing together, or if the clients directly bring up their own religion or spirituality.

Comfort and Ease of these Discussions

Overall, respondents demonstrated a significant degree of comfort addressing religious and spiritual matters, both within their own therapy and in their work with

clients. Previous literature has indicated that this topic can be difficult for practitioners to broach, especially out of a sense of lack of training, unfamiliarity with the subject, or a fear of imposing beliefs. Perhaps the general comfort felt here is reflective of the individuals' own work in therapy. Paired T-tests were run on the below data, but no significant relationships were identified in how comfortable respondents reported feeling as either client or therapist.

Table 5: How Comfortable Did You Feel with Discussing Issues Pertaining to Religion and Spirituality? How Comfortable Did the Therapist/Client Appear in Discussing These Issues?

		Very Uncomfortable	Uncomfortable	Neutral	Comfortable	Very Comfortable
In your own personal therapy	You	3.13%	6.25%	15.63%	40.63%	34.38%
	The therapist	3.23%	0%	19.35%	41.94%	35.48%
In your work with clients	You	0%	3.33%	6.67%	46.67%	43.33%
	The client	0%	0%	16.13%	51.61%	32.26%

Though no significant relationships were identified, what is notable are respondents' perceptions of how comfortable their respective therapist or client roles felt. In their own personal therapy, 77% of respondents felt that their therapist appeared to be either comfortable or very comfortable with discussing these issues. While this is a high percentage, it is lower than the comfort level respondents perceived their own clients to have experienced (84%). Likewise it is lower than the respondents' view of their own comfort level with these conversations while in the role of therapist, as 90% stated that they felt comfortable or very comfortable. This raises the question of whether the respondents felt more uncomfortable discussing these issues with their own therapists than initially revealed or, if in comparison to how they sensed they put the clients at ease in their practices, they didn't not feel quite the same with their own therapists.

Alternatively, it is possible that respondents learned from what they saw modeled in their

own therapy and consequently felt they were able to discuss these issues in their own practice with greater ease, knowing what it is like to be the client.

Participants provided qualitative responses for further explanation. In their own therapy, some respondents noted that they intentionally sought out like-minded therapists so to talk about these issues. Another shared this sentiment and the importance of discussing her faith: “If I could not include my spirituality in the therapy, the therapy is useless. My spirituality shapes me, sustains me, and anchors me to the Almighty that empowers me to overcome.” None of the respondents shared any examples of discomfort in their personal therapy and were much more inclined to speak positively of it:

...I felt accepted, warm, and nurtured. I had many positive experiences and learned much about myself, the world, and others.

...It wasn't a forced conversation; it just came up as appropriate

...I think she was careful to not attempt to influence me, but shared her views as appropriate.

Responses were quite similar when the respondents were in the role of therapist, and they further elaborated by saying that they felt comfortable and safe discussing these matters with their clients, especially if initiated by the clients. What is interesting are the participants' perceptions of their clients' experiences:

...Depending on the person—some are very uncomfortable. Others want to talk more about it. One person for example is comfortable but knows how much we diverge on our points of view. She is usually uneasy about getting in a disagreement but still wants to express herself.

...Almost always very comfortable—and sometimes curious if they don't really have a sense of what I am talking about.

...It was a predominant framework for her decision-making and cognitive schema.

...One client even commented that her parents, her children and her husband see the positive difference in her. One client started to get back to church after several years of isolating herself.

Those who responded to this question have an overwhelmingly positive perception of these discussions with clients. Only one noted that spirituality was “never brought up by either of us.” As seen above, one of the therapists, though she noted a positive response from her client, was also attuned the discomfort that the client may have felt in discussing these matters out of fear of disagreeing with the therapist. Perhaps more clients than therapists even know put up a façade of comfort, when in actuality they are intimidated to fully disclose their religious and spiritual beliefs. Further research should examine the same therapists and clients to see whether or not their experiences in discussing these matters are truly aligned or not.

Satisfaction, Effectiveness, and Benefit of these Discussions

Respondents were overall satisfied in how conversations pertaining to religious and spiritual matters were conducted in their personal therapy and in general spoke positively of their experience.

Table 6: What is Your Level of Satisfaction with How Discussion of Religion and Spirituality was Incorporated?

Very dissatisfied	Dissatisfied	Unsure	Satisfied	Very satisfied
0%	0%	13.33%	56.67%	30%

Table 7: How Helpful Were These Conversations in Your Own Therapy?

