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RELIGION AND SPIRITUALITY IN CLINICAL PRACTICE: AN EXPLORATION OF RELUCTANCE AMONG PRACTITIONERS.

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RELIGION AND SPIRITUALITY IN CLINICAL PRACTICE:
AN EXPLORATION OF RELUCTANCE AMONG PRACTITIONERS.

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
David Drew
Jessica Banks
June 2019

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ABSTRACT

Across the United States, an overwhelming majority of the population claim that religion and spirituality beliefs shape their worldview and assist in coping with life stressors. Yet, the literature has shown that mental health practitioners reported discomfort integrating religion and spirituality in clinical practice. The purpose of this study was to explore whether license-holding mental health professionals in Southern California develop reluctance toward addressing religion/spirituality with their clients. Through snowball sampling, 52 clinicians composed of social workers, counselors, marriage and family therapists, nurses, psychologists, and psychiatrists were recruited across Southern California (N =52). The participants were measured descriptively based on (a) confidence in their ability to integrate client beliefs into treatment and (b) their comfort discussing topics related to RS with their clients. Results revealed an overall level of reluctance ranging from 15 percent (for comfortability) to 25 percent (for ability) among the study participants. Licensed clinical social workers reported slightly lower reluctance level than other licensed professionals. Implications of the findings were discussed.

Keywords: religion, spirituality, licensed mental health professionals

DEDICATION

Philippians 4:13

“I can do all things through Christ who strengthens me.”

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CHAPTER ONE

INTRODUCTION

Problem Formulation

The ecosystems theory is somewhat unique to the field of social work, which aims at identifying how clients interact, whether positively or negatively, with the various interrelated systems that comprise their environment (Kirst-Ashman, 2017). One system identified as a pillar of strength is religion and spirituality (RS), which close to 90% of Americans claim to be important in construction of their worldview and ability to cope with daily stressors (Gallup, 2015; PEW Research Center, 2018). Yet, surveys show only 13% of licensed clinical social workers (LCSWs) have received graduate level training on RS interventions or implementation in their practice (Oxhandler, Parrish, Torres, & Achenbaum, 2015). It is also found that, while acquiescing to the usefulness of RS interventions, LCSWs do not always implement them in their practice. Only a few of these professionals actually do (Canda & Furman, 2010).

Religion is often conceptualized as an institutionalized tradition and community, with beliefs, values, morals and symbols, in reference to a divine power, or God, as opposed to *spirituality*, which pertains to an individual's personal understanding, relationship, and connection with reality and/or a higher power, indifferent of religious affiliation (Canda & Furman, 2010; Hodge, 2015; Oxhandler & Pargament, 2014; Kirst-Ashman, 2017; Senreich, 2012). RS may act as a pillar of support or contribute to the presenting problem, but is most often

tied to improved therapeutic outcomes across a range of mental health disorders (Oxhandler & Pargament, 2014; Oxhandler & Parrish, 2018; Pargament, 1997; Summermater & Kaya, 2017; Vieten et al., 2016). Moreover, awareness of spirituality on client well-being is such that the Joint Commission on Accreditation of Healthcare Organizations mandates assessment of spirituality (Hodge, 2006), as RS beliefs are shown to influence client medical decisions and compliance with ongoing care (Koenig, 2012).

RS is often tied to a client's culture, community, values, and desires to change (Zastrow & Kirst-Ashman, 2016). While social workers are becoming more aware of the ties between RS, mental health and overall physical health a modicum of practitioners consistently assess for or use RS oriented interventions in spite of the prevalence of RS across the nation (Koenig, 2012; Oxhandler & Pargament, 2014; Oxhandler & Parrish, 2018). A mutual awareness of clinician and client RS should also be considered when extending across sociopolitical affiliations; such as between conservative or liberal leaning states in regard to inherent cultural values and religiosity (Jones, 2016; Pew Research Center, 2012, 2016, 2018).

The addressment of RS may be influenced by the disparity between clinician/client values and intrinsic religiosity. In fact, 66% of Republicans claim religion to be "very important" as compared to 35% of Democrats (Pew Research Center, 2016). National surveys identify a pattern illustrating nonwhite Democrats are twice as willing to verbalize their beliefs in God as represented in

the Bible than their white counterparts (61% vs. 32%) who are much closer to the beliefs held by Republicans (70%) (Pew Research Center, 2018). When considering these differing belief systems, it is pertinent to acknowledge that (a) approximately 69% of social workers are white, 19% are African-American, 9% are Hispanic, and 3% are Asian (Salsberg et al., 2017; U.S. Department of Labor, 2018), and (b) 93% of social workers identify as Democrats (Cook & Krulwich, 2016), which may influence clinicians' perceptions on the importance of RS in clinical practice.

Purpose of the Study

The purpose of this study was to explore reluctance toward RS in clinical settings. Discussion of RS with clients assists with fostering the therapeutic alliance, is useful in evaluating potential community supports, as well as identifying how RS beliefs may impact treatment (Oxhandler & Parrish, 2018). A salient understanding of inherent values and motivation to change, pairing interventions with existing client RS practices and the feasibility of suggested interventions with the client's lifestyle may all be addressed with RS implementation. Many clients wish to have RS intertwined with their clinical interventions and prefer clinicians to broach the topic directly, which strongly indicates that social workers be able to effectively and ethically implement RS into treatment without proselytizing their own views (Canda & Furman, 2010; Hodge, 2015; Oxhandler & Pargament, 2014; Oxhandler & Parrish, 2018; Senreich, 2012; Vieten et al., 2016).

