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Andrea Giese-Sweat
The intersection of religion,
Spirituality and social work:
Implications for clinical
practice

ABSTRACT

Although a substantial body of literature has emerged in recent years addressing the role of religion in clinical social work practice, we know very little about what actually happens in clinical practice. The purpose of this exploratory study was to examine what we could learn from the practice wisdom of clinical practitioners about how issues of religion and spirituality actually emerge in their practice.

The sample was comprised of twelve licensed clinical practitioners who agreed to engage in a face-to-face interview to discuss their practice wisdom. The sample was skewed towards white, heterosexual women, which is representative of the field. The research schedule included demographic background questions, more open-ended qualitative questions and a religious value scale.

Findings were that all participants discussed issues of religion and spirituality in their practice although the frequency varied. This suggested that the field is making progress in integrating this content in practice. Religion was not the presenting problem in any of the case examples presented. Rather religion tended to emerge during treatment in connection with other issues. Three such issues were identified: (1) religion/spirituality as a need for external controls; (2) as part of personal identity development and separation-individuation issues; (3) as a sense of connection for persons struggling with isolation.

THE INTERSECTION OF RELIGION, SPIRITUALITY AND SOCIAL WORK:
IMPLICATIONS FOR CLINICAL PRACTICE

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

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2008

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CHAPTER I

INTRODUCTION

Historically, issues of religion/spirituality have received little attention within mainstream clinical social work practice (Faver, 1987). This is particularly surprising given the profession's religious roots (Meinert, 2007). Goldberg suggests that until recently, clinicians have tended "...to follow one of three common pathways when spiritual or religious concerns arise: Duck, punt, or feint" (1994, quoted in Helmeke & Bischof, 2002, p. 196). However, within the last two decades there has been a sharp increase in attention to this issue in the social work literature (Meinert, 2007). Most of this literature has been conceptual and/or theoretical. The major focus of this body of work has been to question when and how a client's religion/spirituality should be addressed in clinical practice. In contrast, relatively little attention has been paid to how issues of religion/spirituality actually emerge and are responded to in clinical practice.

Conceptually, religion is considered an important component of culture. While there are multiple definitions of culture, all tend to emphasize that culture is comprised of knowledge, values, beliefs and attitudes that are shared by large groups. Jacobs indicates, "The inclusion of religious or spiritual problems in the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) as a focus of clinical attention has raised the consciousness of mental health professions regarding the importance of considering a person's faith experiences and spiritual values as important experiences in their psychosocial development" (1997, p. 171). Clinical social work has a long tradition of

attending to culture, both as a system of shared beliefs and as it has been internalized within the person as part of his/her personal identity.

In recent years there has been a growing emphasis on social workers achieving the goal of “cultural competency” in their work with clients. The current section on “Cultural Competence and Social Diversity” in the National Association of Social Workers (NASW) Code of Ethics mandates, “Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures” (NASW, 2008). Religion is cited as a significant component of culture in this document. Similarly, the Council on Social Work Education (CSWE) includes religion as a significant component of culture in its accreditation standard on diversity and difference in social work practice (CSWE, 2008). The Code of Ethics (NASW, 2008) also specifies, “Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability,” including these various demographic characteristics as aspects of culture.

Of all the components of culture, race and/or ethnicity have received the most attention in the literature. A quite substantial body of research and literature has emerged that deals with this topic (Sue & Sue, 1999; Boyd-Franklin, 2006; Falicov, 2000; Gil & Drewes, 2006; etc.). In comparison, the attention to religion has been paltry.

In a review of religious/spiritual journal articles on religion in the social work literature, Meinert notes that the number of articles published has increased from only 3 from 1971 to 1980, to 40 from 1981 to 1990, to 65 from 1991 to 2000 (2007). There is

now a clinical social work journal devoted to the topic of religion, the *Journal of Religion & Spirituality in Social Work*, and the profession has experienced a steady growth in conference presentations and publications devoted to this topic (Sheridan & Amato-Von Hemert, 1999). Indeed, the Smith College School for Social Work has recently implemented one of the first certificate programs devoted to religion and spirituality in a school for social work.

Research suggests that clients express a preference for having the possibility of discussing this issue in therapy (Erickson et al., 2002; Knox et al., 2005; Rose, Westefeld, & Ansley, 2001). Research also suggests that the way in which clinicians address religion/spirituality may have a positive or negative impact that is dependent on the sensitivity of the clinician (Knox et. al., 2005). Other research has focused on how the clinicians' own views may affect the ability to address this topic in clinical practice (Burthwick, 2000; Goldberg, 1996; Sheridan, 2004). The lack of information about how religion/spirituality emerge in clinical practice marks it as a gap in the literature demanding further attention.

The current exploratory study was designed to make a contribution to filling this gap by seeing what can be learned from the practice wisdom of licensed clinical social workers about how issues of religion and spirituality emerge and are responded to in their clinical practice. The study adopted a mixed methods design consisting of face-to-face interviews with a sample of licensed clinical social workers practicing in the Los Angeles area. The research schedule consisted of structured demographic background questions, a standardized survey assessing the religious views of participants, and a series of open-ended questions probing participants' practice wisdom.

CHAPTER II

REVIEW OF THE LITERATURE

Literature attending to the role of religion/spirituality within the mental health fields has increased dramatically in the past 20 years. Much of this literature has focused on the necessity for the incorporation of religion/spirituality into clinical practice as an aspect of culture (Richards & Bergin, 2000; Dowd & Nielson, 2006). However, literature is sparse regarding the question of what actually happens in a therapeutic relationship when religious/spiritual issues arise. The literature which addresses this issue is primarily limited to providing individual case examples of times when religion/spirituality arose as an issue during therapy. It does not provide information about trends or themes that emerge in relationship to this topic.

The Contributions of Religion and Spirituality to Cultural Competency

Definitions of Religion and Spirituality

Definitions of religion and spirituality vary across sources. Northcut uses a definition of religion as “the external expression of faith...comprised of beliefs, ethical codes, and worship practices” (Joseph, 1988, p. 44, as quoted in Northcut, 2000, p. 158). Similarly, Knox et al. utilize Worthington’s 1988 definition of religion as “an organizing system of faith, worship, rituals, and tradition” (2005, p. 287). In contrast, Knox et al. define spirituality as “a phenomenon unique to the individual...[that] has been defined as the ‘breath’ that animates life or a sense of connection to oneself, others, and that which is beyond self and others” (p. 287). Northcut uses Canda’s definition of spirituality as

“the human quest for personal meaning and mutually fulfilling relationships among people, the nonhuman environment, and for some, God” (Canda, 1988, p. 243, as quoted in Northcut, p. 158).

These are only two of many examples of attempts to define religion and spirituality, respectively. Clearly, the definitions contain common components; yet they are by no means identical. Knox et al. acknowledge the lack of agreement about definitions: “We begin with some definitions, about which we acknowledge that full agreement has not been reached” (2005, p. 287). In terms of clinical practice, Northcut points out, “In true postmodern fashion, these definitions may change for clients over the course of their treatment and even after treatment officially ends” (2000, p. 158). The solution, Northcut posits, is to be open to the fluidity of these definitions: “Utilizing constructivism compels the clinician to articulate his or her understanding of the concepts, to ask for the client’s definitions and also suggests that the act of discussing these concepts with clients produces a third definition—one that is constructed between the client and clinician.”

Defining Culture

The idea of “culture,” likewise, is one which has eluded definition. Stuart Hall (1980) notes: “No single, unproblematic definition of ‘culture’ is to be found here [in various discussions of culture]. The concept remains a complex one—a site of convergent interests, rather than logically or conceptually clarified idea” (p. 522, as quoted in Park, 2005, p. 13).

Falicov (1998) draws attention to the multidimensional nature of culture:

Culture is those sets of shared world views, meanings, and adaptive behaviors derived from simultaneous membership and participation in a variety of contexts, such as language; rural, urban or suburban setting; race, ethnicity, and socioeconomic status; age, gender, religion, nationality; employment, education and occupation, political ideology, stage of acculturation (Falicov, 1983, pp. xiv-xv, as quoted in Falicov, 1998, p. 14).

This list is by no means exhaustive. Given the many attributes which may be included as part of “culture,” Falicov concludes, “Culture can then be thought of as a community of individuals and families which partially share particular views, or dominant stories, that describe the world and give life meaning” (p. 14).

Religion and Spirituality as Aspects of Culture

In the above definition, Falicov includes “religion” as a factor contributing to culture. The NASW definition of “culture” includes religious groups, as well: “The word culture is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group” (NASW National Committee on Racial and Ethnic Diversity, 2001).

Though these particular definitions do not include “spirituality” as an aspect of culture, Erickson et al. point out, “One of the difficulties that has hampered research in religion and spirituality is the confusion of the two terms” (2002, p. 113). Furthermore, Erickson et al. highlight that, “In MFT, religion and spirituality are being included with all the other aspects of diversity including race, culture, socio-economic status, ethnicity,

gender, generation, and so on” (p. 113). Subsequently, the lack of inclusion of spirituality in certain definitions of “culture” does not disqualify its contribution to this definition but merely suggests that it may not yet have been identified specifically in this context. Indeed, Falicov’s idea of culture as “a community of individuals and families which partially share particular views, or dominant stories, that describe the world and give life meaning” (1998, p. 14) leaves the definition of culture open to a variety of interpretations.

The Movement Toward Cultural Competency

Whatever its definition, culture as a concept has received considerable attention in the social work field as an area in which social workers should demonstrate competence. In section 1.05, entitled “Cultural Competence and Social Diversity,” the NASW code of ethics mandates:

- (a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.
- (b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.
- (c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability (2008).

A whole group of writing is devoted to educating social workers and other professionals about multicultural practice (e.g., Falicov, 2000; Sue & Sue, 1999; Boyd-Franklin, 2006; Gil & Drewes, 2006; etc.). Given this environment in which cultural competency is considered a necessary requisite for social work practice, and religion/spirituality may be considered aspects of culture, the push for inclusion of religion/spirituality in clinical practice is logical.

Religion and Spirituality in Social Work Literature

The Historical Role of Religion/Spirituality in Social Work

Social work, as a field, has deep roots in religion. For example, the Charity Organization Society (COS) and settlement house movements, which contributed greatly to the formation of the social work profession, were founded on religious principles of morality. “Social welfare agencies, both public and private, were infused with mainline Protestant principles, and religion and social welfare commingled (Meinert, 2007). Up through the present, many social service agencies, such as Jewish Family Service and Catholic Charities, have religious roots.

Surprisingly, though, religion and spirituality have traditionally been ignored in the social work literature (Faver 1987). Meinert cites, “Books about the topic of religion and spirituality in social work began to be published mainly in 1988 and thereafter” (2007). Within the past 20 to 30 years, however, the topic has become increasingly more common in social work literature. Whereas between 1970 and 1980, only 3 articles on the topic in social work journals, between 1981 and 1990, 40 appeared, and between 1991 and 2000, 65 (Meinert 2007). Furthermore, the literature indicates that the social work profession has shown considerably greater sensitivity to this topic than have other mental

health fields (Modesto, Weaver, & Flannelly, 2006). These and other sources suggest that, in the literature at least, religion/spirituality is beginning to receive the attention it deserves.

The Current Role of Religion/Spirituality in Social Work Practice

Multiple authors highlight the importance of including religion/spirituality in clinical practice (Faver, 1987; Gotterer, 2001; Holloway, 2007; Jacobs, 1997; Northcut, 2000; Sermabeikian, 1994). Research suggests that practitioners have begun to exhibit increasing openness to the inclusion of religion/spirituality in the clinical dialogue (Burthwick, 2000; Furman et al., 2007; Joseph, 1988; Sheridan & Amato-Von Hemert, 1999). This may be interpreted as a positive development given that religion/spirituality are identified as sources of strength for the client and as beneficial to the treatment process (Gotterer, 2001; Sermabeikian, 1994).

Religion/Spirituality in Social Work Education

As the role of religion/spirituality in clinical practice has experienced a resurgence, its role in clinical social work education has increased, as well. Hodge cites, “By 1999, more than three quarters of *US News*-ranked social work programs were providing at least some content on religion and spirituality in their educational programs” (2006, p. 249). Additionally, the Council on Social Work Education (CSWE) “revised its accreditation standards in 1994 to include religion in its understanding of human diversity” (Hodge, p. 249).

Sheridan & Amato-Von Hemert highlight the increasing presence of religion/spirituality in professional conference presentations and publications (1999). However, their research also suggests that, although in theory, religion and spirituality

may be integrated into social work integration, this integration may not yet fully exist in practice:

Results revealed a generally favorable stance toward the role of religion and spirituality in social work practice and relatively high endorsement and utilization of spiritually oriented interventions with clients...[however] the majority of respondents reported little exposure to content on religion and spirituality in their educational program (Sheridan & Amato-Von Hemert, 1999, p. 125).

Gilligan & Furness highlight how, in comparison with the UK, religion/spirituality have received substantial attention in U.S. social work education (2006). However, even these authors note that “in the 1990s, more than one study suggested that around two-thirds of social work students in the USA were reporting that they had received very little input related to religion and spirituality in their graduate social work classes” (Gilligan & Furness, p. 619).

Failure to integrate religion/spirituality into social work education holds potentially harmful implications for clients, as in the case of any area of inadequate training. Holloway highlights that “much of the problem for practitioners, even where they identify spiritual need as an issue, lies in the inadequate theorizing and lack of practice guidance developed in the context of UK social work” (2007, p. 265). This issue applies equally to practitioners in the U.S.

Lack of training may even contribute to a failure to address religion/spirituality in therapy. Helmeke and Bischof identify an occurrence of just such a failure to address religious/spiritual issues in marriage and family therapy: “Some topics are just more

difficult than others for therapists to talk about with their clients. Discussions involving spirituality or religion seem to be one of those uncomfortable areas for many therapists” (Helmeke & Bischof, p. 196). According to these authors, “the reluctance involves a lack of training, and therefore confidence, in knowing how religious and spiritual issues can be integrated appropriately into therapy” (Helmeke & Bischof, p. 196). The impact of such a lack of training may extend to social work practice, as well.

Religion/Spirituality As They Appear in Therapy

Though the issue of the inclusion of religion/spirituality in the clinical relationship has received considerable literary attention, the literature addressing what actually happens in a therapeutic relationship when religious/spiritual issues arise remains sparse. The literature which does address this topic is primarily limited to providing individual case examples of times when religion/spirituality arose as an issue during therapy. Minimal information about is available trends or themes that emerge in relationship to this topic.

Goldberg, for example, in an effort to illustrate the countertransference raised by discussion of religion in therapy, provides a number of clinical vignettes (1996). Similarly, Joseph (1988) conducted a study investigating “the religious issues that emerge in clinical social work practice” and identifying “salient issues in various life phases” via a survey of “master’s degree program field instructors...of a church-related school of social work” (p. 443). Additionally, Sheridan (2004) researched practitioner behaviors in addressing religion/spirituality with clients in terms of assessment and interventions. None of these studies, however, sought information about trends as to how religion/spirituality come up in practice.

Clinician Openness to Inclusion of Religion/Spirituality in Therapy

In the current intersubjective atmosphere of therapy exists the idea that the clinician's own views on religion/spirituality may impact the client. Northcut (2000) recommends that the clinician explore her own religious/spiritual identity prior to engaging the client's. Two suggestions are the "spiritual genogram" (Northcut, p. 158) and "drawing a time line of one's religious experiences" (Northcut, p. 159) as ways for the clinician to increase self-awareness. In addition, Northcut addresses the idea that "countertransference...can undermine the therapist's attempts to understand the clients' experience" (p. 159).

Burthwick (2000) identified that the clinician's own system of belief may, in fact, impact a clinician's openness to addressing religion/spirituality in therapy. "Analysis of variance demonstrated that the greater the lifetime frequency of participation of social workers in spiritual or religious activities, the more likely they were to believe it is appropriate to raise the topics of religion and spirituality" (Burthwick, p. 4604). Stewart, Koeske & Koeske identified a similar trend: "A process model utilizing path analysis suggested that personal spirituality increases utilization resulting in corresponding perceptions of appropriateness and attitude toward religion in practice" (2006, p. 69). Sheridan also revealed that "the level of practitioner participation in religious or spiritual services" was predictive of practitioner usage of religion/spirituality in therapy (2004, p. 5). These and other sources reveal the significance of the clinician's own views on the role of religion/spirituality in clinical practice.