They were unhelpful or even detrimental	Slightly unhelpful/detrimental	Neither helpful nor detrimental	Only slightly helpful	Very helpful
0%	0%	24.14%	31.03%	44.83%

However, while it is not clear the extent to which these conversations were very helpful and effective, no one indicated that they were detrimental or unhelpful in anyway. For some, religion and spirituality was simply not an aspect of their identity or their presenting concerns and so these conversations did not come up. Unfortunately, the

survey did present an appropriate choice for this answer, yet clients integrated it into the comments by stating things such as:

- ...these conversations were incidental.
- ...this was not an issue and never brought up by either of us.
- ...not applicable.
- ...again, it wasn't a big part of my therapy.
- ...I think she handled the conversations in a professional manner- it just wasn't a huge part of what we talked about.
- ...It was not an issue for me, so it was never brought up or worked on.

However, for those for whom the discussion was had, 55% felt very much respected or understood and 29% felt somewhat respected or understood with only 13% feeling neutral and 3% feeling somewhat misunderstood. Some noted:

- ...I always felt peaceful, calm, and more centered after sessions.
- ...I always felt different from others and these sessions affirmed for me that there is more out there than what we can see.

This points to attunement on the part of the therapist, as multiple respondents noted the “openness” of their therapists and the “trust” they felt toward them. Perhaps these respondents who had a positive experience discussing these matters in therapy therefore felt more empowered to discuss the topic with their own clients in the same positive, nurturing, open-ended way.

Sixty-two percent of the participants rated their therapist's approach as either effective or very effective. Again there was not an option for respondents to check “not applicable” and so, while several made this comment in the qualitative section, data were likely skewed slightly by those who did not have these conversations. However, respondents provided a vibrant array of answers for what made the approach effective. Responses repeatedly pointed to aspects of the therapist's approach with multiple respondents using the same descriptions: “open,” “inquisitive,” “explorative,” non-

intrusive,” “supportive,” “validating,” “affirming,” “unconditional acceptance,” “flexible,” “non-judgmental,” “very unbiased,” “curious,” “active listening,” and “understanding.” It seems that these characteristics ought to be true of all therapists, regardless of circumstance or topic of conversation, so it is encouraging to see that these same attributes carry into discussion of religious and spiritual matters as, clearly, such attributes were beneficial for clients. Out of all of the above qualities, the one that came up most frequently was “open” or “openness,” which may allude to the therapist’s self-disclosure, as some respondents noted that this was helpful, though more likely “openness” points to the therapist’s ability to be open to the client’s beliefs and to create a safe space to discuss these, regardless of the therapist’s personal beliefs.

In addition to these characteristics of the therapist’s approach, some respondents also noted more directive elements in their therapy, such as introducing the role of Buddhism in mindfulness, reflecting back internal strengths, educating about spirituality, introducing journaling, mindful guidance, suggesting faith-based activities as coping skills, and recommending particular readings. Others noted that the most effective elements of incorporating spirituality in therapy were the integrative approaches---linking the client’s life experiences with spirituality, guiding the client in discussing community supports, naturally weaving spirituality into both talk therapy and EMDR, using spirituality to assess meaning and explore values, morals, beliefs, and decisions, and providing a different perspective.

It seemed that numerous respondents, likely those who found their therapist’s approach effective, incorporated aspects of their therapists’ practices into their own – as, without prompting, 16 of 28 open ended responses stated that they practice similarly.

One even stated that she would practice “hopefully the same way” which alludes not only to a positive experience discussing these topics in her own therapy, but also to a desire to recreate what her therapist modeled for her. Many echoed what it was that their therapists did which they chose to replicate, such as directly “asking the client how she wants her spirituality to be incorporated into therapy,” “ask about internal resources and help clients look at what they can and can’t control using mindfulness,” “bring it up in open ended questions,” and “listen without personal opinion or feelings. I would do my own research to better understand their views.” Those who said they would differ from their own therapists’ approaches provided specific examples of how they would do this:

...I would ask them to rate their level of belief on a scale from 1-10 to see how deeply held the belief is.

...maybe elicited more discussion on the topic.

...very differently. I feel comfortable working within the vast majority of spiritual frameworks clients bring to treatment, and my therapist readily admitted that certain religious views were anathema to her.

...focus more on validation rather than comprehension .

... Differently. I initiate discussions around spirituality with clients--- from inclusion in initial intake packets to inquiry in relevance to client’s daily life or cognitions. Similar to discussions re: sex & intimacy, I think it is part of a holistic approach to understanding a client’s priorities and sense of purpose.

...I would have asked for more questions for clarification and deeper understanding.