Despite the obvious needs of a diverse clientele, there has been some evidence in the literature (although scant) that social work practitioners displayed reluctance toward addressing topics related to RS with their clients (Oxhandler, Parrish, Torres, & Achenbaum, 2015; Oxhandler & Parrish, 2017). Other mental health clinicians—counselors, marriage and family therapists, nurses, and psychologists—were found to have a relatively low proclivity for RS (Oxhandler & Parrish, 2017). The current study sought to extend the literature on RS by asking the following question: Is there a reluctance toward addressing RS in clinical practice among mental health professionals in Southern California?

Significance of the Project for Social Work

The findings from this study have major implications for both macro and micro levels of practice. At a macro level, this study explored the use of RS among the field of social work, which may influence future social work curriculum, competencies and guide ethical practice. Actually, religion is mentioned in five different instances in the National Association of Social Workers (NASW) Code of Ethics (NASW, 2018). In each of these instances, however, the mention is vague or unfocused at best. This study calls on both NASW and the Council of Social Work Education (CSWE) to fully embrace and unambiguously incorporate RS in official social work documents. At the micro level, these findings will hopefully guide social work practitioners in understanding the importance of addressing RS with their clients, as well as delineate nuances that influence social worker efficacy toward RS implementation. The use of RS in therapy may

benefit both the clinician and client during all stages of the generalist model, from engagement, assessment, planning, evaluation, implementation, and through termination.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter contains a review of existing studies pertinent to understanding factors that may influence the use of religion and spirituality (RS) in social work. The following pages will include subsections pertaining to the prevalence of RS across the United States, the role of RS in social work, RS implementation, and RS across sociocultural domains. Perceived gaps in the literature and methodological limitations will be discussed, with the final section devoted to Fowler's Faith Development Theory, conceptualizing how RS may be viewed as a framework.

Religion and Spirituality across the United States

In discussing religion and spirituality (RS) 89% of the United States admits to believing in a God or form of higher power (Gallup, 2015; Pew Research Center, 2018). Half of the population believes that God determines what happens to them the majority of the time, whereas another 27% feel God influences their lives every so often (Pew Research Center, 2018). Furthermore, 80% of adults believe that they have been protected, 67% feel they have been rewarded, and 75% actively attempt to speak with God or their higher power (Pew Research Center, 2018). The prevalence of RS across the United States, the perception of a higher power as a protector, and the desire to communicate with that power exemplifies the significance of RS beliefs on a client's worldview.

Religion and Spirituality within Social Work

The field of social work was initially founded on Judeo-Christian beliefs, engrained within practice by two of its founders: Jane Addams and Mary Richmond (Branco, 2016; Zastrow & Kirst-Ashman, 2016). Drawing inspiration from religious scriptures the field adopted the moral obligation of caring for one's neighbor (Zastrow & Kirst-Ashman, 2016). Academic content and discussion of RS was withdrawn between the 1920s-1980s for several reasons, including but not limited to: 1) disparaging writings on behalf of Dr. Sigmund Freud, 2) course direction adopting a medical model of care, and 3) and the Empirical Movement, providing validity and credibility to the field. RS was reintroduced in the late 1980s (Canda & Furman, 2010; Koenig, 2012; Oxhandler & Parrish, 2018).

Notwithstanding, a cultural zeitgeist has emerged within the field of mental health that has produced numerous studies exemplifying the positive effects of RS on clinical treatment outcomes (Koenig, 2012; Oxhandler & Pargament, 2014; Pargament, 2007). Between 1998 to 2004 MSW programs offering RS training increased from 17% to 33% (Oxhandler & Ellor; 2017). Although mindfulness of RS use is growing, surveys show that 84% of participants claim to have never, or rarely had training on RS use in therapy practice (Sheridan, 2008); supported by Canda & Furman (2010) who found that 64% of clinicians have never engaged in curriculum that presented on the implementation of RS. Recent national surveys of LCSWs found approximately 13% have received graduate level training on RS practice and over 45% have sought post graduate

training, though there is no method to assess continuity of training efficacy (Oxhandler et al, 2015).

Religion and spirituality are becoming more prevalent throughout the healthcare landscape as well. This is evidenced by Hodge (2006) reporting the nation's largest accrediting body, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in partnership with the NASW, require RS assessments of all patient in hospitals, nursing facilities, and mental health institutions. In alignment with the values espoused by the Counsel on Social Work Education (CWSE, 2015) and the standards of the NASW Code of Ethics (2008), social workers must be prepared when addressing client RS. Practitioners must be self-aware to avoid proselytization, allow for client self-determination, and provide competent practice. As a nation inherent with religious and spiritual beliefs there is need to develop and strengthen delivery of RS curriculum in order to meet the needs of those it serves.

Religion and Spirituality in Practice

Assessment of RS provides insight useful in identifying client strife and developing unique treatment interventions. Inquiring about RS early on garners respect, evidenced by client's wanting their clinician to initiate the conversation, which fosters the therapeutic alliance (Hodge, 2015; Leitz & Hodge, 2013; Oxhandler & Pargament, 2014; Stanley et al, 2011; Vieten et al, 2016). Although due to the inherent power dynamic within the alliance clients may not feel comfortable freely broaching the subject on their own, in which case the clinician

may overlook barriers to treatment (Hodge, 2006; Koenig, 2012; Leitz & Hodge, 2013; Post & Wade, 2014; Stanley et al, 2011). Ironically, social workers may be uncomfortable addressing client RS beliefs due to a lack of personal intrinsic religiosity. Oxhandler & Parrish (2017) reference intrinsic religiosity akin to an individual's lived RS framework, which shapes their beliefs and applied values. The aforementioned study compared LCSWs, counselors, marriage and family therapists, nurses, and psychologists, finding LCSWs and psychologists to have the lowest degree of intrinsic religiosity.