Suggestions for Therapists about Including Religion/Spirituality in Therapy

Though few sources address how religion/spirituality emerge in clinical practice, a number of sources address how clinicians should address it (Gotterer, 2001; Hodge, 2005; Northcut, 2000; Sahlein, 2002; Winship, 2004). For example, Hodge addresses the topic of working with Hindu clients with an aim to assist clinicians in being culturally sensitive (2004). Hodge and Nadir (2008) apply a similar lens of “cultural competency” to Muslim clients, describing how therapists might alter cognitive approaches to conform to Islamic tenets.

These types of guidelines aim to aid clinicians in attempting increase discussion of religion/spirituality in therapy. The availability of this type of guidance demonstrates the increasing level of attention to religion/spirituality in clinical social work and stands in contrast to the state of affairs 10 years ago, when few, if any, instructions were available. Sherwood addressed this dearth at the time (1998).

Research on Religion/Spirituality in Other Fields

Religion/Spirituality As They Appear in Therapy

The literature describing how religion/spirituality typically emerge in therapy is sparse in other fields, as well. However, some authors do address this within the context of encouraging therapists to address or be sensitive to the issue. Aponte (2002), Griffith & Griffith (2002), and Strawn (2007) all offer case studies of clients for whom the issue of religion/spirituality arose in therapeutic interactions to illustrate perspectives on the inclusion of religion/spirituality in therapy. Indeed, most authors utilize the case studies as support for their assertions that religion/spirituality should be included in therapy, without addressing the larger issue of how religion/spirituality arise in therapy, in

general. Nonetheless, the case studies provide valuable examples of how therapists might include these issues.

Aponte utilizes a case example to support his assertion that “spirituality enhances the power of therapy” (2002, p. 13). He proposes that the mechanism by which it does so involves “making moral choices the heart of issues clients present... assisting clients in becoming emotionally and spiritually grounded...[and] including spiritually enriched resources among people’s options for solutions.” He describes a family session in which a therapist assists in resolving a family issue while being cognizant of the role that moral values play within the family. Aponte emphasizes, “Layered over their emotional life and relationship dynamics are the difficult value choices that family, church and society present” (p. 26).

Griffith & Griffith likewise illustrate the utility of religion/spirituality in advancing therapy but also highlight ways in which it may hinder progress (2002). The hindrance seems to exist in the belief itself, as opposed to its use in therapy. The authors tell the story of a bipolar client who ceased taking medication based on a religious belief: “Back then he had been convinced that the Christian response to his illness was to depend on God for healing. To take the medicines would show he doubted God’s power” (Griffith & Griffith, p. 170).

Similarly, religious belief may lead a patient to actions supporting his mental health, as it eventually did for this patient. The therapists illustrate the use of the client’s religious faith to enhance the treatment, asking, “Will you continue to talk with God about this? Can you hold open the possibility that God does not require of you that you stop the medicines?” (Griffith & Griffith, 2002, p. 181).

Strawn describes a case in which the client's religion/spirituality is less of a central issue for treatment but nonetheless holds a significant role (2007). Most significantly, the client's religion/spirituality holds information to aid the clinician in understanding her.

Rachel grew up the second oldest daughter of four siblings...in the home of a conservative pastor father and a very anxious and ineffectual mother...As a young child she was very frightened of the "hell and brimstone" preaching she heard from her father's pulpit and was terrified of being sent to eternal damnation. When she was very young she used to physically rock as a self-soothing mechanism. Instead of being concerned about this behavior, when Rachel's father would see her rocking he would jokingly say, "You are rocking for Jesus right Rachel?" This was one of the numerous misattunements common in Rachel's family... Rachel had been so traumatized by her religious experience that it was painful for her to set foot in a church (pp. 10, 12).

This example illustrates the potential importance of taking a client's religious/spiritual history as a matter of course.

In contrast, Knox et al. provide a broad overview of client descriptions of interactions addressing religious/spiritual issues in therapy (2005). The aspects of each interaction which were addressed in the research include: the religious/spiritual topic addressed; who raised the topic; how and why the topic was addressed; when the topic was addressed; facilitating conditions for addressing the topic; the outcome of the discussion; and satisfaction with therapy. Though the article does not provide details

about the client-therapist interactions, it does provide a general perspective on the types of interactions addressing religion/spirituality in therapy and their prevalence. The current study attempts to provide the same type of perspective from the clinician's point of view.

From these articles it is apparent that religion/spirituality may appear in therapy either as a central theme or as an incidental issue. In either case, however, it seems often to function as a support to the work in therapy. The therapist may draw upon the issue of religion/spirituality to enhance the therapeutic relationship and to move the work forward.

Clients Desire the Inclusion of Religion/Spirituality in Therapy

Research suggests that clients feel religion/spirituality should be addressed in therapy (Erickson et al., 2002; Knox et al., 2005). For example, Knox et al. conducted a study interviewing twelve clients for whom religion/spirituality plays a central role in their lives and with whom the topic had arisen in therapeutic relationships (2005). Whereas with therapists, the topic may be taboo, "Clients indeed wish to discuss religious-spiritual topics in therapy...such discussions are often integrated into clients' addressing their psychological concerns, and...therapy effectiveness may be enhanced by therapists' respectful incorporation of clients' religious-spiritual beliefs into treatment" (Knox et al., p. 300).

Erickson et al. also highlight the idea that "clients most often prefer a counselor that would be sensitive and open to their religious beliefs and spirituality" (2002, p. 111). These authors surveyed a group of 38 clients who had received therapy at university clinics. The study aimed to assess whether "clients of MFT interns feel that the religious

and/or spiritual aspects of their lives were adequately and/or appropriately addressed in the therapy process” (p. 115).

In the process of this assessment, however, the researchers had to determine whether clients in fact felt a desire for therapists to address “religious and/or spiritual aspects of their lives” (Erickson et al., 2002). Their results indicated that this desire does exist:

More than half of the respondents (57.9%) indicated that their religious and/or spiritual beliefs had some type of influence, either positive or negative, on the problems or difficulties they went to therapy for. Likewise, more than half of the respondents (59.5%) answered yes to the question “Was religion or spirituality necessary for healing?” (Erickson et al., p. 116).

Thus, research suggests that a majority of clients in therapy do have a preference for therapists to be cognizant of religious/spiritual concerns (Erickson et al., 2002; Knox et al, 2005; Rose, Westefeld, & Ansley, 2001). While this preference may not be present for all clients, its existence for such a significant proportion of clients requires that clinicians be aware of it in the context of therapy.

These studies did exhibit clear limitations. Knox et al. (2005) address that their study was limited by its homogeneity: all participants were White, and almost all were female. Additionally, the low number of responses limits the study’s potential for generalization. Likewise, the study put forth by Erickson et al. (2002) had an extremely low response rate of 16%. Here also, participants were predominantly White and female. In addition, the sample in the Erickson study “represented only Christian clients” (p.

115). Despite the lack of diversity of the participants in each of these studies, nonetheless, they illustrate that, for the respondents, at least, the possibility of addressing the issue of religion/spirituality in therapy was very significant. The preferences of these clients affirm the need for therapists to be open to this possibility.

In particular, participants' responses to circumstances in which therapists did not adequately address this issue are enlightening. Several respondents cited circumstances in which they desired to address religion/spirituality in therapy but chose not to do so (Knox et al., 2005). The authors hypothesized that a possible deterrent in these situations was that participants experienced a "sense of discomfort (e.g., arising from therapist-client differences or a fear of being judged)" (Knox et al., p. 298).

Some respondents additionally cited instances in which the issue arose but was not helpful (Knox et al., 2005). In these instances, "such conversations became unhelpful primarily because clients felt that their therapists were passing judgment or imposing their own beliefs" (Knox et al., p. 298). Likewise, Chesner & Baumeister revealed that perceived differences in religion between clients and therapists affected clients' comfort in the clinical relationship (1985). These investigators suggested that potential discomfort for the client may rule out therapist self-disclosure of religious beliefs.

Impact of Client's Religion on the Clinician

Rarely do writers attend to the therapist's own religious/spiritual orientation in the equation. Given the recent focus in the practice of psychotherapy on intersubjectivity, this is surprising. Strawn (2007) defines intersubjectivity in terms of its use in the therapeutic relationship: "Intersubjectivity...emphasized the genuine contribution that the therapist made to any therapeutic endeavor. Therapists are not passive, objective, professionals..."

Rather therapists are co-constructors of the therapeutic dialogue” (p. 6). With this understanding, any consideration of a client’s religious/spiritual orientation must take the clinician’s into account as well.

Strawn, in fact, shows awareness of the role a clinician’s own religious/spiritual stance may play (2007). “Because of my own countertransference I wanted Rachel to make the same journey I had back to a God and a faith system that was welcoming and accepting, non-dualistic and embodied” (Strawn, p. 12). Not only can the clinician’s religious/spiritual stance affect the client’s view of him; it can also influence the clinician to move the therapy in a direction which may not necessarily reflect the best interests of the client.

For this reason Strawn provides the caution: “working with religious patients may mean ending therapy in a place that is more uncomfortable for the ‘orthodox’ therapist than it is for the religiously oriented patient” (2002, p. 12). This caution is especially important since, as Aponte indicates, “clinicians now hardly pretend to be value neutral as they were expected to be yesteryear...therapists everyday introduce their philosophies and values into the therapy they do” (2002, p. 14). In this intersubjective atmosphere of therapy, now more than ever therapists must maintain self-awareness and attempt to avoid imposing their own values on their clients.

Impact of Clinician’s Religion on the Client

Research suggests that differences between clinicians and clients may affect the decision whether to include certain topics in the therapeutic relationship. Bergin highlights the contrast between client and clinician religious/spiritual beliefs (1980; 1991). He asserts, “Two broad classes of values are dominant in the mental health

professions. Both exclude religious values, and both establish goals for change that frequently clash with theistic systems of belief” (Bergin, 1980, p. 98). The two “classes of values” to which he refers are clinical pragmatism and humanistic idealism, both of which, he suggests, “manifest a relative indifference to God, the relationship of human beings to God, and the possibility that spiritual factors influence behavior.”

While Bergin’s viewpoint assumes a limited range of perspectives on the part of mental health professionals, his point is well taken. Guinee (1999) and Strawn (2007) both caution against therapists imposing beliefs on clients. This caution is particularly important due to the impact the therapist’s values may have on the client.

Chesner and Baumeister revealed the potential impact therapist self-disclosure may have in a study of therapeutic relationships in which therapists either did or did not reveal their own religious beliefs to clients and the clients’ relative comfort in the relationships (1985). The study revealed that, in fact, client awareness of a clinician’s religious ideology did not increase comfort in the clinical relationship and might even decrease comfort in the case that the therapist’s religious identification differed from that of the client. This type of study indicates that self-disclosure of religious identification may not be productive in therapy. On the other hand, Giglio (1993) encourages therapist disclosure of religious values in the interest of openness in the therapeutic relationship and ensuring that clients receive proper care. The issue clearly requires additional research to provide therapists with the best information about how to comport themselves in therapy.

Clinician Openness to Inclusion of Religion/Spirituality in Therapy

Social work, as a profession, has begun to demonstrate a commitment to respecting religious diversity, at least as an aspect of culture. This commitment is reflected in the NASW Code of Ethics, cited above. Likewise, authors in other fields have begun to express, from the clinician's point of view, the importance of bringing religion/spirituality into the clinical relationship. Aponte, for one, considers spirituality "the heart of therapy" and emphasizes that "spirituality enhances the power of therapy" (2002, p. 13).

Bartoli surveyed the attitudes of training psychoanalysts regarding the place of clients' religious/spiritual worldviews in the therapeutic relationship (2003). The survey's results indicated that "Overall, the analysts surveyed reported themselves to be quite open to discussing religious and spiritual material with their patients, irrespective of the analysts' theoretical orientations or religious identifications" (Bartoli, p. 356). Such an attitude reflects the experiences of the clients surveyed by Knox et al. and Erickson et al., who generally reported feeling satisfied with their clinicians' abilities to address religious/spiritual concerns (Erickson et al., 2002; Knox et al., 2005).

However, clinicians' openness may be tempered by the concept that "the more externally imposed and rigid framework a given religious view implies, the less inclined analysts might be to view religion in a positive light" (Bartoli, 2003, p. 359). This concept may contribute to judgment of client beliefs on the part of the therapists. Griffith & Griffith discuss this potential for judgment: "I not only disagreed with Lutchi's beliefs, I was turned off by the way he espoused them...Stereotyping was closing my mind and heart, pulling me to an either/or position" (2002, p. 175). Thus, psychoanalysts may not

be as open to the issue of religion/spirituality in therapy as they hope or claim to be. Unfortunately, this type of judgment and/or imposition of beliefs was precisely the factor which deterred clients in Knox's study from discussing religion/spirituality in therapy (Knox et al., 2005).

Suggestions for Therapists about Including Religion/Spirituality in Therapy

While social work curricula may neglect training for therapists on bringing religion/spirituality into clinical practice, some authors who support this move also provide practical suggestions for doing so (Griffith & Griffith, 2002; Helmeke & Bischof, 2002). Strawn (2007) offers a perspective on "Slouching toward integration" and provides a case study addressing the difficulty in integrating religion/spirituality and therapy. Entire books are even beginning to confront the issue. Dowd and Nielsen (2006) and Richards and Bergin (2000) provide only two out of many examples of books focused on bringing religion/spirituality into clinical work. These sources may address different religions or denominations by chapter, offering cues for conducting "Psychotherapy With" each of the groups in question and providing insight into cultural aspects related to various religious/spiritual groups (Richards & Bergin, 2000).

Aponte (2002) and Bergin (1980) provide more general theoretical bases for including religion/spirituality in therapy. Aponte puts forth a set of principles for this integration:

There are three general ways in which spirituality enhances the power of therapy.

The first relates to making moral choices the heart of issues clients present. The second involves helping clients become grounded, that is, taking control of the solutions of their problems from within their own inner beliefs and motives. The

third has to do with adding spiritually enriched resources to people's recourses (2002, p. 18).

Helmeke and Bischof indicate, "By listening closely to the client's responses, both verbal and non-verbal, therapists are likely to be aware of when they are treading on ground that is sacred for a client, as well as whether they are trespassing or are being invited to journey further" (2002, p. 212). In other words, simply by adhering to the basic tenets of therapy, a clinician may be able to meet a client's needs for addressing religion/spirituality in the clinical encounter.

Social Work in Comparison with Other Fields

Given its apparent importance to clients, the fact that social work and other fields have begun to address the inclusion of religion/spirituality in therapy is significant. Research suggests that traditionally, social work has compared favorably to other mental health fields in clinicians' attitudes toward including religion/spirituality in clinical practice (Sheridan et al., 1992). More recently, Modesto, Weaver, & Flannelly suggest that "social work scholars have given more attention to the role of religion and spirituality in social intervention" (2006, p. 77). These researchers compared the prevalence of quantitative studies measuring "at least one religious or spiritual variable," finding that social work research in this area outnumbers psychology, psychiatry, and medicine at least 5 to 1 (2006, p. 77).

Furthermore, several investigators have highlighted the capability with which the social work profession in the U.S., specifically, has evolved toward the inclusion of religion/spirituality in clinical practice (Furman et al., 2007; Gilligan & Furness, 2006).

Furman et al. identified that “In general, U.S. social workers were more accepting of religion and spirituality than their Norwegian colleagues” (2007, p. 241). Similarly, Gilligan & Furness highlight how “Issues of religion, spirituality and social work have, until very recently, received relatively little attention from British social work educators and at times appear to be actively avoided by most of the profession... This is in apparent contrast to the USA, where from an outsider’s perspective, such issues have been much more to the fore” (2006, p. 618). Thus, research suggests that the social work field in general, and the social work profession in the U.S., in particular, are keeping pace with with client preferences.

Summary

Overall, the literature addressing religion/spirituality in the mental health fields, and specifically in clinical social work practice, has increased substantially over the last 20 to 30 years. The literature suggests that clients and clinicians concur that religion/spirituality is an important component of therapy. As the literature has expanded, clinical attention to this topic has increased, as well. However, the literature about trends as to how religion/spirituality appear when they actually do emerge in clinical practice remains limited.

CHAPTER III
METHODOLOGY

Research Design

This study examined the issue of the emergence of religion/spirituality within the clinical relationship through the lens of practitioners. This exploratory project utilized a mixed methods design, combining qualitative and quantitative methods to reveal how religion/spirituality appear in clinical practice at present. The research schedule consisted of structured demographic background questions, a standardized survey assessing the religious views of participants, and a series of open-ended questions probing participants' clinical practice wisdom.