Since the data are anonymous, it was not possible to determine how those who answered this question answered others pertaining to their own spiritual affiliation or experiences in therapy. Some responses seemed as if the clinicians were looking to supplement what their therapists already did while others, perhaps those who had less beneficial experiences discussing these matters, stated that they would do things very differently.

In addition to therapists being likely to model their own therapists in introducing these topics, therapists were more apt to discuss these things if they had a personal

religious or spiritual affiliation. Some participants responded to this directly. When asked, “How would you describe your feelings towards incorporating discussion of your own religion into personal therapy?” participants noted, “without my spirituality, I am nothing” and “it is a strong factor in my life.” A Spearman’s rho was run on the this same question resulting in a significant positive moderate correlation ($\rho=.599$, $p=.000$, two-tailed) between those who self-define as religious and those who make it a priority to discuss these matters in therapy. Likewise, there was a strong positive correlation ($\rho=.652$, $p=.000$, two-tailed) between those who described themselves as spiritual and discussing religion and spirituality in their therapy. A significant positive moderate ($\rho=.512$, $p=.033$, two-tailed) was also identified with those who stated that faith played an important role in their lives.

Though there were strong or moderate correlations between one’s faith, spirituality, and religion and the priority one placed on discussing these things in personal therapy, there were no significant correlations between one’s religion or value put on faith and any of the other questions. How one identified spirituality, however, did have a bearing on how respondents answered other questions. For instance, there was a moderate positive correlation between the degree to which they considered religion and spirituality to be an important component of therapy ($\rho=.498$, $p=.004$, two-tailed) and how appropriate they felt it was to discuss a patient’s spiritual and religious beliefs ($\rho=.411$, $p=.022$, two-tailed). There was a weak positive correlation between the degree of importance respondents attributed to religion and spirituality in therapy in general and how they felt about incorporating religion and spirituality into practice with clients ($\rho=.363$, $p=.045$, two-tailed). However, neither one’s religious or spiritual

affiliation nor the value they placed on their own faith had any significant correlation in how comfortable they felt discussing these issues with their own therapists. This may perhaps indicate the importance of the therapist's approach to discussing these matters as integral to the comfort and ease of the client.

All in all, those who did discuss religious and spiritual issues in therapy noted that it was a positive experience. Participants noted:

...It helped me to know myself better, to understand how my life is guided.

...It was an important area to explore and I felt like she had spent time prior trying to understand the religion, which helped.

...Therapy grounded in my spiritual belief system helped to ground me and have faith that I could draw on a power higher than myself when I felt overwhelmed.

...important for my growth.

Some participants did not begin therapy with the expectation of discussing these issues, but noted that the discussion happened naturally and helped them to explore their own identity. One noted that "My experience and beliefs were different than they are now. I didn't feel the impact of spirituality. I do now." For one respondent, it was not her own therapy, but her work with clients that made her begin to consider these issues. She interestingly noted that her experience in discussing spiritual matters with her own clients is what triggered her to begin these discussions in her personal therapy: "Working in end-of-life settings and employing cognitive-existential modalities myself lent to having those discussions in personal therapy as well. Working out my own feelings to separate counter-transference, etc." This brings up a dimension that was not otherwise considered in this study-- perhaps it is not just one's personal experience in therapy that can affect the way issues of religion and spirituality are addressed, but in fact, the reverse can also be true. And -- congruent with the research -- this is important as the most effective

therapists have undergone a process of identifying their own belief systems in order to consider how that may have an impact on the work they do with clients.

CHAPTER V

Discussion

This study sought to explore any correlations that may be present between clinicians' personal spiritual affiliation, or lack thereof, and incorporating discussion of these issues into therapy---both their own and in their work with clients. Similarly, it sought to identify whether or not a relationship existed between the experiences clinicians had with regard to spiritual matters in their own therapy and their experiences in working with clients. All in all, the study echoed the literature illustrating that many people, while they may personally value spirituality and religion, do not often bring it into practice with clients. However, those who identified faith as important in their own lives were more apt to address these issues in their personal therapy. Those who did emphasize the importance of faith repeatedly expressed the necessity of discussing these matters with their own therapist. The respondents who answered that they frequently discussed spiritual things also noted the role faith has in their lives:

...spirituality is my anchor and number one resource.

...my spirituality/religious beliefs have always guided my decisions and life changes.

...If I could not include my spirituality in therapy, the therapy is useless. My spirituality shapes me, sustains me, and anchors me to the Almighty that empowers me to overcome.

For these respondents, if spirituality holds such importance in their lives and is such an integral part of identity, it would be detrimental to not be able to discuss these things in therapy.