Similar surveys further elucidate LCSW attitudes, behaviors, and training on RS implementation. LCSWs generally hold high levels of self-efficacy (over 80%) in assessing client RS, over 90% admit identifying and listening to client RS beliefs will improve their own practice, but only 55% feel by addressing RS they are showing more compassion toward their clients (Oxhandler & Ellor, 2017). Furthermore, 80% of LCSWs hypothetically agree to refer clients out to seek RS guidance, two out of three felt capable in directing clients to access said resources, but only 50% admit to referring clients (Oxhandler et al, 2015).

Unfortunately, a national study of Licensed Clinical Social Workers (LCSWs) conducted by Oxhandler, Parrish, Torres and Achenbaum (2015) indicates that barely over 50% consistently assess the realm of RS with their clients. Interesting, as social workers have access to a number of RS tools designed to elucidate aspects of the client's belief systems, the degree to which RS influences their lives, and whether or not they wish to have their beliefs and

interventions interwoven (Oxhandler & Parrish, 2017). It is no surprise that clients want their RS beliefs intertwined with therapy as individuals are often seen coping with daily life stressors by way of their RS beliefs therapy (Canda & Furman, 2010; Hodge, 2007, 2015; Oxhandler & Pargament, 2014). Clients may exhibit positive coping skills such as prayer for self or others, along with meditation, or implement negative coping such as expressing feelings of abandonment toward a cruel and unloving God (Oxhandler & Ellor, 2017). Clinicians need only ask to obtain the value-laden information, but it is often not addressed.

Religion and Spirituality across Sociocultural Domains

The degree of religiosity across the United States fluctuates according to geographical location, cultural norms, and political affiliation (Jones, 2016), though disparities are apparent between a large majority of clinician and client beliefs. Statistics illustrate the field of social work is composed primarily of white (69%) Democratic (93%) practitioners (Bureau of Labor and Statistics, 2018); white Democrats commonly appearing less agreeable with the concept of God than nonwhite Democrats- who mostly identify as Hispanic or African-American (Diamant & Smith, 2018). Nationally, 63% of Hispanics and 84% of African American voters identify as Democrats, of which 95% and 99% respectively, believe in God or a higher power (Diamant & Smith, 2018).

Southern California has a large population of ethnic minority groups, predominantly Latino and Hispanic, which historically have been

disproportionately affected by poverty and less likely to achieve higher education (Coleman-Jensen, 2017). Studies show that 66% of those who complete high school or less have a strong belief in God, as compared to those who have graduated college (45%) (Pew Research Center (2018). Indicating the treatment population of Southern California may have higher reliance on their RS beliefs, further illustrating the potential usefulness of RS practices in the area.

Limitations

Prior surveys conducted on LCSW self-efficacy, attitudes, perceived feasibility, practice behaviors, and overall orientation toward implementation of RS practices have been conducted within the state of Texas; results were then generalized, or externally validated via comparison of LCSW's beliefs and practices across the nation (Oxhandler et al, 2015; Oxhandler & Ellor, 2017; Oxhandler & Parrish, 2017). These results may not be generalizable to Southern California and this study will expand upon their findings.

The majority of surveyed clinicians in prior studies were located because they offered their services online and through private practices (Oxhandler et al, 2015; Oxhandler & Ellor, 2017; Oxhandler & Parrish, 2017). There seems to be a gap in the literature pertaining to the vast number of licensed clinical social workers employed by various government, county, and managed care organizations. Southern California provides a large number of services via managed-care hospitals and county departments that would be beneficial to solicit regarding RS practices, which this study aimed to survey.

Theories Guiding Conceptualization

This study was conducted under the auspices of the Faith Development Theory (FDT) developed by American Theologian and Human Development professor James Fowler in 1981 (Fowler, 1981). Fowler portrays faith as a universal construct that gives coherence and meaning to our shared experiences (Canda & Furman, 2010). FDT is composed of seven stages and was developed in alignment with Jean Piaget's theory of cognitive development and Lawrence Kohlberg's stages of moral-development (Fowler, 1981; Zastrow & Kirst-Ashman, 2016, 351). As cognitive abilities increase so does an individual's perception and ability to process the world around them; formulating evolving concepts of their faith and coherence with their changing individuality (Gathman & Nessian, 1997; Zastrow & Kirst-Ashman, 2016, p. 351).

Fowler's Stages of Faith Development

The first three stages of FDT—Primal/Undifferentiated Faith, Intuitive-Projective Faith, And Mythic-Literal Faith—span between birth to adolescence. These stages (a) build upon an individual's understanding of their formative relationships within their micro/mezzo systems, (b) account for perceived sociocultural concepts void of accrued real world meaning, and (c) provide a more literal interpretations of a God who is righteous and fair (Zastrow & Kirst-Ashman, 2016, p. 351). Individuals within these stages are not truly aware, are unable able to critically assess their beliefs, or how their beliefs may be shaped by the environment.

The last four stages— Synthetic-Conventional Faith, Individuative-Reflective Faith, Conjunctive Faith, Universalizing Faith— illustrate the direct application of FDT toward social work RS practice and may be more clearly understood when combined with ecosystems theory. Individuals entering adolescence and progressing into adulthood are now able to reconcile experiences and derive a unique sense of meaning and personalized faith. Synthetic-Conventional Faith is evidenced as individuals begin to apply their accrued knowledge of God as an ally at the macro level; considering the broader influences of friends, work, and social norms (Gathman & Nessian, 1997). Individuative-Reflective Faith progresses through early adulthood, shifting away from and devaluing the externalized/socialized concepts of God and centers now on the individual's own values and internalized belief systems (Gathman & Nessian, 1997).