Characteristics of the Participants and Recruitment Process

The study's participant population consisted of 12 licensed clinical social workers practicing in the greater Los Angeles metropolitan area, where the research was based. The research employed a sample of convenience recruited via a snowball sampling strategy. The researcher began with contacts advanced by colleagues at the Smith College School for Social Work and UCLA. Once potential participants were identified, the investigator provided recruitment letters to be distributed to participants. Potential participants were asked either to contact the investigator or to provide contact information to the investigator's colleagues so that she could contact them directly.

Once recruitment letters were distributed, the investigator contacted potential participants by phone to explain the study and nature of participation and to determine whether the potential participants met the criteria for participation and were willing to

participate. Potential participants were informed that participation would consist of meeting in a face-to-face interview to discuss their clinical practice experience with religious and spiritual content, including providing information about their own demographic background, and completing a survey about their own religious views.

Participants who had completed the interview were then asked to recommend other practitioners that might meet the criteria for participation in the study. Potential participants who were identified in this manner likewise received recruitment letters and were asked either to contact the investigator or to provide contact information to their colleagues so that the investigator could contact them directly. The investigator subsequently contacted these potential participants by phone to explain the study and nature of participation and to determine whether these potential participants met the criteria for participation and were willing to participate.

Complete anonymity was not possible due to the recruiting process. Recruitment letters were not distributed in a confidential manner. Since participants were recruited by word of mouth, recruiters may have been aware if their colleagues were participating. The investigator aimed to recruit as diverse a sample as possible in terms of demographic background and practice experiences. In reality, the participant population lacked diversity, for undetermined reasons.

The investigator chose not to delineate a requirement that participants have practice experience addressing religion or spirituality in hopes of obtaining as diverse a sample as possible in terms of practice experience. However, the recruitment letter did identify that the study was examining how issues of religion and spirituality emerge and are responded to in clinical social work practice. The participant population may have

been impacted by this specification, as practitioners who felt they did not have experience addressing issues of religion and spirituality in clinical practice may have chosen not to participate in the study.

Data Collection Methods

The study utilized a questionnaire designed specifically to elicit information about the emergency of religion and spirituality in clinical practice. The instrument was piloted prior to the start of the interview schedule to ensure that it would satisfactorily obtain the desired data. A face-to-face interview at a mutually convenient time and place was scheduled with candidates that met the criteria for participation and were willing to participate. Each participant was given the opportunity to ask any remaining questions before signing two copies of the informed consent form, one for the researcher and one for the participant's personal records.

Participants were then asked to respond to a number of questions customized to focus on the issues under investigation. Participants were asked a combination of structured demographic background questions and a series of semi-structured questions designed to probe how issues of religion and spirituality emerge and are responded to in participants' clinical practice. The study employed flexible methods in that the interview tool utilized open-ended questions aimed to elicit the participants' responses; in the event that participants' responses did not include all relevant data, the investigator utilized follow-up probes to elicit additional information.

Participants were also asked to fill out a 62-item survey about their religious values, the Religious Values Scale, that for most participants took less than 10 minutes to complete. The survey was developed by Morrow, Worthington, & McCullough in 1993.

This standardized scale was designed to measure “individuals’ religious attitudes and beliefs and the degree to which she can tolerate others’ holding different religious values” (Hill & Hood, 1999, p. 108). The scale aimed to aid in “understanding the values of highly religious clients of psychotherapy” (p. 108). In this investigation the scale provided additional information about how clinicians’ own religious views correlated with the frequency with which they discussed religion/spirituality in clinical practice.

Each interview lasted approximately one hour, including the time needed for participants to complete the survey. Each interview was tape recorded, and the investigator took additional notes as necessary during each session. Each participant was assigned a code number under which data was maintained and which has been changed for reporting purposes.

CHAPTER IV

FINDINGS

Participant Characteristics

Twelve clinicians agreed to participate in the study and were interviewed as part of the research sample. All participants were licensed clinical social workers currently practicing in the greater Los Angeles area. As part of the interview, participants were asked to provide background information about themselves in terms of demographics and practice experience.

Participant Demographics

Participants ranged in age from 33 to 64, with a noticeable bias toward the high end of the age range. The average age was about 54. The demographics of participants' sex/gender were skewed as well. Most participants (10=83%) were female. Likewise, participant sexuality fell heavily toward the heterosexual end of the spectrum, with ten participants (10=83%) identifying as heterosexual or straight; one (1=8%) identifying as homosexual, gay, lesbian or queer; and one (1=8%) identifying as bisexual. This sample was also overwhelmingly White Caucasian. Nine (9=75%) self-identified as White or Caucasian; two (2=17%) as Latino; and 1 (1=8%) as White and Jewish.

Participant Religious/Spiritual Identifications

Religious identification

Nine participants (9=75%) reported having a religious affiliation of some type, whereas three participants (3=25%) reported that they did not. Two of these participants (2=17%)

Table 1

Participant Demographic Background: Personal Information

Participant	Age	Sex/Gender	Race
A	33	Female	Caucasian
B	41	Female	White
C	46	Male	Latino
D	53	Female	White
E	53	Male	Latino
F	54	Female	White
G	59	Female	Caucasian
H	60	Female	Caucasian
I	60	Female	Caucasian
J	61	Female	White, Jewish
K	63	Female	Caucasian
L	64	Female	Caucasian

indicated that they had previously had some type of religious affiliation but had none at present. Out of the nine participants who identified a (current) religious affiliation, five (5=42%) identified as Jewish. However, two (1=17%) of the participants who identified as Jewish described their religious affiliation as more of a cultural practice than a religious one. Three participants (3=25%) identified as Catholic or Roman Catholic; one (1=8%) identified as Episcopal.

Table 2

Participant Religious and Spiritual Identifications

Participant	Do you have a religious affiliation?	What is it?	Do you have a spiritual orientation/practice?	What is it?
A	Yes	Episcopal	"I don't know"	
B	Yes	Jewish	No	
C	Yes	Catholic	Yes	Related to religious affiliation; prayer; mindfulness/meditation
D	No		Yes	Buddhism; mindfulness/meditation
E	Yes	Catholic priest	Yes	Eclectic; related to religious affiliation
F	Yes	Jewish	No	
G	No		Yes	Eclectic; Buddhist and Hindu philosophies; morality
H	Yes	Jewish	Yes	Mindfulness/meditation; yoga; experiences of nature
I	Yes	Jewish	No	
J	No		Yes	Eclectic; belief in a higher power; mindfulness/meditation; prayer
K	Yes	Jewish	No	
L	Yes	Roman Catholic	Yes	Related to religious affiliation; mindfulness/meditation

Spiritual orientation/practice

Six participants (6=50%) reported having some type of spiritual orientation or practice, and four participants (4=33%) reported having none. Two participants (2=17%) responded neither in the affirmative nor in the negative. One of these two participants (1=8%) identified having an "intermittent" spiritual orientation and/or practice, and the other (1=8%) responded simply, "I don't know." Those participants who did report

having a spiritual orientation or practice identified a variety of different types of practices.

Participant Educational Background and Practice Experience

Overall, this was a seasoned group of practitioners. All had the MSW degree and were licensed in the state of California. Three participants (3=25%) identified having a Master's degree in addition to the MSW. Two participants (2=17%) identified having some type of doctoral degree. The number of years in which participants had been in clinical practice ranged from 10 to 40 for a mean of 25 years. All participants had worked in multiple clinical settings. All had worked with clientele from a range of diverse groups (see Table 5).

Participants were also asked to define whether they practiced using any particular theoretical orientation. Eleven out of twelve participants (11=92%) identified using one or more theoretical orientations; one participant (1=8%) identified using none. Seven participants (7=58%) identified using a variety of theoretical orientations or an "eclectic" orientation. Six participants (6=50%) identified following a "psychodynamic" orientation; five participants (5=42%) identified utilizing cognitive-behavioral techniques; three participants (3=25%) identified with a psychoanalytic orientation; and two participants (2=17%) identified utilizing some form of object-relations. Five participants (5=42%) identified other types of theoretical orientations, including: humanistic; relational-cultural perspective; supportive counseling; Ellis Institute; developmental; Bodydynamics; and DBT.

Additionally, participants were asked to identify whether they had any credentials in addition to a license and a Master's in Social Work (MSW). Eight participants

Table 3

Participant Years of Experience and Theoretical Orientation

Participant	Approximate Years in Clinical Practice	Year Licensed	Theoretical Orientation
A	10	2004	Psychodynamic
B	18	1992	Eclectic: psychodynamic; cognitive-behavioral; relational-cultural
C	14	1999	Eclectic: psychodynamic; humanistic; cognitive-behavioral
D	10	~2005	Eclectic: supportive counseling; cognitive-behavioral; Ellis Institute
E	18	1993	Eclectic: developmental; Bodynamics; object relations
F	29	2004	Psychoanalytic
G	34	1977	Psychodynamic
H	30	1978	Psychodynamic
I	25	1983	Eclectic: psychoanalytic/psychodynamic; DBT; cognitive
J	30	1974	Eclectic: psychodynamic; short-term/cognitive-behavioral; generalist
K	38	1970	Eclectic: psychoanalytic; object relations
L	40	1968	None

(8=67%) identified having some other type of certificate or credential, including: a certificate in psychoanalysis; Board Certified Diplomat, American Board of Examiners in Clinical Social Work; a certificate in Gestalt Therapy; a Licentiate in Sacred Theology

(STL); an Ellis Institute certificate; a certificate in trauma therapy using somatic experiencing; Pupil Personnel Credential; certification for mind/body techniques; and Lifetime Adult Education Credential. Three participants (3=25%) identified having no additional credentials. One participant (1=8%) each had a Master's in Divinity; MLS, a Master's in Library Science; and a Master's in Jewish Studies. One participant (1=8%) had a doctorate in Psychoanalysis; another (1=8%) had a doctorate in Comparative Literature. Participants also identified different types of settings in which they had worked during their careers.

Table 4

Participant Professional Education and Practice Experience

Participant	Other Credentials	Practice settings	Do you have a private practice?	For about how many years have you had a private practice?
A	None	medical social worker; acute care; adult day health care; college mental health clinic; domestic violence shelter; adolescent residential treatment; private practice	Yes	4
B	None	medical social worker; ER social worker; outpatient mental health clinic	No	
C	Master's	community mental health; school social worker; hospice social worker	No	
D	Doctorate, Master's, Certificate/Credential	psychiatric inpatient, unspecified; outpatient mental health clinic; ER social worker; private practice; medical social worker	Yes	12
E	Master's, Certificate/Credential	school social worker; Catholic services; outreach	No	

Participant	Credentials in addition to MSW & LCSW	Practice settings	Do you have a private practice?	For about how many years have you had a private practice?
F	Certificate/ Credential	alcohol and drug rehab; department of social services; AIDS coordinator/educator; employee assistance program; private practice; partial hospitalization program	Yes	27
G	Certificate/ Credential	department of adoptions; inpatient child psychiatry; outpatient child psychiatry; inpatient adolescent psychiatry; director of social work in a psychiatric hospital; outpatient adult psychiatry; medical social worker; employee assistance program; psych. ER; ER social worker	Yes	28
H	Certificate/ Credential	child guidance clinic; family service agency; private practice; Smith; Catholic services; alternative youth projects	Yes	25
I	Certificate/ Credential	adolescent residential treatment; outpatient mental health clinic; inpatient adult psychiatry; outreach; alternative youth projects; inpatient adolescent psychiatry	Yes	24
J	Certificate/ Credential	medical social worker; welfare department; private practice	Yes	15
K	Doctorate, Certificate/ Credential	department of social services; department of adoptions; family service agency; private practice; community mental health; pro bono work	Yes	31
L	None	outpatient child psychiatry; inpatient child psychiatry; inpatient adolescent psychiatry; medical social worker; outreach; school social worker; private practice	No	

Table 5

Participant Exposure to Diverse Client Populations

Participant	Client Race	Client Gender	Client Sexuality	Client Primary Language	Client Age	Client SES	Client Religion
A	White/Caucasian; Black/African-American; Hispanic/Latino; Asian	Male; Female; Transgender	Heterosexual; Homosexual/ Gay/Lesbian/ Queer; Bisexual	English; Spanish	Child; Adolescent; Adult; Elder	Low SES; Middle SES; High SES	Jewish; Catholic; Protestant Christian; Non-denominational; Mormon; Atheist; Agnostic
B	White/Caucasian; Black/African-American; Hispanic/Latino; Asian; Native American	Male; Female; Transgender	Heterosexual; Homosexual/ Gay/Lesbian/ Queer; Bisexual	English; Spanish; French	Child; Adolescent; Adult; Elder	Low SES; Middle SES; High SES	Jewish; Muslim; Catholic; Protestant Christian; Lutheran; Atheist; Agnostic; Hari Krishna
C	White/Caucasian; Black/African-American; Hispanic/Latino; Asian; Middle Eastern; Persian/Iranian	Male; Female; Transgender	Heterosexual; Homosexual/ Gay/Lesbian/ Queer	English; Spanish; Farsi	Child; Adolescent; Adult; Elder	Low SES; Middle SES; High SES	Jewish; Muslim; Hindu; Catholic; Protestant Christian; Atheist
D	White/Caucasian; Black/African-American; Hispanic/Latino; Asian	Male; Female; Transgender	Heterosexual; Homosexual/ Gay/Lesbian/ Queer; Bisexual	English; Spanish; Czech; Italian; Tagalog; French	Adolescent; Adult	Low SES; Middle SES; High SES	Jewish; Muslim; Hindu; Catholic; Protestant Christian; Fundamentalist; Jews for Jesus; Mormon; Atheist; Agnostic; Ba’hai; Buddhist; Wicca; Zoroastrian; Sikh

Table 5, continued

Participant	Client Race	Client Gender	Client Sexuality	Client Primary Language	Client Age	Client SES	Client Religion
E	White/Caucasian; Black/African-American; Hispanic/Latino; Asian; Native American; Micronesian; Fijian; Samoan; Pacific Islander	Male; Female	Heterosexual; Homosexual/ Gay/Lesbian/ Queer; Bisexual	English; Spanish	Child; Adolescent; Adult; Elder	Low SES; Middle SES	Jewish; Catholic; Protestant Christian; Revivalist; Atheist; Agnostic; New Age; Native American; Buddhist
F	White/Caucasian; Black/African-American; Hispanic/Latino; Asian	Male; Female; Transgender	Heterosexual; Homosexual/ Gay/Lesbian/ Queer; Bisexual	English; Spanish; Hebrew; French	Adult; Elder	Low SES; Middle SES; High SES	Jewish; Catholic; Protestant Christian; Agnostic
G	White/Caucasian; Black/African-American; Hispanic/Latino; Asian; Native American; Gypsy; Pakistani; Indian	Male; Female; Transgender	Heterosexual; Homosexual/ Gay/Lesbian/ Queer; Bisexual	English; Spanish; Japanese; Chinese	Child; Adolescent; Adult; Elder	Low SES; Middle SES; High SES	Jewish; Muslim; Hindu; Catholic; Protestant Christian; Mormon; Atheist; Agnostic; Unitarian
H	White/Caucasian; Black/African-American; Hispanic/Latino; Asian	Male; Female	Heterosexual; Homosexual/ Gay/Lesbian/ Queer; Bisexual	English; French	Child; Adolescent; Adult; Elder	Low SES; Middle SES; High SES	Jewish; Muslim; Catholic; Protestant Christian; Atheist; Agnostic; Buddhist
I	White/Caucasian; Black/African-American; Hispanic/Latino; Asian	Male; Female; Transgender	Heterosexual; Homosexual/ Gay/Lesbian/ Queer; Bisexual	English; Spanish; Vietnamese; Cantonese; Mandarin; Russian	Child; Adolescent; Adult; Elder	Low SES; Middle SES; High SES	Jewish; Muslim; Hindu; Catholic; Wicca; Protestant Christian; Atheist; Agnostic; Mormon; Jehovah's Witness; Fundamentalist

Table 5, continued

Participant	Client Race	Client Gender	Client Sexuality	Client Primary Language	Client Age	Client SES	Client Religion
J	White/Caucasian; Black/African-American; Hispanic/Latino; Asian; Persian/Iranian; Filipino; Russian/Eastern European	Male; Female; Transgender	Heterosexual; Homosexual/ Gay/Lesbian/ Queer; Bisexual	English; Spanish; Farsi; Russian; Korean	Adult; Elder	Low SES; Middle SES; High SES	Jewish; Muslim; Hindu; Catholic; Protestant Christian; Satanic; Atheist; Agnostic
K	White/Caucasian; Black/African-American; Hispanic/Latino; Asian	Male; Female	Heterosexual; Homosexual/ Gay/Lesbian/ Queer; Bisexual	English; Chinese	Child; Adolescent; Adult; Elder	Low SES; Middle SES; High SES	Jewish; Catholic; Protestant Christian; Atheist; Agnostic; Buddhist
L	White/Caucasian; Black/African-American; Hispanic/Latino; Asian; Native American; Middle Eastern	Male; Female	Heterosexual; Homosexual/ Gay/Lesbian/ Queer; Bisexual	English; Spanish; Farsi; Korean; Tagalog; Arabic	Child; Adolescent; Adult; Elder	Low SES; Middle SES; High SES	Jewish; Muslim; Hindu; Catholic; Protestant Christian; Fundamentalist; Mormon; Atheist; Agnostic

Religious Values Scale

In addition to responding to qualitative questions, each participant completed a 62-question survey known as the Religious Values Scale, developed by Morrow, Worthington, & McCullough in 1993 (Hill & Hood, 1999). “The scale consists of seven subscales: religious commitment, authority afforded sacred writings, authority afforded religious group identification, authority afforded religious leaders, tolerance for others holding different views on Scripture, tolerance for those with different group identification, and tolerance for those with different views regarding the authority of religious leaders” (Hill & Hood, p. 108). The scale also includes 6 questions not pertaining to any of these subscales.