Salient Findings

Not surprisingly, no significant correlation was drawn between any of the demographic information (including age, race, gender) and the tendency to incorporate issues of religion and spirituality into therapy. However, there was also no evident relationship between the frequency of these conversations and the length of time the therapist had been either in his or her own therapy nor the time spent in practice. Prior to this study, I believed that those who had been in practice longer would be more apt to endorse the value of addressing spiritual matters with clients and consequently more apt to initiate these discussions. Likewise, I thought that length of time in personal therapy might also have a bearing on this, yet the data do not support these hypotheses.

One of the most striking, and perhaps worrisome, of the findings is that while 26% of participants expressed that religion and spirituality are “very important” in therapy, only 10% of clinicians reported “almost always” discussing these issues with clients and even less, only 6%, stated that they “almost always” discussed these issue with their own therapist. It is interesting to note that in spite of these responses and in the face of low percentages of clinicians initiating these conversation, it doesn’t appear to be on account of discomfort as one might suppose -- since 75% of participants stated that they felt comfortable or very comfortable discussing these matters with their own therapist and 90% said they felt comfortable or very comfortable having these conversations with clients. For a topic that can be taboo in so many circles, this level of expressed comfort is notable. So -- if not discomfort, then what inhibits these conversations? If religion and spirituality are vital to one’s sense of self and if these

issues are considered to be important in therapy, then what prevents clients and clinicians alike from discussing these matters?

The answers provided in this study tended more to illustrate what *promoted* these discussions-- such as being made to feel comfortable, perceiving openness, acceptance, and lack of judgment from the therapist—than what *inhibited* them. However, the recurring response to what held both client and clinician alike back from discussing these matters was a perceived difference in their own religious beliefs and that of the client or the therapist with whom they were working. This parallels the research literature discussed in Chapter II, which further expounds upon this idea by pointing out that when there is a difference of spiritual beliefs in the clinical dyad, then discussions of faith may be avoided out of fear of misunderstanding or lack of knowledge (Cragun & Friedlander, 2012). However, it partially contrasts the review put out by Cummings et al. (2014) which indicated that it was not a sameness in spiritual beliefs between the client and their therapist that mattered, but *degree* of spirituality, regardless of differing religious beliefs. Several respondents noted that it was personal preference whether a therapist shared the client's spiritual views or not. However, the difference seemed to be a stumbling block for some, including the participant who noted:

My therapist respected my beliefs but it was clear that she couldn't work within the parameters of a certain belief systems. Of course the fact that I knew she thought certain religions were repressive and people should be talked out of them would limit my speculation that there might be a literal God (capital G) but honestly that wasn't a big thing for me.

If differing spiritual beliefs is a significant impediment to discussing these issues, though they have already been determined as valuable and to some, essential, then what does that

mean for clinical practice? Sometimes participants noted a need to refer out to another clinician.

Occasionally a client would ask if I was, am, a Christian counselor. I would respond with ‘What is that?’ If they felt they needed that kind of therapist, I would refer out.

So ought clients to be paired with like-minded clinicians? Perhaps: though, is it questionable whether any two people can ever be fully like-minded in spite of holding similar views? And might a presumption of like-mindedness also be detrimental—for therapists who may run the risk of essentializing the client’s experiences or over-identifying and consequently not really hearing and understanding the client’s perspective, as well as for the client if one is presuming one’s therapist to be fully aligned with oneself only to discover difference?

Limitations of the Study

Although a wide range of qualitative and quantitative responses were elicited, the mixed-methods, anonymous nature of the study, while it allowed for a greater number of participants and a breadth of questions, was limited in depth. Follow-up questions and clarifying a respondent’s meanings in a text-box narrative answer could not be done in an interview-based survey. Direct interviews with participants would allow for greater exploration of individual experiences and beliefs and opportunities to expound upon the groundwork laid in this study.

Other limitations of this study include the small sample size, as its findings cannot be generalized to the population at large. Future studies should seek to procure a greater sheer number of participants as well as specifically participants from a more varied background. Most of the respondents in this study probably were from Maine and

Vermont, as those states' NASW state chapters were willing to distribute the survey through their list-serves, and the numbers recruited increased once these chapters were involved. While this was incredibly useful in receiving responses from states beyond the researcher's own, it does not provide a wide representation of clinicians' viewpoints from across the country. Likewise, the only clinicians who participated were social workers. This is understandable given the recruitment done through NASW sites and a convenience sample of others known to my acquaintances; however, it may be interesting in future research to compare and contrast experiences from mental health workers across various disciplines, including psychologists, licensed professional counselors, psychiatrists, social workers, and other professionals.