Practitioners attempting cultural competency should strive to reach the sixth stage of FDT. Conjunctive Faith, rarely reached before the age of 30, is marked by the security of one's own beliefs, an acceptance of diversity and contrasting views, and comprehension of universal values (Parker, 2011; Zastrow & Kirst-Ashman, 2016, p. 352). The final stage of FDT, Universalizing Faith, has less relevance to practice application as it pertains to the outliers who utilize selfless actions to move nations and change societal norms. Dr. Martin Luther King, Mother Teresa, and Mahatma Gandhi are all paragons of such level of faith (Zastrow & Kirst-Ashman, 2016, p. 352)

An ability to practice RS at the sixth stage, with self-awareness and acceptance of others, allows social workers to better comprehend the value and meaning of another's RS belief system. Heightened awareness and appreciation for others' RS will aid in preventing proselytization and boundary crossing. FDT may also provide valuable insight in determining therapeutic relevance and guidance in implementation of RS interventions.

Since its development in the early 1980s, FDT has received considerable attention in the literature (Clore & Fitzgerald, 2002; Coyle, 2011; Fowler, 1981, 2001; Fox, 1995; Jardine & Viljoen, 1992; Jones, 2004; McDargh, 2001; Streib, 2005; Webster, 1984). Yet, much of the attention has been of the conceptual aspect of the theory. Although the premises of the FDT was originally grounded in qualitative data, this theory fails to attract methodologically rigorous research over time. In fact, the FDT has not moved much beyond the conceptual stage.

In this study, the researchers appraised the quality of the FDT through the lenses of the Joseph and Macgowan's (2019) Theory Evaluation Scale (TES). The TES assesses the merits and shortcomings of theories based on several criteria including but were not limited to theory coherence, conceptual clarity, philosophical assumptions, empirical evidence, explanation of theory boundaries and limitations, connections with previous research, and usefulness for social work practice (Joseph & MacGowan, 2019). The appraisal yielded an overall score of 29 for the FDT (please see Figure 1 below). This score places the FDT in the good quality range on the TES (Joseph & MacGowan, 2019).

Joseph and Macgowan's Theory Evaluation Scale (TES)		
<p><i>When assessing the merits and shortcomings of theories through the lenses of the TES, users should adopt an item-level score ranging from 1 to 5—with 1 as the lowest possible point and 5 the highest for an overall score varying from 9 to 45. The higher the score the better the quality of a theory which, as a rule, should be based on the following ranges: (1–10 = Poor; 10–19 = Fair; 20–29 = Good; 30–45 = Excellent). For more accurate scoring, users are encouraged to refer to the description of the items on the scale and the caveats related to the interpretation of some of them (please see “Results, Part II” and “Discussion” sections of the study).</i></p>		
Item	Criteria	Score
1	The theory has coherence.	4
2	The theory has conceptual clarity.	4
3	The theory clearly outlines and explains its philosophical assumptions.	4
4	The theory describes its historical roots in connection with previous research.	3
5	The theory can be tested and proven false via observational and experimental methods.	3
6	The theory has been critically tested and validated through empirical evidence.	3
7	The theory explains its boundaries or limitations.	4
8	The theory accounts for the systems within which individuals interact with people around them.	3
9	The theory recognizes humans as active agents within their environment.	2
Overall score	Fowler's Faith Development Theory	29
<p><i>Theory quality based on overall TES score: _____ Good</i></p>		

Figure 1. Joseph and Macgowan's Theory Evaluation Scale

Summary

This study will explore factors that influence integration of a clients' RS beliefs in clinical practice, along with potential sociocultural differences between states/regions that increase awareness of RS. RS beliefs may be a tenet of strength for the majority of the population, allowing the clinician to develop rapport through mutual understanding and develop interventions tethered to an individual's core values increasing the positive outcomes. The field of mental health, along with medical health have taken notice of the impact of RS on overall well-being, yet there is much room for improvement on behalf of individual practitioners. Fowler's theory effectively conceptualizes an individual's development of faith in parallel with cognitive development, allowing clinicians to, in essence, "meet clients where they're at". This project will illustrate the need for courses in Religion and Spirituality in an effort to offer competent and ethical services to those in need.

CHAPTER THREE

METHODOLOGY

Introduction

This study explored social worker's reluctance to address spirituality with their clients. This chapter will outline the specific details of study implementation focusing on study design, data collection and instruments, procedures, protection of human subjects and data analysis.

Study Design

This cross-sectional study aimed to test the generalizability of previous studies conducted on LCSW views and behaviors pertaining to the integration of client Religion/Spirituality in practice. Embracing a descriptive design, this study explored the attitudes of a specific group of people through survey investigation. More specifically, this research used scale to collect and measure quantitative, subject-supplied data from LCSWs in the Southern California area.

Well collected quantitative data collection yield specific and statistically measurable results, freer of unconscious bias and subjectivity associated with qualitative analysis. Therefore, survey data are less likely to yield multiple explanations or unclear interpretations. Limitations to quantitative data collection include the need for large, generalizable sample sizes and the use of closed ended questions preventing participants from elaborating on their answers. Closed ended questions may have limited potential data due to a lack of probing

or exploration of deeper meaning on behalf of the researcher used to infer causal relationships. Unanswered survey questions may also contribute to statistical errors.

Sampling

This study utilized a snowball approach to target license-holding mental health professionals that have direct interactions with clients. 52 clinicians were recruited from various occupational institutions including: acute hospitals, state mental health hospitals, state mental health hospitals, county agencies, universities and private practice locations. Participants agreed to participate outside of the obligations to their respective employers, via personal email correspondence. This nullified the need to obtain agency approval. Descriptive characteristics of the participants are presented in the *Results* section.