Authority Afforded Religious Group Identification

Questions 35 through 42 of the Religious Values Scale pertained to the subscale of authority afforded to religious group identification, with possible total scores from 8 to 40, wherein a higher score suggested a higher level of religious group identification. Participants’ average score on this subscale was about 13.5, with a standard deviation of about 4. Five participants (5=42%) conveyed a relatively low level of religious group identification by scoring 1 standard deviation or more below the average. Two participants (2=17%) conveyed a relatively high level of religious group identification by scoring more than 1 standard deviation above the average.

Authority Afforded Religious Leaders

Questions 52 through 59 on the Religious Values Scale pertained to authority afforded to religious leaders, with possible scores from 8 to 40, wherein a higher score suggested a higher level of authority afforded to religious leaders. The average score for

this question was about 8, with a standard deviation of about 1. Two participants (2=17%) had scores of 10 on this scale, 2 standard deviations above the average; however, given that the highest possible total for this scale was 40, these scores do not suggest high levels of authority afforded to religious leaders. Participants scoring 1 standard deviation or more below the average did so due to failing to answer 1 or more questions within this subscale.

Authority Afforded Sacred Writings

Questions 21 through 31 on the Religious Values Scale addressed the level of authority which participants afforded to sacred writings of their respective religious groups. Total possible scores for this subscale ranged from 11 to 55, wherein a higher score suggested a higher level of authority afforded to sacred writings. The average for this subscale was 24.5, with a standard deviation of 6.5. Four participants (4=33%) received scores more than 1 standard deviation higher than the average, suggesting a relatively high level of authority afforded to sacred writings; conversely, four participants (4=33%) received scores more than 1 standard deviation lower than the average, suggesting a relatively low level of authority afforded to sacred writings.

Tolerance for Others Holding Different Views

The Religious Values Scale included 3 sections addressing participants' tolerance for others holding different views: tolerance for others holding different views on Scripture; tolerance for those with different views regarding the authority of religious leaders; and tolerance for those with different group identification. Questions 32 through 34 addressed participants' tolerance for others holding different views on Scripture, with possible scores from 3 to 15. Within this subscale, higher scores suggested lower levels

of tolerance for others holding different views on Scripture. The average score for this subscale was 8, with a standard deviation of $3\frac{1}{3}$. Four participants (4=33%) scored greater than 1 standard deviation below the average. Three participants (3=25%) scored greater than 1 standard deviation above the average.

Questions 60 through 62 addressed participants' tolerance for those with different views regarding the authority of religious leaders, with possible scores, again, from 3 to 15. Within this subscale, higher scores suggested lower levels of tolerance for others holding different views regarding the authority of religious leaders. The average for this subscale was about 10, with a standard deviation of about 2.5. Again, three participants (3=25%) scored greater than 1 standard deviation above the average, and three (3=25%) scored greater than 1 standard deviation below the average.

Questions 49 through 51 addressed tolerance for those with different group identifications, with possible scores from 3 to 15. Within this subscale, again, higher scores suggested lower levels of tolerance for those with different group identifications. The average for this subscale was 4, with a standard deviation of $1\frac{1}{3}$. Three participants (3=25%) received scores higher than 1 standard deviation above the average. Participants receiving scores lower than 1 standard deviation below the average did so due to failure to answer 1 or more questions. However, participants' deviation from the average was minimal, overall.

Overall, 9 questions pertained to participants' levels of tolerance for those with different views. Total scores for this subsection could range from 9 to 45, wherein higher scores suggested lower levels of tolerance for those with different views. The average score for this subsection was about 22, with a standard deviation of about 6. Two

participants (2=17%) received scores that totaled 1 standard deviation or more above the average, suggesting lower levels of tolerance relative to other participants. Two participants (2=17%) also received scores that totaled greater than 1 standard deviation below the average, suggesting higher levels of tolerance relative to other participants.

Religious Commitment

The last subscale of the Religious Values Scale, comprising questions 1 through 20, addressed participants' levels of religious commitment. Possible scores ranged from 20 to 100 on this subscale, and higher scores suggested higher levels of religious commitment. The average score on this subscale was approximately 46.5, with a standard deviation of about 9. Participants' scores ranged from a low score of 28 to a high score of 58. Four participants (4=33%) scored more than 1 standard deviation higher than the average, suggesting relatively high levels of religious commitment in comparison with other participants. In contrast, three participants (3=25%) scored more than 1 standard deviation lower than the average, suggesting relatively low levels of religious commitment.

In addition, participant responses to the Religious Values Scale were correlated to a more recently introduced tool, the Religious Commitment Inventory-10 (RCI-10, Worthington et al., 2003). The questions comprising the RCI-10 are the same as or very similar to questions addressing religious commitment in this subscale of the Religious Values Scale (see Appendix F). Notably, all of the participants who scored more than 1 standard deviation higher than the average on the Religious Values Scale showed a similar trend when their responses were correlated to the RCI-10. However, only one of the participants who scored more than 1 standard deviation lower than the average on the

Table 6

Participants' Totals on the Religious Values Scale

Participant	Authority afforded religious group identification	Authority afforded religious leaders	Authority afforded sacred writings	Tolerance for others holding different views on Scripture	Tolerance for those with different views on the authority of religious leaders	Tolerance for those with different group identification	Tolerance for others holding different views	Religious commitment	RCI- 10
A	10	8	24	4	7	3	14	28	11
B	12	8	15	13	7	7	27	48	16
C	24	10	32	14	14	6	34	56	34
D	12	8	32	7	10	3	20	57	37
E	9	4	36	4	12	2	18	56	39*
F	10	8	15	10	10	6	26	38	16
G	10	7	18	7	15	4	26	48	23
H	17	8	22	12	10	5	27	54	25
I	12	8	23	7	10	3	20	36	16
J	10	7	17	3	3	3	9	30	17
K	16	8	23	11	14	3	28	48	22
L	21	10	37	4	10	3	17	58	35
Range	9-24	4-10	15-37	3-14	3-15	3-7	9-34	28-58	11-39
Average	14	8	24.5	8	10	4	22	46	24
SD	4	1	6.5	3	2	1	6	9	8

* A score of 38 or higher identifies a client as “highly religious.”

Religious Values Scale simultaneously exhibited scores greater than 1 standard deviation lower than the average when correlated with the RCI-10, and two additional participants scored more than 1 standard deviation below the average on the RCI-10 when correlated with the Religious Values Scale.

Worthington did specify a standardized method of assessing “high” levels of religious commitment: “according to theory...a full-scale RCI-10 score of 38 or higher would justify considering a person to be highly religious” (Worthington 2003, p. 31). Notably, only one participant (1=8%) in this study received a score above 38 when the scores from the Religious Values Scale were correlated with the RCI-10. However, one might hypothesize that, similarly, a “full-scale RCI-10 score” of 22 or lower “would justify considering a person to be highly” irreligious. Six participants (6=50%) in this study received scores of 22 or lower when their responses to the Religious Values Scale were correlated with RCI-10. According to the preceding standard, these six participants might qualify as “highly irreligious.”

In summary, this group’s responses to the Religious Values Scale exhibited a low level of authority afforded to sacred writings, a high level of tolerance for those with different group identification, and a mid-range level of religious commitment.

Frequency of Discussing Religion/Spirituality with Clients

Participants were asked to describe how often they discuss religion/spirituality with clients with the choices of “often, sometimes, rarely or never.” All twelve participants (12=100%) reported discussing religion/spirituality with clients. The frequency ranged from “rarely” to “often.” The most frequent response was “sometimes,” with five participants (5=42%) reporting this response. Four of the twelve participants

(4=33%) indicated that they discussed religion/spirituality “often.” Three participants (3=25%) indicated they discussed it “rarely.” None of the participants reported “never” discussing the topic with clients.

Table 7

Correlation of Religious Commitment, RCI-10, and Frequency of Discussing Religion/Spirituality with Clients

Participant	Religious commitment	RCI-10	Frequency
A	28	11	Rarely
B	48	16	Sometimes
C	56	34	Often
D	57	37	Often
E	56	39	Often
F	38	16	Rarely
G	48	23	Rarely*
H	54	25	Sometimes
I	36	16	Sometimes
J	30	17	Sometimes
K	48	22	Often*
L	58	35	Sometimes

* These responses stood out as lacking face validity correlation with participant reports of religious commitment.

Correlation of Frequency of Discussion of Religion/Spirituality in Therapy with Religious Commitment

With two exceptions, there did seem to be a face validity correlation between the frequency with which the participants discussed religion/spirituality in their practice and their own levels of religious commitment. Of the six participants (6=100%) who might qualify as “highly irreligious,” three (3=50%) reported discussing religion/spirituality “sometimes” with clients; two (2=33%) “rarely”; and one (1=17%) “often.” Of the five participants (5=100%), who scored in the middle range of responses in terms of religious commitment, two (2=40%) reported discussing religion/spirituality “often” with clients; two (2=40%) reported discussing religion/spirituality “sometimes”; and one (1=20%) reported discussing religion/spirituality “rarely.” As expected, the one participant (1=8%) who qualified as “highly religious” based on the score on the RCI-10, as correlated with the Religious Values Scale, reported discussing religion/spirituality “often” with clients.

Defining Religion/Spirituality

Before responding to qualitative questions about clinical practice, participants were asked to define religion and spirituality. Their responses revealed ways in which these terms overlap as well as ways in which they are different.

What Is Religion?

Two themes emerged as most common as participants attempted to define religion in response to question 1a: the idea that religion involves some type of structure, and the idea that religion involves some type of belief. Eight participants (8=67%) brought up both of these themes; three (3=25%) brought up only the idea that religion involves some

type of belief; and one (1=8%) brought up only that religion involves some type of structure.

Religion involves both some type of structure and some type of belief in something beyond oneself

Participant C:

Religion...would be, sort of like, the...structure...that'd be the rituals...sort of the organization, that goes...in...to finding somebody's faith arc...so...it can be, sort of a hierarchical structure...ritual they use...maybe...particular symbols, are used, that help define a person's faith, and, y'know, articulate it and everything...there's regulations...a particular organization...they're all...versatile...help express their belief.

Participant E:

[Religion includes] some kind of...a relationship, with...some acknowledgement, of the divine...some...higher purpose, higher power...religious groups have some kind of...acknowledgement, respect, reverence for some[thing] higher, bigger than meets the eye...

Participant F:

It's not something I would have thought about very much...I guess, you know, most people think about the...organized religions...that there's some...framework...for...the religious belief...and usually, some kind of group to belong to—it's not something somebody does on their own...and, some sort of faith...in something.

Participant G:

A religion is an organized social group with a specific religious belief.

Participant H:

Religion...is...a belief, or series of beliefs...that—usually...involves the...belief in some kind of higher power...as well as...code of ethics, on how to lead...one's life...I was raised Ethical Culture...which...considers itself a religion, and does not have a...belief in God...it's really a code of ethics for living...the original...founders were offshoots of Judaism. And most of the people who join, are...disaffected Jews, who...just...don't...feel the theology piece of it...very well...but they want the rest of it, you know, the community, and the...values,

and...all of that. So...the question of does it...need to...involve a higher power, according to them, no.

Participant K:

[Religion is] an institutional effort to address questions of existence.

Religion involves some type of belief

Participant I:

I guess it's...spirituality; it's...sort of...for many people, guiding principles by which they...structure and orient their lives and get some meaning, and value, and mores.

Religion involves some type of structure

Participant J:

I see religion more...like spirituality...religion is more of...I would say...belonging to a particular church, or an organized church...

What is spirituality?

One theme appeared prominently in response to the request that participants define "spirituality": the idea that spirituality is a personal meaning system. All 12 participants (12=100%) brought up this idea in some manner.

Participant A:

[Spirituality is] not organized...not necessarily as...specific, about...the higher power...and who, what...it is, just that...something...bigger's out there...and it's more of an internal process.

Participant B:

Spirituality...I think of it as the way people see their place in the world in the bigger world...their relationship with nature, as well.

Participant C:

Spirituality, I define it as...a connection...with what provides meaning...I see it as sort of...God...higher power, it can be sort of life's...natural...forces...it can be, y'know, significant...moments...that...bring people, sort of, to a

deeper...sense of themselves, or a deeper connection...with other people...deeper sense of meaning...those kinds of, y'know, moments that people have...

Participant E:

Spirituality is...the desire for fulfillment...that longing for...and, you don't know...always, exactly what it is, but it's...longed for, nonetheless...even infants...you know, I mean, it takes a long time for a human to...be able to function on their own...it's that...relational...need for another...and that one, who is...there for them...immediately responds, you know so they have this, immediate relationship to reality, and...they need that...caregiver, that mother...to be there...that—kind of satisfies them. So it's kind of a heaven...sense...babies...just need one hundred percent unconditional...care. No judgment...so then...all of a sudden...reality makes demands on us. Key to that might be, like, toilet-training, and...it's hard to be toilet-trained, but then...mom's not giving me that look...I want that look again, and so I think kids do that...random act, and they're just so happy when mom is all excited that they...did their first...*caca*, or whatever...so then...we enter into a world of meaning and value...where meanings and values given to us by parents and society mediate our reality...and we think that they're satisfying...but the spirituality is that longing...It's a fire in us...

Participant H:

Spirituality...to me, feels like a...philosophical...way of looking at...life, and the world, and...maybe a feeling inside?...as opposed to a belief system...kinda...a part of what emotionally connects you to...a...religion, or...belief system...but more the...something...larger than yourself...like spirituality, might encompass nature, or...belief in all living beings...so...that part feels more expansive to me...emotionally expansive, than...the sort of tenets of a religion...the rules.

Participant I:

I don't know if I can, it's just something that...you have a deep belief in, so it doesn't necessarily have to be God...you know, or...a structured religion, but...some people are very...sort of...spiritual in the way that they feel about...the environment, and nature.

Participant J:

Whatever people believe in...of a higher nature, that helps them get through life. Very broad definition.

Participant K:

[Spirituality is a] personal effort...to explore issues of existence.

Participant L:

It's...quite different, individually...some people it's...through...organized religion, other people, it's, you know...their...their meditation kinda thing, without going to any specific...church.

Is there a distinction between religion and spirituality?

When asked whether they make a distinction between religion and spirituality, nine participants (9=75%) answered “yes,” and three participants (3=25%) answered “no.” Four (4=44%) of the nine participants (9=100%) who answered “yes” elaborated on their responses. Three of the nine (3=33%) reiterated the ideas that religion involves some type of belief in something and that spirituality is a personal meaning system.

Participant B:

Religion is more about God...and power...spirituality, is a way of being in the world.

Participant E:

I think you can approach religions...almost...with a certain distance. And I can...appreciate...Islam, and...Buddhism, and all the other religions...and...respect them, and...reverence them, for...the role that they have, in helping people to aim...higher...and...to...aim for a...perspective that...transcends...the...littleness...of our lives...spirituality...I think it's kind of personal...maybe it would be...how one lives. Not only one's religion, but...I was reading...something...and I...kind of agree with it...one of the things is...saying that...monotheism...if it's an idea...is dangerous...but...when it's like...what do I long...for, getting to...the spiritual bond inside us...and the messiness of...that, and then...the fears that accompany...not knowing, and not being sure, but wanting so badly...the vulnerability that's needed...when I see clients...there's a certain...prayer I make to just be...small before them, to allow their greatness...to be present...