Another limitation in terms of the sample may have been incorporating a skewed number of those who were already interested in the topic of religion and spirituality in therapy. Since 94% of participants described themselves as spiritual or very spiritual and 72% of the participants stated that their faith was either somewhat or very much an important part of their life, it is worthwhile to consider that those who participated in the study may have already had a vested interest in the area of spirituality and social work, as typically the numbers for mental health workers who adhere to a spiritual affiliation is significantly lower. When presented with the opportunity to take part in this study, upon seeing its title and what it sought to explore, perhaps those who considered themselves spiritual or those who had already begun to give thought to integration of spirituality and social work, were more apt to participate. This means that others, whose opinions and experiences would have been valuable to include in the study, may have overlooked it or declined participation on account of lack of interest or past consideration of this topic.

That said, there were still those who did not claim any spiritual affiliation who took part in the study and shared their own insights. Also, of those who did claim a spiritual affiliation, their spiritual and religious beliefs vastly varied.

Overall, the data received did answer the research questions posed as participants shared their experiences, both in their personal therapy and in their professional work, with regard to discussing spiritual and religious matters. One's personal spiritual affiliation as well as one's positive or negative experiences in broaching spiritual conversations with one's own therapist were focused on and provided a wide range of responses. However, since the object was to see if and how these elements affected the nature and frequency of spiritual conversations with their own clients, it may have been effective to directly ask these questions, perhaps in the form of "How do your own spiritual beliefs or lack thereof affect your discussion with clients about these matters?" and "Do you feel that the experience you had with your own therapist in discussing these matters had any bearing on the way you addressed spirituality with clients?" Through piecing together the qualitative responses and running a Spearman's rho to identify correlations, some of this matrix was illuminated; yet there still may have been value in asking explicitly.

Also, in terms of the instrument used, the wording and order of the questions posed some confusion for some of the participants and clarification was not possible due to the nature of the study, as noted above. Some of the questions were rather repetitive and so elicited some of the same answers. The repetition also may have discouraged some participants from completing the entire the survey. The sheer number of questions may also have been daunting for some participants and if this study were to be repeated,

there would be value in reducing the number of questions and streamlining the remaining ones so to elicit more specific responses.

Yet, some of the seeming redundancy was intended as similar questions were asked, using the same rating scale, to compare experiences of participants as both client and clinician. For example, question five asked “As a client in your own personal therapy, how often did discussion of religion and spirituality enter into therapy?” and question 21 asked “As a therapist, how often did discussion of religion and spirituality enter into therapy with your clients?” While the parallelism of these questions was intended, it is apparent this provided some confusion for participants. For instance, one participant stated, “I often introduce the topic and check if the client wants to discuss/explore this further and tie it into their presenting issue” in response to question 17 which asked, “To what extent did you feel respected and understood in raising issues of spirituality and religion?” If confusion was only indicated by erroneous responses in the comments, it raises the concern that perhaps other participants also misunderstood the questions and responded from the clinician’s point of view when it ought to have been the client, or vice versa, and that this went undetected, thus potentially distorting the data. Again, this particular problem might be avoided in an interview situation where nonverbal indications that a participant misunderstood a question could lead to rephrasing or explaining the item; and a clarification could be requested when a respondent’s answer showed evident confusion about the question posed.

There was also an overt error in one of the questions which may have only compounded the confusion. Question 25, though it was in the section inquiring about therapist experience in working with clients, asked “How comfortable did your therapist

appear in discussing these issues?” whereas question 26 asked correctly: “How comfortable did *you* feel when discussing issues pertaining to religion and spirituality?” Question 25 should not have been included at all as this question had already been asked in the first section pertaining to the respondents’ experiences as client. Therefore, to have the question repeated in the incorrect section and then followed up by a similar, though accurate question, confused responses for these and the questions following.

Sometimes the questions themselves were limiting for participants. For instance, there was not a space for those who did not have any religious or spiritual conversations in therapy to check “not applicable” or skip a question when it would ask “How effective were these conversations?” or something to that extent. This may have created an underlying assumption that the expectation was that they *were* or *ought* to be having these discussions when that was not at all the intention. Likewise, the data may have been impacted again in that there was not clearly marked space for participants to abstain from answering, and so may have responded with something like “ineffective” to the above question. It was helpful, however, to have the comment section following each quantitative response so that the participant was able to elaborate and alert the researcher about a possible error to consider.