Data Collection and Instruments

Quantitative data was collected via personal email correspondence taking place over the course of six months. The interval measure of the Duke University Religion Index (DUREL) was administered to assess for practitioner religious beliefs and practices. The DUREL was used as the independent variable (IV) along with age, ethnicity, years of experience, prior courses taken on RS, and political affiliation. The DUREL is designed for use in acute healthcare, inpatient and outpatient mental health facilities, along with private therapeutic practice.

This tool was intended to measure practitioner religious beliefs and practices across three domains: organizational religious activity (such as attending church), non-organizational activity (such as personal prayer and/or readings), and intrinsic religiosity (personal degree of inherent faith) (Lace & Handal, 2018).

Participants also completed the interval Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS), which was used as the dependent variable (DV). The RSIPAS is composed of four subscales (DVs) aimed at assessing social worker self-efficacy, attitudes, behaviors and perceived feasibility related to use of client RS beliefs in practice (Oxhandler & Parrish, 2016). Data were descriptively analyzed via Statistical Package for the Social Sciences (SPSS).

Both the DUREL and the RSIPAS are existing instruments that were utilized in this study. The DUREL scale has wide cultural sensitivity due to its use amongst various demographics and has been translated into several languages (Koenig & Bussing, 2010; Lucchetti, et al., 2012). The DUREL scale was found to have strong discriminant validity, internal consistency and test- retest reliability (Lucchetti, et al., 2012). Some limitations identified in a study by Koenig and Bussing found that the DUREL scale was intentionally designed to measure western religions such as Christianity, Judaism and Islam. The scale is not as effective as in eastern religions such as Buddhism and Hinduism. Although a comprehensive measure, the DUREL does not adequately account for intrinsic religiosity. The RSIPAS was also found to be a reliable and valid measure of RS

and behavioral health. A study done by Oxhandler and Parrish (2016) assessed the RSIPAS scale and found evidence in support the scale's reliability criterion validity, discriminant validity, and factorial validity. A limitation of the RSIPAS is that the scale does not factor in other barriers aside from intrinsic religiosity that contribute to reluctance of integrating religion into practice (Oxhandler & Ellor, 2017).

Procedures

Data was gathered through personal email correspondence over the course of no more than 3 months. Researchers solicited participants through networking and coordinating with numerous personal and professional social workers. Contact information was collected and input into an excel spreadsheet that was stored in a secure location. After initial contact was established with professional licensed clinical social workers, recruitment was attained from word of mouth communication of the participants. Each participant received an email of the survey with attached informed consent and debriefing statement that included the purpose of the study, anticipated duration to complete the scale and information regarding where to send the completed scale.

Protection of Human Subjects

Approval to conduct this study was granted by the Institutional Review Board at California State University San Bernardino. In an effort to ensure the protection of identity of the participants of this study, researchers utilized a

university approved email account while corresponding. Upon gathering emails, researchers stored the contact information in a password encrypted USB device. Upon completion of the study information was disposed of. Researchers ensured that no health or sensitive information was collected via email. Researchers sent a discreet and secure email that utilized third-party, survey software to send a link containing the survey for the study in efforts to keep participants anonymous. Participants were not required to supply their names. Researchers referred to numerical code names if further correspondence was necessary.

Study Variables

Dependent Variables

The study had two dependent variables: (a) ability to integrate RS into practice and (b) comfortability discussing RS with clients. These variables were captured by the following statements from the RSIPAS scale: “I am comfortable in my ability to integrate my client’s religious/ spiritual beliefs into their treatment” and “I am comfortable discussing my clients’ religious / spiritual struggles in therapy.” Participants were asked to respond on an ordinal scale ranging from strongly agree to strongly disagree. Both dependent variables were recoded dichotomously to facilitate further testing.

Independent Variables

The study had one independent variable measured by the RSIPAS scale: Profession of the participants. Participants were required to identify as: 1)

Licensed Clinical Social Worker, 2) Psychologist, 3) Psychiatrist, 4) Licensed Marriage and Family Therapist, 5) Mental Health Nurse Practitioner, 6) Licensed Professional Counselor, or 7) Other.

Control Variables

The control variables were primarily composed of demographic input. The list of these variables include gender, race/ethnicity, age group, political affiliation, and religious preference. Age and gender were coded in a binary manner. The other variables were coded ordinally.

Data Analysis

The researchers ran multiple tests that are consistent with to the purpose of the study. First, the researchers performed cross-tabulation analysis in SPSS to determine the level of resistance to RS among the participants. Then the researchers used the Kruskal-Wallis H Test to look for any relationship between participants' academic discipline and resistance to discuss and integrate RS in practice. This non-parametric test also allows to assess whether there is a statistically significant difference in level of resistance to RS between LCSWs and other clinicians. Finally, the Mann-Whitney U Test was used to determine potential correlations between the binary control variables and the dependent variables.

Summary

This study aimed to measure licensed clinician's reluctance to implement religion and spirituality into practice. This study utilized two statically valid and reliable scales called the DUREL (Duke University Religion Index) and the RSIPAS (Religion and Spiritual Integrated practice assessment). Researchers utilized a snowball approach to recruit participants for the study. Communication with participants was established through email correspondence. An email containing the surveys was sent electronically. Once data was collected researchers analyzed data by running multiple tests, including descriptive and non-parametric methods.