Participant H:

I don't know that spirituality would necessarily be a belief in God...the culture views religion as more of a...belief in God...maybe Ethical Culture is more spiritual...but it wasn't. It wasn't spiritual, that was one of my...complaints about it, it...didn't...do things to make you feel emotionally connected. It was missing

something. Maybe some of the ritual, or something, it was missing...something...but I think there is a distinction.

One of the nine participants (1=11%) reiterated the idea that religion involves some type of structure, whereas spirituality is a personal meaning system.

Participant C:

A lot of people say, well, I'm spiritual, not religious...I...could see why, you know, people...don't necessarily need, sort of, the structural...stuff that most organized religion...they can experience their own spirituality, their own sense of God...in, sort of...non-traditional...ritual structures, organizations...that are out there.

As mentioned, three participants (3=25%) indicated that no distinction between religion and spirituality exists.

Participant I:

I don't, but I guess one could...I don't. 'Cause...I don't think...I've taken the time to...think about it.

Participant J:

It totally overlaps.

What implications does the distinction between religion and spirituality have for clinical practice?

Of the nine participants (9=100%) who identified a distinction between religion and spirituality, all nine (9=100%) brought up the theme that religion is more restrictive than spirituality in terms of interventions. Participants identified a series of concerns, such as language, respect for particular regulations around abortion, suicide, etc. On the other hand, working with spirituality was considered more flexible.

Participant A:

Well...I would say, on a basic level...once the client has communicated to me, a basic belief system, it would depend on...the terminology I use...references to a

specific...church...priest, pastor...versus just...the sort of, you know, higher power...giving up control.

Participant B:

I think it's important to know, people's...where they feel that they fit in the world...their sense of powerlessness...or control...if everything is the way God wanted it, then...everything is always out of their control...power is always...someone else's responsibility...so that's...important. And then...to make sure that you're respectful of people's religious beliefs, like when you talk about...things like abortion, or...if someone is gay, and they're very religious...you're gonna be able to understand their struggle more...so understanding...your client's...interpretation.

Participant C:

I think for...a lot of people I see here at the clinic...that belonging to...a church, and attending an organized, you know, service...on a weekly level...is a huge...coping mechanism...and, it...is their doorway into...spiritual experience. So...without that structure...they're frequently...alienated, isolated, which leads to depression, anxiety, and all of that. So...frequently...what I do is...if they, tell me that...their faith is important to them, I really try to connect them to a particular church...because, if they've told me that, that gives them a lot of meaning...then I need to sort of...point 'em in that direction, and really follow up...so, that's sort of on the positive end of things...religion...has...a hook...to hook them in...

Other people have a bad experience with religion...but nevertheless, they still believe...in God, or they're struggling with...trying to update, their view of God?...because maybe they're...stuck, in...what they thought...God was when they were 5 years old...so, they're looking for...something meaningful, but don't wanna go back to what...was...traditional...so it means, finding other, sorta ways, to...connect to that sense of meaning...

With substance abusers...it's...12-step meetings...and whether that's...a more traditional...higher power, type meetings, or, some...that don't have the higher power...component...there's still that, you know, connection...with other people, sharing their stories, and that leads them to...become sober.

So...I just think it sorta depends on the person's history...with organized religion, and...their history, and their own spiritual development...and depending upon when I...can get a measure of that...then, I can try to sort of...point them in a direction...that might...ignite some of the coping, sort of, skills.

Participant D:

Well...I guess it...very much depends on the individual patient's identity...with their religious background...and the need for...the therapist, to...not just respect it, but, understand it, and...I've never had somebody that needed me to agree with their beliefs...really...but, they very much have...needed to...look at the situation through their beliefs. So...in those instances, I would not...generally be bringing up information from other religions...but spirituality, as just a general framework, is very helpful and flexible...in dealing with many, any of the religions, so...it has a lot more flexibility in it...as a tool.

Participant E:

Religions can be, kind of dangerous...you have very rigid...ideas...sometimes...in religion. And they can be in any religion...and I think a lot of that is...human fear...how do we...become vulnerable, and how do we become...humble before...the divinity...in the other person. And sometimes religion can get in the way of that...

So, for example...a very...rigid, traditional, Catholic, or maybe...Evangelical, or something like that...would already have some ideas about morality. About what's right or wrong...and so for that person to get better, and to heal...it's according to how they see religion...so...this...openness...to the divinity of other...helps us...and heals us...and...teaches us, about God...and that's where we really can discover...the beauty of our own religion, whatever it is.

Participant F:

I guess it doesn't have...significant, difference, except that if you know that somebody belongs to a particular religion, and has a particular belief, such as...that suicide is wrong...I think Catholics...maybe Protestants, in general, believe that, I think...Jews are not so fond of it either...but...you might make some reference to that...I don't necessarily. It's not the way I would work.

Participant G:

I don't know that they do. Well, I guess they would...if...a patient had a conflict between them. That would be an important...issue to address. Sure an awful lot of people have that problem. They're raised in one religion...and their own spirituality doesn't develop in that direction. Or if it's an issue in their marriage.

Participant H:

I guess...because spirituality feels more expansive...it...provides...maybe a wider range of things you could tap into, to...engender that feeling. You might suggest...meditation, or you might suggest...yoga, or you might...suggest going

out in nature...while...religion, would feel more...restricted. You know, you might...find out more about their...what church they belong to, or...synagogue, or whatever...and they might...use that, in some way to build supports, but...it's narrower.

Participant K:

I think people that are very identified with an institutional process of religion...have...a...perhaps more difficult time...with the open-ended nature of...the way I practice in clinical practice. So it...has to do more with the character structure, or rigidity...I think people that are very very...identified, and involved with...something...that is their institution, and it...contains them, and structures them...provides something of a social and familial...role...function, in someone's life...might have a more difficult time...relaxing into an open-ended sort of relational, psychodynamic...psychotherapy. Which is...what I...do.

Case Material

The second qualitative question requested that each participant "Describe a case that stands out in your mind in which religion/spirituality came up as a major focus."

When participants were unable to identify cases in which it came up as a "major focus," they were asked to describe a case in which religion/spirituality came up.

Demographic Background of Clients Discussed

In the twelve cases (12=100%) identified, clients were either adolescents or adults: nine participants (9=75%) discussed adult clients, and three participants (3=25%) discussed adolescent clients. In terms of the sex or gender of the clients discussed, seven participants (7=58%) discussed female clients; three (3=25%) discussed male clients; and two (2=17%) discussed couples they had worked with, both heterosexual (male/female). Only three participants (3=25%) identified the client's race or ethnicity. One participant (1=8%) identified an African-American client, one participant (1=8%) identified a White client, and one participant (1=8%) identified a client who was Black and Hispanic.

Table 8

Demographic Background of Clients Discussed

Participant	Age during time of Tx	Sex/gender	Race/ethnicity	Religion
A	Adolescent	Female	African-American	* Client attended a church
B	Adult	Male	White	Anti-Semitic; Irish-Catholic
C	Adult	Female	*	* Client attended a church
D	Adult	Couple (Male/Female)	*	Modern Orthodox Jewish
E	Adult	Male	*	Catholic
F	Adult	Female	*	Non-religious
G	Adult	Male	*	Anti-religion
H	Adult	Couple (Male/Female)	*	Catholic
I	Adolescent	Female	*	Fundamentalist
J	Adult	Female	Black/Hispanic	Santería
K	Adult	Female	*	Converted from Episcopal to Jewish
L	Adolescent	Female	*	Christian

Participants also discussed clients' religion/spirituality in terms of its impact on the treatment. The religious/spiritual backgrounds of the clients varied substantially. Two participants (2=17%) identified that their clients were Catholic. Two participants (2=17%) identified that their clients attended some type of church but did not specify which. One participant (1=8%) each identified a client who was anti-Semitic and Irish-Catholic; a couple that was Modern Orthodox Jewish; a client who was non-religious; a

* Not specified

client who was, specifically, anti-religion; a client who belonged to a Fundamentalist group; a client who practiced Santería; a client who converted from Episcopal to Jewish; and a Christian client.

In terms of the formats of the case contacts, eight participants (67%) identified the unit of treatment with the clients. Of these eight (100%), four (50%) identified conducting individual treatment; two (25%) conducted couple's therapy; and two (25%) conducted family therapy. Ten out of twelve participants (83%) also identified a time frame in which religion/spirituality emerged in the treatment. Five of these ten (50%) specified that religion/spirituality arose in the middle phase of treatment; four (40%) specified that religion/spirituality arose in the early phase of treatment; and one (10%) specified that religion/spirituality arose in the late phase of treatment.

In terms of client diagnoses/presenting problems, only seven of the participants (7=58%) mentioned a formal diagnosis for the client identified. Most frequently identified was depression, with five participants (5=42%) mentioning that the clients were experiencing some type of depression. Two of these participants (17%) identified clients experiencing some type of anxiety, either social anxiety or unspecified, in addition to depression. One of these clients (1=8%) had a diagnosis of Anorexia Nervosa in addition to depression and anxiety. One of the five participants (1=8%) who identified a client experiencing depression mentioned that the client also had a diagnosis of Narcissitic Personality Disorder. Three participants (3=25%) identified that the clients were experiencing some type of partner or couples issue, comprising: Partner Relational Problems; divorce; and communication problems. One of these clients (1=8%) was also identified as experiencing depression and conduct problems. One participant (1=8%)

Table 9

Treatment Details of Clients Discussed

Participant	Age during time of Tx	Type of Case Contact	When did religion/spirituality come up?	Case Diagnoses/Presenting Problems for Client
A	Adolescent	Individual	*	Major Depressive Disorder; R/O Dysthymia; Partner Relational Problems; R/O Conduct Disorder
B	Adult	Individual	Middle treatment	Narcissistic Personality Disorder; Depression
C	Adult	*	Early treatment	Major Depression with Psychotic Features
D	Adult	Couple	Middle treatment	Couples' issue: infertility
E	Adult	Individual	Late treatment	Major Depressive Episode; social anxiety
F	Adult	*	*	Borderline Personality Disorder; alcoholism; PTSD
G	Adult	*	Middle treatment	Couples' issue: divorce
H	Adult	Couple	Middle treatment	Couples' issue: communication problems
I	Adolescent	Family	Early treatment	Major Depression, anxiety, Anorexia Nervosa
J	Adult	*	Early treatment	Schizophrenia
K	Adult	Individual	Middle treatment	"a lotta issues"
L	Adolescent	Family	Early treatment	Suicidality

identified that the presenting problem, for a couple in treatment, was infertility. One participant (1=8%) identified a client experiencing Borderline Personality Disorder, alcoholism and PTSD; one participant (1=8%) identified a client diagnosed with

* Not specified

Schizophrenia; and one participant (1=8%) had a client presenting with suicidality. One participant (1=8%) did not identify any type of diagnosis or presenting problem.

Presenting Problems

In all twelve cases (12=100%) highlighted by the participants, neither religion nor spirituality was the presenting problem. Rather, religion/spirituality arose during the course of treatment, in a variety of ways.

Participant A:

She was...a 17-year-old African-American girl...who...was living in a group home, had been removed from her parents...for...abuse, several years prior...and had decided she did not want to return...to the home...she had...one child...who, at the time, was probably...a year and a half...

[Her diagnosis was] Major Depressive Disorder. Actually...probably...rule out...dysthymia...with...some...V-code relational...was definitely an issue. Partner relational problems...and...there may have been some conduct...rule-out...it was probably a rule-out, conduct...disorder...[the treatment plan] was pretty basic, to...improve mood...decrease running-away behaviors, decrease acting out...behaviors, with staff...very basic.

Participant B:

I had a case a while ago...he's...very, very sick...he...sort of has a Narcissistic Personality Disorder, but his very severe episode, he was...pretty pathological...his presentation was depression...but he's very low-functioning, had no friends...couldn't hold onto a job, was...pretty much homeless. Actually was homeless. And... he came in for depression...yeah, so the presenting problem was depression, nothing to do with religion, or...you know, nothing...spiritual.

Participant C:

Just a simple...one, is...a woman who was...maybe...60-something...extremely depressed...Major Depression with Psychotic Features, so she was hearing voices, and...had a...rocky relationship with her son, and had a history of depression, since coming to America...and...in this country did...really struggle with isolating...herself.

Participant D:

One that comes up ...was a couple...who did do IVF, and who did end up...conceiving triplets. And...the mother was so very ill...she hyperstimulated...so she was hospitalized. She couldn't hold down any fluid, she was on IVs...even in her best, when she went home...she was on an IV...she had to go on Disability. And the couple...agonized over the decision of, do we continue with triplets, or do we reduce, to...try to keep this whole thing viable.

Participant E:

One, he...was...former...gang member, and...served a number of years in jail, and...his presenting problem, was...a Major Depressive Episode...dealing with his transition...the big...contributing stressor to that was...being...out of prison, after being there nine years...being out...feeling...some social...anxiety...and he got into school...and, not knowing...how that worked...he was going to...a community college...and...was feeling threatened...by...a couple of things.

Participant F:

I have one now...who...we've been trying to get her...to go to AA, this is a Borderline young woman...who...typically drinks before she...either cuts herself, or overdoses...I was telling her the other day, that alcohol is her gateway drug to...cutting and...overdosing. To self...injurious behaviors...

In her case, she's had severe...childhood trauma. She was sexually abused by her father, and apparently somebody else...at least...from the age of 6. And...she didn't remember any of it, until her father died 2 years ago, and she...essentially...incapacitated...since then, with PTSD, and other sorts of things.

Participant G:

A private client...his presenting problem was that...his wife had just gotten pregnant, and...they had been trying to get pregnant, and he...very much wanted to have a child, and...the minute she got pregnant he realized...that he really wanted a divorce. It was very challenging for him...he got divorced...the new woman in his life...[I've been seeing him for] about a year and a half...she's a tarot card reader.

Participant H:

I'm working with a couple, who are...Catholic... it started out being...just sort of communication issues...really, you know, couple communication issues...and each of them had different...things from their background, that I think were...blocking the progression of their lives forward into adulthood. They

were...in their early 30's when they came in, and...in different ways, each of them...had...barriers to really...fully embracing adulthood, and...so really the work has been about...about...each of them...being able to identify what some of those things are, and clearing...the path...and, sharing that with each other, really I don't think...that, they have...much in the way of communication problems, actually...they communicate really well, relative to most couples, but...he's been kinda depressed, and blah, and I think that has...made her, angry.

Participant I:

They were a family that had 8 children...and...you know, didn't believe in birth control...or...they just kept having children, and...it was hard for them to make a living...it was difficult...to get them to come, because...the father was working three jobs, to keep the family financially...afloat, and...the mother had...a newborn baby, plus...you know, she had seven other kids...lived a very far away...even if they could afford that...so, it was hard just getting them to come, so initially...we just tried to work with...being able to do a lot of...telephone...sort of, contact, and sessions...child had...enormous anxiety...and...probably, had a depression...actually. A Major Depression, and anxiety, on top of...Anorexia Nervosa.

Participant J:

She was black...and, Hispanic...the islands, but also I think she was part Mexican...the border of Texas and Mexico, somewhere down there...she was in the clinic I was working in...best we could hope was that she would get...some medication relief...she was schizophrenic...I tried to focus on...positives in her life...the progress she was making, day to day...worked a lot with the doctors in terms of medication...but it was...kind of like I would say almost a treatment failure, in some ways...because...I mean, I don't think she really got better. And I don't think she was basically gonna take her meds when she left.

Participant K:

I...worked with a woman...number of years...and she...had a lotta...issues...she came from...the highest of high...Yankee...Episcopal...world.

Participant L:

I'm actually working with one right now...and...I've been in contact, with...the therapist that's been working with the family...and Department of Mental Health...it's an issue...this, is a very closed system, which I'm concerned about...and...this girl is home-schooled...and...this girl is becoming...suicidal. Because...she wants to try...to break out of the system, and...there's no way for her to do that.

Emergence of Religion/Spirituality

In the case examples provided, religion/spirituality emerged in connection with three major themes: control; separation/individuation; and connection. For five participants (5=42%), religion/spirituality emerged as an external control. For four participants (4=33%), their clients were struggling with religion/spirituality in terms of issues of personal identity development and separation/individuation. For three participants (3=25%), religion/spirituality provided a sense of connection for persons struggling with isolation.