Strengths of the Study

Though the number of questions may have been detrimental to the study, there was strength in the breadth and depth of questions that were asked as well as the range of quantitative and qualitative responses that were elicited. Providing participants space to comment on all of the Likert scale questions allowed respondents to elaborate or clarify their ratings, which was extremely useful in analyzing the data -- permitting much greater

insight into the participants' thoughts behind the ratings. Likewise, this made space for participants to share any questions pertaining to the survey and it allowed the researcher to identify points of confusion as were discussed with regard to survey limitations. In addition, asking open-ended questions allowed for data that could have never been identified using only quantitative means.

Benefits for Social Work

Some participants began to consider these issues in a new way, simply by thinking about them and having to answer questions. It seemed to allow for a degree of self-exploration and discovery as participants had to consider where they stood and what they believed and what implications this may have on practice. For instance, one respondent noted, "My own personal discomfort leads me to explore it less often." He or she is noting what he or she is bringing to the table in therapy and is beginning to draw connections between his/her views and the impact they have on discussions with therapist and client alike. Similarly, in reflection, another participant responded that her own therapist had seen these issues as important and made an effort to explore them, which the respondent then carried into her own work with clients: "It was an important area to explore and I felt like she had spent time prior trying to understand the religion which helped." For one participant, it seems that simply partaking in the study revealed the importance of conversations of religious and spiritual matters as the respondent stated, "Now when returning to therapy it will be on my list of priorities of discussion issues" when asked "How would you describe your feelings toward incorporating discussion of your own religion and spirituality into your own personal therapy?" Although the sample size is small and the results cannot be generalized, if this study inspired practicing

clinicians or challenged them to consider the value of incorporating a client's faith into the work they do with the client, it has achieved some benefit and success.

Implications for Future Research

Future studies may consider directly seeking out those with no particular spiritual affiliation to assess in contrast with those who consider themselves spiritual. Though both types of participants were acquired for this survey, the title of it may have attracted someone who was already considering the impact of spirituality in social work, even if he or she did not personally affiliate. While this kind of recruitment will not provide an accurate representation of the percentage of mental health workers who affiliate, it may provide greater insight on contending points of view and perhaps either confirm differences in approach to discussing these topics with clients or reveal unexpected similarities.

Though no participants in this study specifically noted it, according to the literature, lack of training in addressing spiritual matters with clients may also inhibit clinicians from broaching this topic, especially when the client/clinician one is working with comes from a distinctly different spiritual background (Canda & Furman, 1999; Holloway, 2006). Further research ought to be done in this area—to identify *why* a difference in spiritual beliefs in the clinical dyad is an impediment to discussion regarding spiritual matters, even when both parties acknowledge the importance of discussing these issues.

Is there instead a way for clinicians to make clients feel comfortable discussing these issues even in the midst of difference? If “openness,” “lack of judgment,” “active listening” and “unconditional acceptance,” all of which are characteristics that make for

an effective clinician, are components that promote conversation of spiritual matters, then how can these be further developed in clinicians so to make space for these valuable conversations? These are questions to be explored in further depth in future research.

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APPENDIX A

HSR Approval Letter

Smith College School for Social Work

January 7, 2015

Lauren Raymond

Dear Lauren,

You did a very nice job on your revisions. You have made all requested changes and clarifications to questions raised. 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: Gael McCarthy, Research Advisor

APPENDIX B

Informed Consent

Screening Questions

Thank you for your interest in my survey! Please respond to the following items to be sure that you are eligible for participation in this study:

1. I am a licensed mental health clinician (for example, a clinical social worker, psychologist, psychiatrist, nurse practitioner, or licensed clinical practicing counselor) with at least six months of practice after receiving my license;
2. I have had a personal therapy of my own either in the past or currently.

If you have answered “No” to either of these questions, I regret that your responses cannot be used in this current study, but I am very grateful for your interest.

[Participants will then be exited from the study.]

Now that you have responded affirmatively to the above eligibility questions, please read the following Informed Consent before beginning the survey. If you enter the survey following Informed Consent, your willingness to participate is assumed.



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

.....

Title of Study: Clinicians' Experiences of Addressing Issues of Religion and Spirituality in Therapy

Investigator(s): Lauren Raymond, MSW Candidate

.....

Introduction

- You are being asked to partake in a research study that investigates the experiences clinicians, both those who affiliate with a particular spirituality and those who do not, have had in addressing issues of religion and spirituality in their personal therapy as well as in their practice with clients.
- You were selected as a possible participant because you are a clinician holding a master's degree or higher in social work, psychology, or other related discipline; you hold an LCSW or equivalent licensure to practice mental health treatment; and you have both been in your own therapy and have worked with individual clients.
- 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 explore the experience of clinicians in addressing issues of religion and spirituality, both in their own therapy and in their practice, regardless of the clinician's own spiritual beliefs.
- This study is being conducted as a research requirement for a master's in social work degree at Smith College School for Social Work.
- Ultimately, this research may be published, presented at professional conferences, or used in secondary analyses of the data.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to complete an anonymous online survey that should take 20-30 minutes of your time.