CHAPTER FOUR

RESULTS

Introduction

This chapter discusses the results of the descriptive analysis that was conducted to explore the clinician's reluctance in addressing religion and spirituality. This chapter will describe the demographic characteristic of the study sample. The chapter concludes with a summary of the findings.

Results

Descriptive Statistics

Table 1 below displays the frequency distributions of study participants. As shown in Table 1, the sample consisted of 52 participants with the majority of them identifying as female. Approximately half of the participants were Licensed Clinical Social Workers (LCSWs). Slightly less than half of the participants identified themselves as White or Caucasian. Almost one-third of the sample reported being Hispanic, while African American made up of less than one-fifth of the total sample. In terms of political affiliation, most participants identified as democrats. Virtually, half of the participants were under the age of 40. About half of participants had more 10 years of experience in their respective field. The tabulation of religious preference indicated that the vast majority of participants identified as either Protestant, Catholic, or Spiritual.

Table 1

Participant Demographic Characteristics at Baseline (*N* = 52)

Variable	N	%	Variable	N	%
Age		100	Discipline		100
21-30	4	7.7	LCSW	24	46.2
31-40	22	42.3	LMFT	14	26.9
41-50	14	26.9	Mental Health Nurse Practitioner	3	5.8
51-60	8	15.4	Psychiatrist	3	5.8
61 and up	4	7.7	Psychologist	5	9.6
Race/Ethnicity		100	Other	3	5.8
White/Caucasian	19	36.5			100
			Religious Identification		
Hispanic/Latino	14	26.9	Protestant	9	17.3
Black or African American	9	17.3	Catholic	7	13.5
Native American/Alaskan Native	1	1.9	Spiritual	8	15.4
			Buddhist	2	3.8
Asian/Pacific Islander	4	7.7	Hindu	2	3.8
Other	5	9.6	Jewish	1	1.9
Political Party			Muslim	1	1.9
Democrat	32	62.7	Other	16	30.8
Republican	7	13.7	None	6	11.5
Independent	7	13.7	Years' Experience		
Libertarian	1	2.0	Under 10 years	25	48.1
Other	4	7.8	Over 10 years	27	51.9

Findings

The findings from this study are presented in Figure 2 below. These figures specifically report clinicians' confidence in their ability to integrate client beliefs into treatment and their comfort in discussing client RS beliefs in

treatment. As exhibited in Figure 2, of all the participants, three quarters of them reported no reluctance in their ability to integrate religion/spiritual beliefs into treatment. The remaining quarter did report resistance. In terms of comfortability, the vast majority of the sample (84.7%) reported no discomfort discussing RS in therapy. In other words, few participants (15.3%) indicated a sense of discomfort discussing SR in clinical practice.

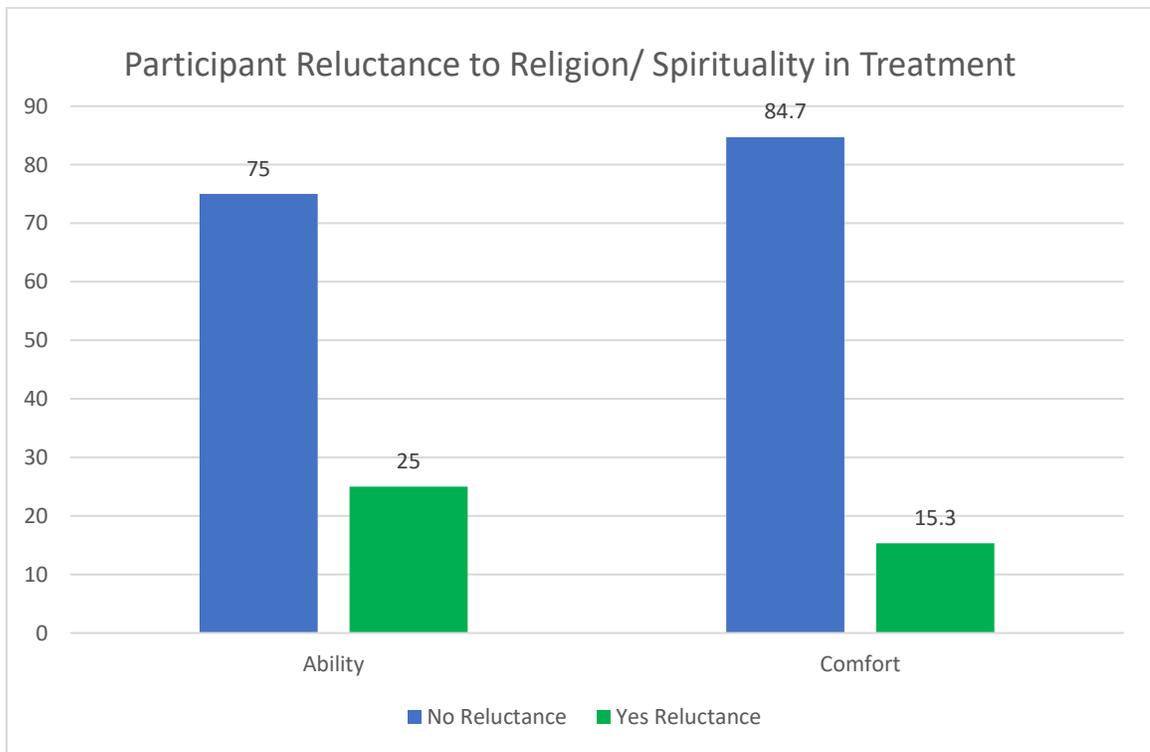


Figure 2. Participant responses to reluctance to religion/ spirituality in treatment.