Religion/spirituality as an external control

Participant A:

She had started to...go to church...I believe with her family. She was seeing them on weekends, would go with her family—and she became...much more involved spiritually, but also talking about...what had come up, in sermons, and, in...talking to the priest, or the pastor...and...it became a big focus for her to try to...live a life that she felt was more cohesive with her...newfound...religion, and spirituality...

It meant trying to be nicer to her peers, her family...trying to not...lose control of anger, as often...not stealing...not...being verbally abusive of the staff at the group home...not...running away...pretty much just trying to follow the rules more. And be nicer in general...and so she would talk a lot about...trying to do that...

[The religion] wasn't a long-term change that she made, she did not continue to go to church...and spirituality became less of a focus...however I think it was...pivotal, in getting her to...see that changes needed to be made.

Participant D:

So...[the couple with triplets] had to consult their rabbi. And, they were an Orthodox couple, a Modern Orthodox couple, but it was a matter of which rabbi do we consult, and how do we...make this decision...and...she...was so very very ill...that she felt...that she just wanted...to get rid of...whatever it was...that was...making her ill...but he...needed...to know...that the decision...would have been...acceptable...and understood...in the context of their religion.

And it came down to...the Jewish concept of...*Pikuach Nefesh*, which is “saving a life.” And in this case, given how ill the mother was...the rabbi said...you can do this...for the sake of saving the life, of the mother, and the other...babies. And it wasn't their decision, which...fetus would be terminated...it was the doctor's decision...based on location, and size, and...risk factors...so...between the two of them, they made a very...well-rounded, and well-considered decision. And...they did terminate one...and she carried to term...

Participant F:

She's just very typical...in that one of her main objections, to going to AA, is they don't like the God part...a lot of people feel that...12-step program is very religious...and...it really turns them off...and, it's a moment...where one...might try to...educate someone about the difference between...religion and spirituality, but, I don't usually get into that...

The way I usually handle that...because frankly the God stuff never really appealed to me either...is...to think of the group itself as a higher power...the idea that I can't do this, but we can...and for some people that works...very well...I mean...in 12-step...some...people...say...to make anything your higher power, like, even that chair. To me...that doesn't make any sense...but, to say that...there is a power in the group, that you don't have within yourself, that makes a lotta sense to me...I think...sometimes the issue is the God thing...but lotsa times it's just...the resistance to admitting their alcoholism, and just going to AA...when people are really ready...for 12-step...then none of that stuff...stands in their way...

[I took that approach with the woman]...you know it didn't make her...dying to go...she promised to go to her first meeting...last night. So...I don't know if she went...if she said she would...she probably did. I'm hoping.

Participant H:

I have been seeing...[the Catholic couple] quite a long time...this just came up...last night...the...wife, is...trying to get pregnant...well, they're both trying to get pregnant...and, they've had a little bit of difficulty, and she started talking about...some of her fears, and anxieties...God is angry with her. And...that God was punishing her, and that she's mad at God...and, that she's having talks with God...

She's in...her, mid-30's now, but she felt she was...wild...in college, wild and crazy, and had abused her body, and...slept around a lot, and...I think she feels...some guilt about that...she finally said, “I just had so much sex”...and she said, I don't know really, if it was so much sex, really...compared to other people, but...“I think it was a lotta sex”...

So I think she was feeling guilty about that...that God...that—that might have done to her body, and...maybe there's something wrong now, or...maybe, God is punishing her, and...really what I...did with that...was to...talk about how...I wondered if God was kind of her projective...screen, at that moment...and...they both...felt that that was true.

Participant I:

When we interview people, we ask them about...their...spiritual and religious...backgrounds, and beliefs which I think is very important to the whole understanding of a person. So...it came up at that point. Very fundamentalist family...particularly the father...his way of...coping and dealing with things was around what he thought the church would want...and because it was actually...a very small...fundamentalist sect...really, his guiding principles sort of clashed with the rest of the world actually...in many ways...which made it very difficult, because...here, particularly, it's very secular.

Religion/spirituality as an issue of separation/individuation

Participant B:

This guy...was anti-Semitic...and...I'm Jewish, and he didn't know...and those little...things that he said, that I would...let go, it wasn't a big deal, and then one day he came and said, "I'm...anti-Semitic and I know you're Jewish." And, so it became an interesting clinical issue for us, to figure out how to work that out, and, we worked through it in a nice way, you know, just giving me...Hannukah cards, and Passover cards, you know, and—always acknowledging my Jewishness, but in a positive way, from his perspective...

And it ended up...not getting in the way, because...he really realized that his anti-Semitism came from his dad, and he really...had no reason to be anti-Semitic, it just was, kind of...passed down to him...like a bad kind of way...so that was...an interesting...time.

Participant G:

A private client...[I've been seeing for] about a year and a half...who...grew up in a kind of...anti-organized religion family...and, is now in love with a woman who...has many spiritual beliefs, that his family thinks are crazy. And, he has had to...sort himself out, and grow himself up...in regard to that, which has been a very interesting...process for him—and he has asked for...help in thinking about it. Which has been very interesting...anyway I would say she has a much more organic kind of spiritual philosophy, and his...childhood...spirituality...was...kind of founded in...his stepfather's opposition, to organized religion...which had been...an oppressive factor in his stepfather's life. And, so, he was pretty much...“All religion is hogwash, grr”...

What we discovered, which was the most interesting thing in terms of his life and development was...how much he...as a...thirty-four year old man was still tied to his parents'...views...in terms of judging everything in the world. And that...because of that, he...approached some...very...important issues to this woman...with a kind of...disparagement, and disregard, which almost lost him the relationship.

And...so, the most...important thing for him was to examine...what his own point of view was, separate from his stepfather's and his mother's...he likes it...it's going well, he's very happy.

Participant K:

I...worked with a woman...[for a] number of years, who was non-Jewish, and decided to convert to Judaism in the course of our work. And...it had a lot to do with me. And, wanting to...be more part of my...world...it also had to do with her...wish, to...relieve herself, of...the...constraints, and...difficulties she had with her family of origin...it also had to do with her interest, in Judaism...and...how she could...use her...tremendously...intellectual...ethical orientation, she's an attorney...in, a spiritual way...she became far more observant as a Jew than I am. And, that tension in our work together...I could never figure out...why would somebody make this choice?...it was not syntonic with me. So that was a countertransference issue that I really didn't resolve.

Participant L:

The mother, the first question she asked is, "Are you a Christian?" And, "What's your religion," and, she's done this, to...the Department of Mental Health...the...case manager...the therapist...and myself...I...just told her that that's a personal matter. You know. And I respect all people...Well, she says oh, okay...[religion's] not [something we've talked about] yet...

It's really difficult because...they live quite a distance...but we are going to speak with the mother today. She's coming in at 11. And I'm gonna talk to her about it today...the more I hear about this...particular group that this mother's with, the more I'm concerned...really—very...fundamentalist...and...from the people that I've spoken with, in a community...somewhat like a cult. So...that's of concern...it's definitely...impacting on this girl's functioning.

Religion/spirituality as a sense of connection

Participant C:

One of the things...I talked to her about was...her own faith life. And...she said, oh yes, it's so important to me, and...frequently what happens is when people are so depressed, that way...they always might begin to sort of...not do the things

that...sustain them—They forget, we forget. We just—that’s the nature of depression...

So, she was not attending church...she would just say, I don’t feel like going...so, we talked about, you know, going to the local church that...was not that far from her, and...it was a simple kind of a thing. And...that, in combination with...some other things, too, she started medications...it was all part of the treatment plan, you know...[religion] wasn’t the main thing that...pulled her out of the depression...but it was...a significant part, because it could break down her isolation...she began to feel again...had a...deeper experience of God...through all of this...[God] was putting...people in her path, to help through this depression, to manage it. And, so...literally, you know...within about three weeks or so, she looked enormously better.

Participant E:

[The former gang member]...wanted to reconnect...with his...tradition, which is Catholic...and...I, recommended that he...just...go to a church, and that he...really, talk to a priest...he...went to the church...he connected...and now he’s very...active, and very involved...in the church again...and he does bring that up, you know, certain questions...I mean, it’s just a way of supporting where he’s coming from.

Participant J:

A woman who was involved in...Santería...it’s sort of like...a, lot of Mexican...Caribbean...ritualistic stuff, where they...sacrifice animals...it’s like, the voodoo thing...and that was very weird...that’s kinda...weird stuff. So those...stand out...as obstacles to treatment, because that was—the...fixed...belief...

I think I brought it up. ’Cause I usually ask about...that...what...orientation...what gets them through, ’cause it’s part of a coping skill. You hope someone has a positive spiritual...or religious connection...and I’m always happy when they do. And then this came up, it’s like, oh, my God...very bizarre...that was really awful for me. The whole thing with sacrificing animals...I think it’s illegal...but...that was her culture. And I just saw right away, there was no way I was gonna change her...

Best we could hope was that she would get...some medication relief...I tried to focus on other...positives in her life...the progress she was making, day to day...worked a lot with the doctors in terms of medication...but it was...kind of like I would say almost a treatment failure, in some ways...because...I don’t think she really got better. And I don’t think she was basically gonna take her meds when she left.

Impact of Religion/Spirituality

When the case material provided by participants was analyzed, themes appeared suggesting whether religion/spirituality had a positive or negative impact on the clients and/or on the treatment (see case examples above). Seven out of twelve participants (7=58%) illustrated that religion/spirituality had a negative impact on the client or on the treatment. Four out of twelve participants (4=33%) illustrated that religion/spirituality had a positive impact on the client or on the treatment. One out of twelve participants (1=8%) illustrated that the impact of religion/spirituality on the client and on the treatment was neither positive nor negative.

Participants' Views of Responses to Religious/Spiritual Content

In response to the question of whether participants would change anything about how they responded to the religious/spiritual content of the cases, six of the participants (6=50%) responded “no”; three of the participants (3=25%) had no response* ; two participants (2=17%) responded “yes”; and one participant (1=8%) was unsure.

Participants J and K responded “yes.”

Participant J:

I would've somehow tried to...get consultation, and find...either...online, or...some kind...expert...maybe at UCLA, or something, that was some kind of expert in that...religion, Santería. I should've done that. Really had a consultation. Maybe even had somebody come, and talk, to the whole staff. If they would've. Because that's like, what involves...cultural sensitivity...really...I think it would've...created...less—countertransference from the staff...maybe more empathy. Yeah. Although it's still pretty gross...but still. To educate us...in how to proceed. We should've had a team meeting about it. 'Cause I kinda did it

* For one of these participants, the case was a current case in which religion/spirituality had not yet been fully addressed.

by myself...and...I wasn't in—I'm in therapy now, but...had I had a therapist...that's definitely something I would've brought up in therapy, personally, as a therapist. Those are the things I would've changed.

Participant K:

I think I would have worked...more...directly, with...her wish...that she could become me. And had to face herself.

Participant H was unsure.

Participant H:

Well I think it was effective in terms of her psychological issues. I don't know if it was effective in terms of...the...religious meaning, or what God meant to her. You know, that seems like a piece that...could have gotten explored more, perhaps, before I made that interpretation...I mean, I know her well, so...I was using some stuff that I've known from the past, but...I maybe could have...asked...well what does God...represent to you, in that...statement?...rather than...moving in with the interpretation...of what...I thought it meant...and then it would also get at some of...the more religious...part of it, because...I think she would have said, "Well I'm all confused about God. I don't know if I...believe in God or not," 'cause...she had said that, in other...discussions.

Was Case Illustration/Response Typical?

In terms of the cases, seven participants (7=58%) indicated that the cases they described were atypical; four participants (4=33%) indicated that the cases were typical; and one participant (1=8%) did not identify whether the case was typical or atypical. In terms of clinician responses, six participants (6=50%) reported that their responses were typical; five participants (5=42%) did not identify whether their responses were typical or atypical; and one participant (1=8%) reported that the response had both typical and atypical aspects.

Participant D:

Well I'd say it's very typical of how...the issues emerge...and...it's...pretty typical of how I would respond...I use myself, and self-disclosure, when needed, for them to be comfortable...but I would say it was more typical of how the issue

arises than how I actually would use myself, in...directly working it...I saw them both, as a couple...and then...individually...in this process, so that they could talk out their issues. And, when she was...at home on bedrest, I even did home visits...because she had no connection. With, the outside. And they were not going to tell people...what they were doing...or having to look at. Except their closest, closest family...so...

I would say that...it was out of the ordinary, because I've only done home visits, maybe three times...and each time it was a pregnant woman who couldn't...leave the house...I would say, that...my presence helped normalize the whole...bizarre...nature of the situation, in which they found themselves...and, it's rather like...accompanying somebody who's terminally ill, or has a devastating illness...when they think they're all alone, and there's nobody else...who would possibly...want to join them...or accompany them...or be present to what they're experiencing. So...I think that that helped them greatly.

Of the seven participants (7=100%) who felt the cases described were atypical, three themes emerged in terms of what made the cases atypical. Three participants (3=43%) spoke to the rigidity of the clients' religious/spiritual beliefs. Two of these clients (2=29%) were fundamentalists, and one (1=14%) was a practitioner of Santería.

Participant I:

I would say it was a little bit atypical...just from the point of view of the rigidity...and the dad really...he was freaked out...about medication...and...I think...that...being able to stand on the religion...was his way, also, of being able to say, I don't wanna do it...I mean, who knows if he would have gone and talked to the church elders, or something like that, what they really might have thought about it...and it may not have been necessarily a religious thing. You know, I don't think we really knew them well enough to really...be able to...sort that out...

[More typical would be] just...really being able to join with families...wherever they're from, and whatever their belief systems are, and...really trying to...give people...sort of, the genuine experience, of really being...interested...in who they are, and how they got to be where they are...I think that's part of just being...a therapist, and...social worker...

I think...my response...you have your moments, where you have...some countertransference...but I also generally like these people, d'you know...as...quirky, and as different as they may have been...from me, and...a lot of the families I work with...I like them. So...I really felt bad...about the kid. You know, this kid had to go home...and I felt like in some way, you know, we

just reinforced the father's...belief systems, of...can't trust, you know...large...institutional care...I think it's typical in terms of how I respond.

Participant J:

They're not typical...I would say, you know, like...on a curve...of the most...benign, or whatever, easy...that—they were hardest. Like the most extreme...what I do...either privately, or in group...is...on an intake...ask somebody's...orientation...to spiritual/religious...it's part of the social...network. It's very important. Especially with elderly, but also...anyone...

And you know, AA, the 12-step programs...I consider that somewhat of a spiritual program. It is. Even though, the people that hate spirituality and are agnostic are against it...I would say, well, just go and get what you can...it's a higher power...use it...as you like...[you can use whatever high power you believe in.] it could be a tree, you know. And...the sense of community...which was what religion does anyway. So that's community. At the very least...so...I find it...very important.

It's not something, that...you study that much in school...a very long time ago...I think now they're much more...sensitive to that, in terms of teaching...even...on the intake forms...in the hospital, now...it comes up right away. Right away. I mean, along with everything else, like, demographics, and...personal history, family background. I—I include it.

Two participants (2=29%) felt that these cases were atypical in that religion was discussed at all.

Participant A:

I would say my response was pretty typical...I wait for...the person to...kind of give an indication, but...once they do, I'll definitely be open to...use it, I think it's an important tool...especially since religion is...such a huge part of people's lives...to ignore it, pretend it doesn't exist, would be...naïve...and it's more helpful to...blend it all together. As far as in my practice, I think it was pretty atypical...I don't see very much of it. I, I think see...mostly people who...they may be...spiritual, but they don't talk about it...and most of the people I see are not religious.

The remaining two participants (2=29%) felt that the cases were atypical in that they focused on the therapists' religious/spiritual orientations.

Participant B:

The way I responded was typical, in terms of like, what's that like for you, and all that...it's not of a typical case, 'cause...the way it usually comes up is...they're talking about Catholicism, and...almost everyone's Catholic here...so then...they're, so...are you Catholic? And...I somehow avoid it...

I...explore why it's important to them...what is it that they're actually wanting to talk about...in terms of God...and they're seeing if...there is a difference, if I still understand them...it—always comes up...the subcontext is...does this person get what I'm saying, do they understand...do they get me...but I also find that...in the end, clients don't really care?...a lot about us. I mean not, they don't care about us as human beings...they don't care all about, all the different parts of us.

What Other Trends Exist in Terms of How Religion/Spirituality Emerge in Practice?

Participants identified a number of other trends in terms of how religion/spirituality emerge in clinical practice. Most frequently noted was that religion/spirituality emerge at times of crisis or transition, when one's usual mode of operation is interrupted; seven participants brought up this theme (7=58%).