Risks/Discomforts of Being in this Study

- There are no reasonable foreseeable risks in participating in this study.

Benefits of Being in the Study

- For you as the participant, benefits of participation could be increased reflection about, and self-awareness of personal experience in, incorporating religious and spiritual elements into therapy in order to guide future practice.
- The benefits to the mental health profession as a whole is further recognition of the spiritual dimension as an element of cultural competence and greater awareness of the importance of addressing these issues in therapy as well as an increased level of comfort for clinicians in

doing so. The goal is that this study, amongst others, will encourage self-examination and spur increased training for clinicians in the area of religion and spirituality.

Confidentiality

- This study is anonymous. We will not be collecting or retaining any information about your identity.
- All research materials will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

- I am not able to offer you any financial payment for your participation.

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 at any time, even midway through the survey, 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 to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely. If you do decide to withdraw, you need only to exit the survey without submitting it and none of your responses will be retained for this study.

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, Lauren Raymond by email or by telephone. If you would like a summary of the study results, an abstract of the study will be available through the Smith College library 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.

Consent

- Your completion and submission of the survey indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above.

APPENDIX C

Recruitment Letter

Dear [NASW _____ Chapter] [or Listserv][or Clinician],

My name is Lauren Raymond and I am an MSW student at Smith College School for Social Work. I am currently conducting an empirical study for the completion of my master's thesis. The purpose of this study is to explore how clinicians who have been both in their own therapy and who are in practice address religious and spiritual issues in therapy, regardless of whether or not they personally align with a particular spiritual belief. Research has shown that while religion and spirituality contribute to one's identity and worldview, it is often avoided by clinicians due to lack of training and personal discomfort. However, if this is an integral part of a client's life or if it is a way of meaning making or coping, it seems it ought to be addressed in therapy. Therefore this research study seeks to explore both whether one's personal view on spirituality as well as one's experience in discussing spirituality with a therapist will have any correlation with one's tendency to address these issues with patients of their own, how such topics are navigated by those who do and those who do not espouse a religious/spiritual orientation, and what the participants report about the impacts of these various perspectives and discussions on the clinical outcomes they are familiar with.

The study will be conducted via online anonymous survey which will be available for clinicians who have the license to practice as an LCSW or equivalent in other field and who have been in their own personal therapy. It is open to clinicians from varying or no spiritual background with the hope of recruiting a diverse sample. Participants may be of any age and years of experience post-licensure, of any theoretical orientation, and of any gender, religion, sexual orientation, ability, race, etc.

In order to recruit these clinicians, I ask that you please consider posting the link to the survey (see below) on any relevant websites or email list serves that might appeal to eligible clinicians. If you are able and willing to share this survey, I would greatly appreciate hearing back from you so that I might know where the survey is being posted. Thank you for your attention and any help you are able to offer to this study. Please find the link below:

<https://www.surveymonkey.com/r/ReligionAndSpiritualityInTherapy>

Thank you!

Lauren Raymond, MSW candidate

APPENDIX D

Survey Questions

This section focuses on your experience as the client in your own personal therapy. If you wish to elaborate, please supply additional responses in the text box provided following each question. Your comments will be most appreciated.

1. As a *client* in your own personal therapy, to what extent did discussion of religion or spirituality enter into therapy?

- 1- Never
- 2- Rarely
- 3- Occasionally
- 4- Frequently
- 5- Almost always

2. If this discussion was a part of your therapy, who initiated it?

- therapist
- you

3. If you can remember, how was the topic introduced?

4. To your knowledge, did your therapist have similar views towards religion and spirituality as your own?

- yes
- no
- I don't know

5. How comfortable did you feel with discussing issues pertaining to religion and spirituality?

- 1- Very uncomfortable
- 2- Uncomfortable
- 3- Neutral
- 4- Comfortable
- 5- Very comfortable

6. How comfortable did your therapist appear in discussing these issues?

- 1- Very uncomfortable

- 2- Uncomfortable
- 3- Neutral
- 4- Comfortable
- 5- Very comfortable

7. How helpful were these conversations in your own therapy?

- 1- They were unhelpful or even detrimental
- 2- Slightly unhelpful/detrimental
- 3- Neither helpful nor detrimental
- 4- Only slightly helpful
- 5- Very helpful

8. Please rate the effectiveness of your therapist's approach to addressing issues of spirituality and religion.²

- 1- Very ineffective
- 2- Ineffective
- 3- Neutral
- 4- Effective
- 5- Very effective

9. Please use the space below to describe therapist's approach and to comment on what you found to be effective or ineffective.