Meanwhile, the Kruskal-Wallis H Test results showed no statistically significant difference in reluctance level between LCSWs and with that of other license-holding professionals. Yet the reluctance to RS in clinical settings was slightly higher among other clinicians. Furthermore, separate Mann-Whitney U Test results revealed no statistically significant relationship between the binary control variables and the dependent variables.

Summary

This chapter presented findings of collected data evidencing demographic breakdown of participants and the outcomes of statistical analysis. The descriptive statistics displayed a diverse study sample in terms of age, discipline, political affiliation, race/ethnicity, religious identification and years or practice experience. Descriptive tests were conducted to explore the reluctance licensed clinicians have in addressing religion/ spirituality. The results indicated reluctance in utilizing R/S in treatment were influenced by clinician lack of confidence in ability and level of comfortability discussing client RS struggles. Findings show 25% of participants reported lack of confidence in their ability, while 15.3% of participants were not comfortable discussing RS struggles in therapy.

CHAPTER FIVE

DISCUSSION

Overview

This paper assessed for reluctance toward the integration of client RS beliefs in clinical practice among in Southern California among license-holding mental health professionals in Southern California. Deepening understanding of RS is important due to approximately 90% of Americans claiming RS as a key aspect in shaping their worldview and coping with daily stressors (Gallup, 2015; Pew Research Center, 2018). Equally important is the fact slightly more than half of clinicians consistently assess and integrate client RS into therapy, spotlighting an area to improve competent practice (Oxhandler, et al., 2015; Oxlander & Parrish, 2017).

This study assessed for clinician attitudes, behaviors, perceived feasibility, and self-efficacy related to RS implementation. Participants across various occupational institutions including, acute hospitals, state mental health hospitals, county agencies, universities and private practice locations participated in this study. Key findings gleaned from this study found that 25% of clinicians expressed reluctance toward integration of client RS due to lack of confidence in their ability to do so. Furthermore, 15.3% of clinicians reported reluctance due to lacking comfortability in addressing RS with their clients. In addition, although there was no statistically significant difference in resistance level among the

various professionals, LCSWs registered higher ability and comfort toward RS in practice than others clinicians.

Overall, these results are consistent with previous studies evidencing clinician reluctance in addressing client RS (Oxhandler et al., 2015; Oxlander & Parrish, 2017). However, current findings indicate less social worker reluctance than in prior studies conducted at the state and national level. In fact, only 5% of LCSWs reported reluctance due to lacking confidence, far less than the 30% rate found in Texas or the 17.3 percent score registered across the nation (Oxhandler et al., 2015; Oxlander & Parrish, 2017). Surprisingly, only 2% of LCSWs felt uncomfortable in addressing client RS, compared to 15% practicing in Texas and 11% nationally (Oxhandler et al., 2015; Oxlander & Parrish, 2017). Possible explanations for a lower than average rate of reluctance in this study include RS trainings, awareness of RS importance, clinician intrinsic religiosity and diversity. These are covered below.

Religion/Spirituality Trainings

To begin with, mean years of clinical experience surveyed from all clinicians was reported at 12.4 years, less than the means reported in Texas and across the nation, at 17.3 and 22.9 years respectively. It's possible that fewer years of field experience influenced clinicians' self-efficacy, with 65% reporting they were not adequately trained. Though, continuing along that line of thought, data shows 24% of clinicians reported completing graduate coursework, while 28% completed continuing education specializing in RS integration. These

reports of completed graduate coursework are higher than findings made by Sheridan (2008), and prior studies conducted in Texas and nationally, at 11.3% and 13%, respectively (Oxhandler et al., 2015; Oxlander & Parrish, 2017).

Considering the completion rates of graduate coursework, there is an increase in the implementation rates of empirical interventions that specifically outline integration of client RS into practice of 27%, which is higher than figures reported by clinicians in the state of Texas (17%) and nationally (15%) (Oxhandler et al., 2015; Oxlander & Parrish, 2017). This increase in RS implementation following prior training is supported by previous studies, indicating correlated increases in practitioner self-efficacy, attitudes, perceived feasibility, and behaviors (Oxhandler et al, 2015; Vietenet al, 2016).

Awareness of Religion/Spirituality Importance

Clinicians held positive attitudes toward RS integration evidenced by behavioral items involving engagement, such as assisting clients in identifying how their RS support systems may be beneficial, and exploring the RS meaning and possible purpose of their current situation over 70% of the time. Participants also reported they would facilitate linking clients with appropriate RS resources 42% of the time, in alignment with previous state (51%) and national studies (43%) (Oxhandler, et al., 2015; Oxlander & Parrish, 2017). Close to 90% of clinicians, versus 61% nationally, reported it is essential to assess client RS and believe it improves therapeutic outcomes (Oxhandler et al, 2015). Furthermore, most participants believe RS assists clients in achieving goals, with close to

100% expressing assessment and integration of client RS represents an ethical practice.

Instances of clinicians seeking consultation evidences attempts to provide competent practice close to 60% of the time, slightly higher than previous national studies reporting 52% (Oxhandler, et al., 2015). Social workers are required to provide competent practice, espoused by the Counsel on Social Work Education guidelines (CWSE, 2015) and the ethics of the National Association of Social Workers (2008). Therefore, consultation and referral to appropriate RS resources are requisite to allow for client self-determination. This collection of data indicates that useful RS services are being provided in various forms throughout the diverse occupational institutions surveyed.