Participant B:

It comes up with...unwanted pregnancy...like abortion...and then there's this whole thing of like...it's my cross to bear, or that's what God wants for me...so that comes up...when bad things happen to people.

Participant D:

When...there's a life crisis...and that could be, just...“I can't believe this is happening to me”...to, “why is this happening to me?” And that's when people look for forces beyond themselves...so that happens...very very frequently, whether it's...the infertility issues...or, a health issue...or, a loss...early...loss of a parent...leads to spiritual challenges. It changes the meaning of life. Whenever you get into, what is the meaning of life, you can easily get into the spiritual.

Participant H:

With this older woman...whom, I did home visits with, she was...in her late 80's...she was a very religious person, and, she belonged to the Crystal Cathedral, or something, and...donated lots of money, and...that...particularly as she was getting older...had more relevance...

Participant K:

Significant developmental events, I would say. Obviously like death, illness...weddings...graduations...you know, the moments of...clear...development. And/or demise.

Participant L:

In terms of...chronic...illness issues...it seems that...some of the families that I've worked with...who have some sort of religious base, whatever it is...really...hold strong to that, during these times.

Four participants (4=33%) identified that religion/spirituality emerge as a positive support for clients.

Participant H:

With this older woman...she really talked about that...from the point of view of it being...one of the things...that, held her together...it was a real organizing...principle for...her life now...she talked about it...like it provided...a skeleton...of support...for her, how she organized her...week, and her life...and I think that was the meaning for her...

This couple that I talked about...they both went to Catholic school, as...kids, and they went to a Catholic college...this has been, you know...part of their family framework, and...I don't know how much they actually...believe literally in all of it, but it is a very important...glue, for them.

Participant I:

Having a client that may, suddenly...decide that they wanna go back to church, and join a church group, or a Bible group, or something like that, and, I just think...if they're gonna find that helpful, why not...because...I just think it's another way...that you can use to examine your life, your values, and your belief systems...because sometimes people...are just...in such need of structure.

Participant L:

Especially in terminal illnesses...I've really noticed, that people that have some sort of, regardless of what it is, faith...it's my impression they get through the situation easier...than people that don't.

Three participants (3=25%) discussed that religion/spirituality emerge when it is a barrier in clients' relationships.

Participant D:

Certainly it comes up...in dating, if you're dating somebody of a different background. It comes up in families, when there are...intermarriages...the decisions to be made...whether it's who to spend the holidays with, or how to raise the kids. Certainly comes up then—I would say that's when religious issues come up...as opposed to the spiritual issues come up with the life crises.

Two participants (2=17%) mentioned discussion of AA, or 12-step programs, as a context in which religion/spirituality emerges.

Participant A:

When...clients are...in the process of exploring...their drug use...and stopping...that drug use...because it's...sort of the first step of AA—it tends to come up about the higher power...and then we can use that...as an inroad to...spirituality versus religion...it's usually about, I need to realize...I don't have control over it, I need to give it up...to my higher power...like, straight off the AA...literature...and then what I'll do is I'll...ask them...what does it really mean to you...what do you picture the higher power being, what has it been in your life.

Two participants (2=17%) identified that religion/spirituality emerge based on their integration with clients' culture.

Participant C:

People I see are...primarily...monolingual Spanish speakers...so...I guess...for, you know, most of the people...culturally, I think are raised...faith is...such an integrated part.

Participant H:

I'm sure this is true of other religions, but I think it happens a lot with Judaism, there's a lot of pieces of Judaism that are not religious at all, but are...more cultural, and...you know, people talk about...different holidays...like Passover's coming up, I'm sure I'll get a bunch of people who...talk about...whether they...have a Seder to go to...so they'll talk about maybe the meaning of the Seder, and what they wanna get from it, and...then they'll come in the next week and they'll talk about...how it went...all the family dynamics, and...which ones got in the way, so, I mean, is that about religion, no, it's about family dynamics, but it's also about the...hope, and expectation, that this...holiday...celebration will bring a certain meaning to their lives...

I have clients who talk about Christmas that way...about how...their families celebrate Christmas, and...the meaning of that to them...rituals that...have to go along with it...not religious rituals, really, but...it's all mushed together, really, the...religious and the...emotional and cultural...experience...of it.

Two participants (2=17%) brought up the idea that religion/spirituality emerge in relation to morals and values.

Participant G:

Morality, or...things that I would call spirituality...come into...a lot of psychotherapy...over the debate about right action. You know, what is the right thing to do. And...people draw on many...sources for that...that may not be considered religious or spiritual...I don't have that many clients who have a strong religion...who even belong to a religion...but...they do...feel it...and discuss it...in terms of...moral action. What the right thing to do is, why it's the right thing to do.

Two participants (2=17%) made note of how religion is not typically a focus in therapy.

Participant F:

I guess the trend would be...that...it does not seem to be so much of an issue with people most of the time.

Participant H:

I don't...have that many clients who talk about...religion, and...religious tenets, and...religious beliefs...they don't volunteer that information.

One participant (1=8%) identified that religion/spirituality emerge in relation to discussion of the Holocaust.

Participant F:

The only other...thought that comes to mind... is...the effect of...religious persecution...like, as in, Holocaust survivors, or 2nd-generation Holocaust survivors...but, I think that's a different issue...than what you're really asking about...I had...at least one patient, who stands out in my mind who was the child of Holocaust survivors. And I think was very affected by that...[but] it was more a trauma issue.

What are the Challenges for Clinical Social Workers in Addressing Religion/Spirituality?

Participants identified a number of themes as far as challenges in addressing religion/spirituality in clinical practice, as well. The most prominent theme was countertransference, which five participants (5=42%) identified.

Participant B:

I think...we have to be really careful of our boundaries, 'cause, when you're very religious...it's probably very hard to keep your boundaries as a therapist...as a social worker...spend time...part of our profession, is cultural...sensitivity...and religion's part of culture...and so, you have to kind of watch...where you walk, and...watch...that your own personal biases don't...get in the way.

Participant J:

I mean there's countertransference, big-time. And your own beliefs are kind of...either in question, or challenged, or...you've got weird judgments about what's someone's doing.

Two themes of challenges for clinicians in addressing clients' religion/spirituality were mentioned by four participants. One of the themes mentioned by four participants (4=33%) related to the idea that religion/spirituality may be a barrier to treatment.

Participant C:

There are some times when...you know, sort of, it's my duty to suffer...in this bad relationship, or...guilt...if my...parents have been estranged from me, and if I don't, you know, kind of respond to them now that they're getting older, somehow or other...that's...bad, you know, I'm bad. And...I feel guilty in the eyes of God, that kind of thing...feeling marginalized, or less than...not feel connected, which cause you to act out, which can cause you to...do unsafe things, which...leads to...substance abuse...so...

Participant G:

It's...rigid religious belief then says...we can't mentalize in that territory because...I'm right and everybody else is wrong...and I know, and you don't. And then...that's a tough one.

Participant I:

I really think it becomes more difficult...and this just isn't to religion...but...when...you have a...paternalistic...religion...d'you know, and so...the male, the head of household...me being a female, is...not able to communicate with me...because, of my...being female, and...the role...of the woman...but I don't think that's necessarily...just to religion. But...you know, you could name religions...that, that could be more difficult with.

Four (4=33%) participants also mentioned the idea that addressing religion/spirituality is not a challenge at all.

Participant H:

Just, different religions, I don't find challenging, I really find it interesting. You know, tell me about it, well how do you celebrate that...what's that like for you...all of that aspect of it, would...feel...very interesting to me.

Participant I:

I don't think I have [identified challenges]...it hasn't been an issue...I mean it's something that we have talked about...and then...when things are understood...you move on, from that.

Three participants (3=25%) identified clients' prejudices, i.e., anti-Semitism, as potentially challenging for the clinician.

Participant G:

Probably the toughest one for me...is if somebody...had...very rigid...religious beliefs, that...condemned other...forms...of spirituality, or religion...that would be somebody I probably couldn't treat. Because...I would find myself...so bumping into that.

Participant H:

One challenge would be if somebody didn't like Jews. Which...people have made, like anti-Semitic comments...and, then, as a...Jewish therapist, I've had to...figure out whether to say something, and...what to say, that would be useful, and helpful.

Three participants (3=25%) also identified the idea that addressing religion/spirituality in therapy may be difficult for the clinician.

Participant A:

I would actually say that...the biggest challenge is...helping them to emerge. I think I handle it when they do emerge...well...but in waiting for my clients to say something...I may be losing opportunities. To have it be more of a...if not focus...an aid, or a...tool...so I'd say my biggest challenge is...in getting them to open up about it. And being more comfortable asking about it.

Participant C:

People hold on to...their images of God...and...whereas the image of God...that they had...helped them at one point in their life as a child...as an adult, it's maybe...not as helpful...it's not...an easy thing...I can...try to help people point themselves in the direction, sort of, of what needs a little updating...in your life...you know, as I challenge people to look at...other cognitive distortions...then I feel it's my duty, at least to...pull the mirror up there...and say, let's take a look at how accurate...how...realistic is this view...is this something that you...continue to wanna hold on to, are there other alternatives.

Two participants (2=17%) identified the challenge of the overlap between religion/spirituality and mental illness.

Participant B:

I had...my...Hari Krishna...patient...he actually was schizophrenic...and so I had to...kind of weed out, what was his psychosis, and what was normal stuff...with religion.

Participant J:

My red flag is fanaticism...I see that more in the context of mental illness...I mean, who's gonna blow themselves up? A sane person? I mean, y'know, there's a very thin line.

One participant (1=8%) mentioned the idea of the difficulty of staying within the scope of therapy in discussing religion/spirituality with clients.

Participant B:

I think we need to be careful of our scope...and what our role is...and that we keep what we're doing in the scope of our practice.

The last challenge identified in response to this question, brought up by one participant (1=8%), was the idea of the therapist's own lack of knowledge about particular religious/spiritual beliefs as a potential challenge.

Participant F:

Sometimes I feel like the—lack of knowledge...of...religions...that I'm unaware of what the belief system is. And how do I talk to somebody about a belief system that I'm not educated about.

Other Significant Observations

At the end of the interview, participants were asked whether they had anything else to add about how issues of religion and spirituality emerge in treatment and how clinical social workers should respond to this content. Eleven of the twelve participants (11=92%) provided additional information at this point. The most common theme which emerged in response to this open-ended question was the idea that paying attention to clients' religion/spirituality is important, which nine participants (9=75%) mentioned.

Participant A:

I think you just have to be...comfortable...being open to whatever they say. And...going with...their vocabulary...their beliefs...being...questioning, but wondering, not, like, you need to change...but just...how does it play into your world?

Participant C:

I just, I think it's...such...an important part of people's lives, that we miss out, if we don't simply ask about...it's okay to ask, it's not gonna do any harm...you're not imposing, sort of any particular viewpoint, but you're simply asking...they're not incompatible...they can actually work closely together. You know, as a mentor of mine told me...good theology is good psychology, good psychology is good theology.

Participant D:

I think, next to ethnicity and race, and...probably economic status...religion is very big, in determining...a belief system, perspective...meaning...so...I think that a lot more attention should be given to it.

Participant G:

I think...spirituality...and religious values, often come out without...a framework of a specific religion...and, certainly, without mention of a relationship to God...but they do come up, and it is important to listen for them...and...not to over-clinicalize them...and, to have...respect...for...that person's current thinking, and to...expand...the thinking space...I think that's the clinical goal.

Participant L:

Well I think like...anything else...you start where the client is.

Five participants (5=42%) mentioned the idea that discussion of religion/spirituality in therapy may bring up countertransference for the therapist.

Participant A:

We're told not to put our own values...on...the client...and that can be especially hard, with...religion. Because it is so personal...that it can be hard not to.

Participant F:

For me personally, I was raised in a household, my father was raised religious...and...the one prejudice that I felt like my parents taught me...was against religious people. That my father saw that—specifically, we're talking about Jews in this case, as...intolerant, and inflexible. So...that was a bias...that I grew up with...I grew up thinking...that...religion was a reason for people to kill each other...and not much more than that. It was only much later in my life that I saw that there were actually positive aspects to it.

Participant J:

I think it has a lot to do with your own personal journey...how open you are...as a clinician...to this...I think it starts with us...and how we are...I really do.

Three participants (3=25%) brought up the idea that religion/spirituality is traditionally a “taboo” topic in therapy.

Participant A:

It's—similar to sex, in that a lot of therapists don't know how...to respond...and they get so uncomfortable with it...

Participant J:

It's hidden, like a lot of clients don't bring it up...because it's one of those taboo things...and...back in the old days...it wasn't brought up...we're so much more apt to ask about personal medical history, for instance, you know, or...daily habits, and...not ask about that...

Two participants (2=17%) identified that the role of religion/spirituality in clinical practice is not adequately addressed in social work education.

Participant D:

I don't think it's...really taught...in schools, enough...at all...it might be treated as another demographic factor, but it is not treated as...this is what you need to know.

Participant J:

I think...this kinda thing should be talked about in graduate school, big-time...and, medical school. And Ph.D. programs, in psychology...

Two participants (2=17%) indicated that religion/spirituality may be a barrier to treatment.

Participant B:

It also comes up, I work a lot in domestic violence...and so, the church kind of comes up, we bump up against the church a lot...when we're encouraging people to...be safe...which could entail leaving...which could entail divorce...so it's really kind of...when we bump up against...some of the teachings of the old-fashioned church...you know...like, they don't believe in abortion, but they'll have sex before they're married...so that's kinda...looking at the contradictions.

Participant L:

Dealing with parents that are very rigid...regardless...is a difficult task...whether it's a religious...issue, or whatever...it's just very difficult.

Two participants (2=17%) described that religion/spirituality are included as part of other topics.

Participant D:

They emerge all the time. They're always there...

Participant H:

I suspect there are a lot of things get merged, where it's hard to sort out what part is religion and what part is...other stuff...they're all merged together...so I think that...part of how it may present is merged...with other things, and it's hard to...sort that out

One participant (1=8%) identified divorce as a context in which religion/spirituality may emerge in clinical practice.

Participant H:

People...talk about...religious concerns, particularly in relation to...post-divorce...continuation of religious...education for their children, planning for that.

One participant (1=8%) identified that religion/spirituality may cause clients guilt and shame.

Participant B:

I think religion and spirituality comes up...with shame...a lot of religions have a lot of guilt in it...and so people struggle.

One participant (1=8%) identified that religion/spirituality may provide clients with positive support.

Participant H:

Religion certainly comes up when I'm...talking with people about their support system, and...trying to help them mobilize...the various components of it, you know where they can go, and they might identify that...they belong to a church, or synagogue, or...they might go into this, and such and such...belief.

The final theme which emerged as additional information, provided by one participant (1=8%), was the idea that the distinction between religion and spirituality is significant.

Participant J:

They don't say "spiritual," I think that's...kind of a dirty word...there's a difference. Even though there's an overlap, there is a difference...and some people get very offended...because they're not part of an organized religion anymore.

CHAPTER V

DISCUSSION

The purpose of this exploratory study was to examine the issue of how religion and spirituality emerge and are responded to in clinical practice. While a substantial body of literature now exists addressing the role of religion/spirituality in clinical social work practice, the major focus of this body of work has been to question when and how a client's religion/spirituality should be addressed in clinical practice. In contrast, relatively little attention has been paid to how issues of religion/spirituality actually emerge and are responded to in clinical practice. This qualitative study aimed to investigate the practice wisdom of licensed clinical social workers about how issues of religion and spirituality emerge and are responded to in their clinical practice. The sample for the study consisted of twelve licensed clinical social workers.

Limitations

This is a qualitative study that employed a sample of convenience recruited via a snowball sampling strategy. As such, the findings of this study cannot be generalized beyond the current sample. Participants were overwhelmingly white, female, and heterosexual. Thus this sample is not entirely unrepresentative of the social work field, in which clinicians are predominantly white, female, and heterosexual, as well. However, the participant population consisted of a group of very practiced clinicians, suggesting that the data they provided had merit, despite the drawbacks of the sample.