10. As a therapist yourself, how would you have approached the issue similarly or differently to the way your own therapist did?

11. How would you describe your feelings towards incorporating discussion of your own religion and spirituality into your personal therapy?

- 1- Not a priority
- 2- Somewhat of a priority
- 3- Neutral
- 4- Moderate priority
- 5- High priority

12. What is your level of satisfaction with how discussion of religion and spirituality was incorporated?

- 1- Very dissatisfied
- 2- Dissatisfied
- 3- Unsure
- 4- Satisfied
- 5- Very satisfied

13. To what extent did you feel respected and understood in raising issues of spirituality or religion?

- 1- Very disrespected or misunderstood
- 2- Somewhat disrespected or misunderstood
- 3- Neutral
- 4- Somewhat respected or understood
- 5- Very much respected or understood

14. What would you say either promoted discussion of religion and spirituality in your therapy or inhibited this discussion?

15. Please share any further thoughts on your experience as the CLIENT in discussing these matters.

16. To what degree do you consider religion and spirituality to be an important component of therapy?

- 1- Not at all important
- 2- Slightly important
- 3- May or may not be an important component
- 4- Moderately important
- 5- Very important

17. Please explain your above rating

The following section focuses on your experience as *therapist* in practice with your clients.

1. As a *therapist*, how often did discussion of religion or spirituality enter into therapy with your clients?

- 1- Never
- 2- Rarely
- 3- Occasionally
- 4- Frequently
- 5- Almost always

2. If this discussion was a part of your therapy, who initiated it?

- you
- client

3. Please share an example of how this conversation was initiated: (*Fill in*)

4. In the example above, to your knowledge, did your client have similar views towards religion and spirituality as your own?

- yes
- no
- I don't know

5. How comfortable did you feel with discussing issues pertaining to religion and spirituality?

- 1- Very uncomfortable
- 2- Uncomfortable
- 3- Neutral
- 4- Comfortable
- 5- Very comfortable

6. How comfortable did your client appear in discussing these issues?

- 1- Very uncomfortable
- 2- Uncomfortable
- 3- Neutral
- 4- Comfortable
- 5- Very comfortable

7. How would you describe your feelings towards incorporating discussion of religion and spirituality into your practice with clients?

- 1- Not a priority
- 2- Somewhat of a priority
- 3- Neutral
- 4- Moderate priority
- 5- High priority

8. How appropriate would you say that it is to discuss a patient's religious and spiritual beliefs?

- 1- Usually inappropriate
- 2- Sometimes inappropriate
- 3- Both appropriate or inappropriate depending upon several aspects
- 4- Sometimes appropriate
- 5- Often appropriate

9. To what extent do you think your experience in discussing religion and spirituality in your personal therapy has affected your experience in incorporating it into your practice?

- 1- No effect
- 2- Minor effect
- 3- Neutral
- 4- Moderate effect
- 5- Major effect

10. Please explain the rating above: *(fill in)*

11. What factors inform whether or not you raise these issues with clients? *(fill in)*

12. If you have raised these issues with clients, please share an example of a way that you raise them that you have found effective. *(fill in)*

13. Please share any further thoughts on your experience as the THERAPIST in discussing these matters.

Please provide the following information about yourself so that I can more accurately categorize the diversity of my sample. As you know, there will be no way of attributing any of your answers directly to you personally as this survey is completely anonymous; SurveyMonkey removes all your individuals' identifiable information before sending me the data.

Credentials:

Age:

Years in Practice:

Time spent in personal therapy:

___ none (*will not qualify for survey*)

___ less than 6 months

___ 6 months to 1 year

___ 1-3 years

___ 4-10 years

___ longer than 10 years

Gender:

Race/Ethnicity:

Please rate the following three questions on the scale to which they reflect you:

1 – Very untrue of me

2 – Somewhat untrue of me

3 – Neutral

4 – Somewhat true of me

5 – Very true of me

I consider myself to be religious

1 2 3 4 5

I consider myself to be spiritual

1 2 3 4 5

My faith is an important part of my life

1 2 3 4 5

Please use the space below to further describe your religion/spirituality or to indicate that you do not affiliate with any particular practice.