Major Findings

The major findings were:

1. All twelve participants (12=100%) reported discussing religion/spirituality with clients, with frequencies ranging from “rarely” to “often.”
2. In all twelve cases (12=100%) highlighted by the participants, neither religion nor spirituality was the presenting problem but came up during the course of treatment.
3. In defining spirituality, all 12 participants (12=100%) brought up the idea that spirituality is a personal meaning system.
4. Nine participants (9=75%) identified making a distinction between religion and spirituality in that religion was more restrictive than spirituality in terms of interventions.
5. Nine participants (9=75%) identified the idea that paying attention to clients’ religion/spirituality is important.
6. In defining religion, eight participants (8=67%) brought up the idea that religion involves some type of structure and some type of belief in something beyond oneself.
7. Participants were able to identify three ways in which religion/spirituality typically emerges in practice : (1) as an external control at times of crisis or transition when one’s usual mode of operation is interrupted; (2) as part of personal identity development and separation-individuation issues; a sense of connection for persons struggling with isolation.

It is significant that all twelve participants reported discussing religion spirituality with clients since this was not a requirement for participation in this study. This suggests that the field is making progress in addressing this issue, although it was not clear whether they address it because the client initiates it or they bring it up. It is also significant that in this sample, issues connected with religion/spirituality were not part of the presenting problem but emerged during treatment connected with other themes. Participants’ definitions of religion and spirituality were consistent with what has already been presented in the literature.

Recommendations for Future Study

Since most participants indicated that the case they chose to discuss was atypical of the way religion usually emerges, it would be important to conduct future studies that deal with more typical cases. It would also be important to see if the three ways that were identified by this same for how religion/spiritual issues generally emerges are sustained in future studies, and whether additional ways can be identified.

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Appendix A

Human Subjects Review Approval Letter

February 20, 2008

Andrea Giese-Sweat

Dear Andrea,

Your revisions have been reviewed and all is now in order. We are glad to give final approval to your interesting study. My hunch is that you will get people who have an interest in spirituality and thus hear that content in interviews because they will be more likely to volunteer to participate.

Please note the following requirements:

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

Maintaining Data: You must retain signed consent 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.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Mary Hall, Research Advisor

Appendix B

Informed Consent Form

Dear Participant,

My name is Andrea Giese-Sweat. I am a second-year student in the Master's of Social Work program at Smith College, in Northampton, MA. I am conducting a research study examining how issues of religion and spirituality emerge and are responded to in clinical social work practice. This has been identified as a gap in the clinical literature. Data obtained in the study will be used in the writing and production of my Master's thesis and for future presentations and publications.

In order to participate in this study, you must be a licensed clinical social worker practicing in the Los Angeles greater metropolitan area of California. You have been identified as someone meeting these criteria. If you agree to participate in this study, you will take part in a face-to-face interview that should last no more than an hour. At the beginning of the interview you will have the opportunity to ask any remaining questions that you may have about the study before signing two copies of the informed consent, one for me and one for your personal records. You will then be asked a combination of structured demographic background questions and a series of semi-structured questions that probe how issues of religion and spirituality have emerged in your clinical practice. You will also be asked to fill out a 62-item survey about your religious values that should take no more than 10 minutes.

Interviews will be tape recorded, and I may take some additional notes during the session. All information which you provide will be kept confidential. Interviews will be transcribed by the investigator. In addition to myself, only my research advisors will have access to the data. Informed consents will be kept separate from interview information, and a numeric code will be utilized to identify research materials. Data collected during the study will be reported in aggregate form only and any quotations included in reports of the study and future presentations will be sufficiently disguised to prevent identification of specific participants. All data will be stored in a locked, secure location for a period of at least three years, as specified by Federal guidelines. All materials will remain secured until no longer needed, at which time they will be destroyed.

There are few potential risks to participation in this study. However, you should be aware that in any experience of self-reflection the possibility exists that strong feelings may emerge which you may feel require further attention. You will receive no financial compensation for your participation in this study. However, you may benefit from knowing that you have contributed to expanding the profession's knowledge base about how issues of religion and spirituality emerge and are responded to in clinical social work practice. You may also benefit from having this opportunity to reflect upon this issue in your clinical practice.

Your participation in this research is completely voluntary. You have the right to refuse to answer any particular question(s) or to withdraw from the study at any time up until April 15, 2008, when the study will be written up. Should you choose to withdraw, all materials connected with your participation will be immediately destroyed. Please contact me with questions or concerns, either by cell phone at (706) 338-7466 or by e-mail at agiese@email.smith.edu. You may also contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Thank you for your participation.

Sincerely,

Andrea Giese-Sweat

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Participant's Signature

Date

Investigator's Signature

Date

Appendix C

Recruitment Letter

Andrea Giese-Sweat, M.S.W. candidate

1215 Brockton Ave. #106 • Los Angeles, CA 90025

Phone: 706.338.7466 • agiese@smith.edu

February, 2008

Dear Potential Research Participant,

My name is Andrea Giese-Sweat. I am a second-year student in the Master's of Social Work program at Smith College, in Northampton, MA. I am conducting a research study examining how issues of religion and spirituality emerge and are responded to in clinical social work practice. Data obtained in the study will be used in the writing and production of my Master's thesis and for future presentations and publications.

You have been invited to participate in this study because you are a licensed clinical social worker practicing in the Los Angeles greater metropolitan area of California. If you agree to participate, you will take part in a face-to-face interview that should last no more than an hour. The interview will take place at a time and location convenient to you.

At the beginning of the interview you will have the opportunity to ask any remaining questions that you may have about the study before signing two copies of an informed consent, one for me and one for your personal records. You will then be asked a combination of structured demographic background questions and a series of semi-structured questions that probe how issues of religion and spirituality have emerged in your clinical practice. You will also be asked to fill out a 62-item survey about your religious values that should take no more than 10 minutes.

Interviews will be tape recorded, and I may take some additional notes during the session. All information which you provide will be kept confidential. In addition to myself, only my research advisors will have access to the data. A numeric code will be utilized to identify research materials. Data collected during the study will be reported in aggregate form only and any quotations included in reports of the study and future presentations will be sufficiently disguised to prevent identification of specific participants.

You will receive no financial compensation for your participation in this study. However, you may benefit from knowing that you have contributed to expanding the profession's knowledge base about how issues of religion and spirituality emerge and are responded to in clinical social work practice. You may also benefit from having this opportunity to reflect upon this issue in your clinical practice.

THANK YOU FOR YOUR INTEREST IN PARTICIPATING IN THIS STUDY.

PLEASE CONTACT ME OR ALLOW ME TO CONTACT YOU AT YOUR CONVENIENCE TO DISCUSS SCHEDULING AN INTERVIEW.

Andrea Giese-Sweat
M.S.W. Candidate
Smith College School for Social Work

Appendix D

Interview Guide & Probes

DEMOGRAPHIC QUESTIONS

Age:

Sex/gender:

Sexual orientation:

Race:

Ethnicity:

PRACTICE-ORIENTED QUESTIONS

Qualifications (LCSW, PhD., etc.):

When did you receive your license?

How many years have you been in clinical practice?

Do you have a private practice?

(If yes:) For how many years?

Do you follow a particular theoretical orientation in your clinical practice?

(If yes:) Which?

What settings have you worked in? (positions, roles, populations, # of years)

With which of the following client populations have you worked (yes or no)?

- | | | |
|---|---|---|
| 1. Race | 2. Gender | 3. Sexuality |
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Male | <input type="checkbox"/> Heterosexual |
| <input type="checkbox"/> Black/African-American | <input type="checkbox"/> Female | <input type="checkbox"/> Homosexual/Gay/
Lesbian/Queer |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Transgender | <input type="checkbox"/> Bisexual |
| <input type="checkbox"/> Asian | | |
| <input type="checkbox"/> Native American | 4. Primary language | |
| <input type="checkbox"/> Other, please specify: | <input type="checkbox"/> English | |
| | <input type="checkbox"/> Other, please specify: | |
| 5. Age | 6. Socioeconomic status | |
| <input type="checkbox"/> Child | <input type="checkbox"/> Low SES | |
| <input type="checkbox"/> Adolescent | <input type="checkbox"/> Middle SES | |
| <input type="checkbox"/> Adult | <input type="checkbox"/> High SES | |
| <input type="checkbox"/> Elder | | |

7. Religious/spiritual orientation

Jewish

Atheist

Muslim

Agnostic

Hindu

Other, please specify:

Catholic

Protestant Christian

Other Christian, please specify:

QUALITATIVE QUESTIONS

1. How do you define “religion”?

How do you define “spirituality”?

Do you make a distinction between them?

(If a distinction is made:) What implications does the distinction have for differences in interventions?

2. Describe a case that stands out in your mind in which religion/spirituality came up as a major focus. Please be careful not to include information that would directly identify your client. (Listen for: presenting problem; assessment (diagnosis) of client; treatment plan; how & when religion/spirituality emerged and was responded to; what determined therapist response; treatment outcome.)

2b. In retrospect, is there anything you would change in terms of how you responded to the religious/spiritual content in this case?

3. How typical was this case in terms of how issues of religion and/or spirituality have emerged in your practice? How typical was this case in terms of how you generally respond to issues of religion and/or spirituality in your clinical practice?

4. How often do you discuss religion/spirituality with clients:
Often, Sometimes, Rarely, or Never?

4b. What other trends have you been able to identify concerning when and how issues of religion and spirituality have emerged in your clinical practice? Listen for: particular problems, treatment populations, etc.

5. What do you consider to be the major challenges you face as a clinical social worker in responding to issues of religion/spirituality when they emerge in your clinical practice?

6. Is there anything else you would like to add about how issues of religion and spirituality emerge in treatment and how clinical social workers should respond to this content?

7. Do you have a religious affiliation? Yes____ No____ If yes what is it?
8. Do you have a spiritual orientation? Yes____ No____ If yes what is it?

Appendix E

Religious Values Scale

Instructions: After each of the following 62 statements circle one of the numbers (1 through 5) that best describes how true the statement is of you.

1 = Not at all true of me

4 = Mostly true of me

2 = Somewhat true of me

5 = Totally true of me

3 = Moderately true of me

1. I am concerned that my behavior and speech reflect the teachings of my religion.

1 2 3 4 5

2. I do not accept what I hear in regard to religious beliefs without first questioning the validity of it.

1 2 3 4 5

3. It is important to me to conform to my religious standards of behavior.

1 2 3 4 5

4. I enjoy spending time with others of my religious affiliation.

1 2 3 4 5

5. Religious beliefs influence all my dealings in life.

1 2 3 4 5

6. It is important to me to spend periods of time in private religious thought and meditation.

1 2 3 4 5

7. I feel there are many more important things in life than religion.

1 2 3 4 5

8. I enjoy working in the activities of my religious organization.

1 2 3 4 5

9. I keep well informed about my local religious group and I have some influence on its decisions.

1 2 3 4 5

10. I make financial contributions to my religious organization.

1 2 3 4 5

11. I often read books and magazines about my faith.

1 2 3 4 5

12. I spend time trying to grow in understanding of my faith.

1 2 3 4 5

13. I have personally tried to convert someone to my faith.

1 2 3 4 5

14. I talk about my religion with friends, neighbors, or fellow workers.

1 2 3 4 5

15. Religion is especially important to me because it answers many questions about the meaning of life.

1 2 3 4 5

1 = Not at all true of me
2 = Somewhat true of me
3 = Moderately true of me

4 = Mostly true of me
5 = Totally true of me

16. My religious beliefs lie behind my whole approach to life.
1 2 3 4 5
17. I would break fellowship with my local religious group if there were things being said of me that are damaging and untrue.
1 2 3 4 5
18. I am willing to be persecuted for my religious beliefs.
1 2 3 4 5
19. My living environment (room, apartment, house, office) reflects my religious beliefs (i.e., posters plaques, bumper stickers).
1 2 3 4 5
20. I would publicly defend my religious beliefs.
1 2 3 4 5
21. I believe the scriptures of my faith are completely true.
1 2 3 4 5
22. I think it is important to obey my faith's scripture.
1 2 3 4 5
23. My faith's scriptures have practical value in the modern world.
1 2 3 4 5
24. I read my faith's scriptures almost every day.
1 2 3 4 5
25. I memorize my faith's scriptures.
1 2 3 4 5
26. I depend on my faith's scriptures to help me make decisions in conflict situations.
1 2 3 4 5
27. I have experienced the usefulness of my faith's scriptures in my daily life.
1 2 3 4 5
28. It is important to understand the historical significance of my faith's scriptures.
1 2 3 4 5
29. I understand my faith's scriptures.
1 2 3 4 5
30. I like to study my faith's scriptures.
1 2 3 4 5
31. I believe that my faith's scriptures are important but other books of wisdom are equally important.
1 2 3 4 5
32. I enjoy being with people whose attitudes toward my faith's scriptures are similar to my own.
1 2 3 4 5

1 = Not at all true of me
2 = Somewhat true of me
3 = Moderately true of me

4 = Mostly true of me
5 = Totally true of me

33. I prefer to take advice from people whose attitude toward my faith's scriptures is similar to my own.

1 2 3 4 5

34. If I went to counseling, I would like a counselor whose attitude toward my faith's scriptures is similar to mine.

1 2 3 4 5

35. What other members of my religious group expect of me is important.

1 2 3 4 5

36. I avoid doing things that members of my local religious group would disapprove of.

1 2 3 4 5

37. I feel accepted by the members of my local religious group.

1 2 3 4 5

38. I share the goals of the members of my local group.

1 2 3 4 5

39. The standards of my local religious group guide me in making decisions.

1 2 3 4 5

40. If I have a conflict with what my local religious group tells me is right, I go along with the religious group.

1 2 3 4 5

41. I couldn't get along without involvement in my local religious group.

1 2 3 4 5

42. Being recognized by non-members as a member of my local religious group gives me a good feeling.

1 2 3 4 5

43. I can get along with the goals of my local religious group but not with the overall goals of the whole organization (e.g., national or world-wide religious group).

1 2 3 4 5

44. I prefer the local chapter of my religious group to the larger overall organization.

1 2 3 4 5

45. The goals of my local religious organization are the same as the goals of the entire organization.

1 2 3 4 5

46. It is more important to me to belong to a particular part of my religious group than to think of myself as merely Christian or Jewish or Muslim (or other faith).

1 2 3 4 5

47. I enjoy being with people in my local religious group more than people who are not in that group.

1 2 3 4 5

48. I enjoy being with people who belong to my overall religious organization.

1 2 3 4 5

1 = Not at all true of me
2 = Somewhat true of me
3 = Moderately true of me

4 = Mostly true of me
5 = Totally true of me

49. I prefer not to take advice from people outside my overall religious group.
1 2 3 4 5
50. I prefer not to take advice from people outside my overall religious organization.
1 2 3 4 5
51. If I went to counseling, I would like a counselor whose faith is similar to mine.
1 2 3 4 5
52. It is a religious duty for me to obey governmental authorities.
1 2 3 4 5
53. One should follow the guidance of one's pastor, priest, or rabbi without question or complaint.
1 2 3 4 5
54. It is a religious publication for children to obey their parents.
1 2 3 4 5
55. Husbands should exercise wise, loving authority over their wives.
1 2 3 4 5
56. It is a religious obligation even for adults to obey their parents.
1 2 3 4 5
57. When counselors make suggestions, they should be obeyed.
1 2 3 4 5
58. When the board of elders (or the leaders of a local religious group) take a stand, the congregation should follow their leading.
1 2 3 4 5
59. One should obey the leader(s) of one's organized religion (e.g. Pope, President of denomination, or other leaders).
1 2 3 4 5
60. I enjoy being with people who share my attitudes toward human authorities.
1 2 3 4 5
61. I prefer not to take advice from people whose attitudes toward human authorities differs from my own.
1 2 3 4 5
62. If I went in to counseling, I would like a counselor whose attitude toward human authorities is similar to mine.
1 2 3 4 5

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Appendix F

RCI-10 (vs. *Religious commitment subscale, Religious Values Scale*)

1. I often read books and magazines about my faith. (*Religious Values Scale #11*)
2. I make financial contributions to my religious organization. (*Religious Values Scale #10*)
3. I spend time trying to grow in understanding of my faith. (*Religious Values Scale #12*)
4. Religion is especially important to me because it answers many questions about the meaning of life. (*Religious Values Scale #15*)
5. My religious beliefs lie behind my whole approach to life. (*Religious Values Scale #16*)
6. I enjoy spending time with others of my religious affiliation. (*Religious Values Scale #4*)
7. Religious beliefs influence all my dealings in life. (*Religious Values Scale #5*)
8. It is important to me to spend periods of time in private religious thought and reflection. (*Religious Values Scale #6: "It is important to me to spend periods of time in private religious thought and meditation."*)
9. I enjoy working in the activities of my religious organization. (*Religious Values Scale #8*)
10. I keep well informed about my local religious group and have some influence in its decisions. (*Religious Values Scale #9: "I keep well informed about my local religious group and I have some influence on its decisions."*)