Intrinsic Religiosity and Diversity

Oxhandler and Parrish (2017) refer to intrinsic religiosity as an individual's lived RS framework that shapes their experiences, beliefs and worldview. Intrinsic religiosity has been shown as a predictor of integration of client RS in practice (Larsen, 2011; Oxhandler et al., 2015). 18 of 24 LCSWs who participated in this study reported moderate to high intrinsic religiosity. Including scoring highly on DUREL domains that included, (1) I try hard to carry my religion over into all other dealings in life, (2) My religious beliefs are what really lie behind my whole approach to life, (3) In my life, I experience the presence of the Divine (i.e., God), and (4) the frequency of their religious activities. This may evidence why participants completed a higher percentage of graduate courses in

spirituality. The degree of intrinsic religiosity reported by social workers may also speak to the overall sociocultural RS composition of Southern California, and the Inland Empire in particular, which is home to a dense population of minority groups. Social workers may also be more willing to address RS due to the large percentage of their service population viewing RS as an important aspect of their worldview (Diamant & Smith, 2018).

The current study presented a more diverse composition of social workers than compared to prior studies. Oxhandler and Parrish (2017) reported their sample characteristics at 79% Caucasian, 12.1% Hispanic, and 5% African American. The national study of social workers conducted by Oxhandler et al. (2015) reported 87% of participants were Caucasian, 4.3% Hispanic, and 3.9% African American. Participants in the current study reported a demographic mixture of 36% Caucasian, 26% Hispanic, and 17% African American; evidence of the diverse cultural composition of Southern California, which again, may have influenced social worker reluctance in addressing RS with their clients.

Implications

This study allowed for the evaluation of licensed Southern Californian social work clinicians, reporting less reluctance in addressing client RS beliefs as compared to other national regions. These findings have theoretical implications indicating an increased emphasis for the consideration of client cultural environment in relation to the importance of RS beliefs and social

supports. Use of Fowler's FDT may assist social workers in better understanding their clients and fostering the therapeutic alliance.

Combining findings with prior research there are direct implications toward industry and organizational policy, indicating mutual benefit for client and clinician, through the use of a structured RS assessment tool. Consistent utilization of an RS instrument, such as the RSIPAS, would increase clinician self-awareness of intrinsic religiosity, decrease the potential of boundary crossing and proselytization of RS beliefs, elucidate client worldviews and improve therapeutic outcomes. Adoption of new policies handed down by the Board of Behavioral Sciences (BBS) mandating implementation of RS would direct clinical practice toward increased cultural competency and support the standards timidly laid out by the CWSE (2015) and NASW (2008).

Helping professions operating within the field of mental health would see an increase in RS graduate coursework, increasing clinician awareness and confidence, further decreasing reluctance to integrate client RS beliefs. Exploring human behavior in the social environment through the lens of religion and spirituality bolsters the social work systems theory and espousal of a holistic recovery model. Increasing availability of RS specializations would usher in additional empirically based approaches for use across varying client populations and belief systems. The union of practitioner awareness and widespread organizational policy has the potential to establish a more inclusive and

accepting atmosphere within mental health, further extending services to those in need.

Limitations

As human work, this study is not exempt from weaknesses. First, though acquiring a sample size of 52 licensed professionals is quite an achievement, the size of the sample was not appropriate for more robust data analysis methods. Additionally, the descriptive nature of the study—although boding well with its exploratory purpose—prevented the researchers from establishing causal inferences between the variables. Another limitation relates to the geographical location. Although similar to other findings across the country, the current findings are only reflective of Southern California. Finally, the cross-sectional nature of the findings does not reflect how the professionals' perceptions of RS varied over time.

Recommendations

Future research should attempt to extend the literature beyond the descriptive level. Researchers should also do their best to explore the clients' experiences vis-à-vis RS in clinical settings. Rigorous qualitative inquiries can help researchers assess the extent to which RS needs of individuals and families are met in clinical practice. This would allow to capture the depth and breadth of the issue. The literature would also benefit from a replication of this study in different areas of the countries, preferably at the state and local levels. Where

longitudinal approaches are conducted, researchers can rely on strong, quasi-experimental research design to extend the scholarship on RS.

APPENDIX A
RELIGIOUS/SPIRITUALITY INTEGRATED
PRACTICE ASSESSMENT SCALE

Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS)

Section 1: Self-Efficacy With Religious/Spiritually Integrated Practice

Please indicate with an "X" the response that best fits how much you agree or disagree with the statements regarding religious/spiritually integrated practice.

1. I know how to skillfully gather a history from my clients about their religious/spiritual beliefs and practices.

Strongly disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

2. I am able to recognize when my clients are experiencing religious/spiritual struggles (e.g. tension or conflict with his/her higher power, religious/spiritual community, spiritual beliefs, etc.)

Strongly disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

3. I know what to do if my client brings up thoughts of being possessed by Satan or the Devil.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

4. I consider the unique needs of diverse clients with different religious/spiritual backgrounds in my practice.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

5. I am able to recognize when my clients utilize positive religious/spiritual coping strategies (e.g. trying to find a spiritual lesson in the presenting issue, etc.)

Strongly Disagree___ Disagree___ Neutral___
Agree___ Strongly Agree___

6. I am able to ensure my clients have access to religious/spiritual resources if they see this as an important aspect to their healing process (e.g. religious/spiritual reading materials, pastoral counseling, contact information to local clergy, or a prayer room/ place or worship)

Strongly Disagree___ Disagree___ Neutral___
Agree___ Strongly Agree___

7. I feel as though I have the skills to discuss my clients' religious/spiritual strengths.

Strongly Disagree___ Disagree___ Neutral___
Agree___ Strongly Agree___

8. I feel confident in my ability to integrate my clients' religious/spiritual beliefs into their treatment.

Strongly Disagree___ Disagree___ Neutral___
Agree___ Strongly Agree___

9. I know when it is beneficial to refer my client to pastoral or religious counseling.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

10. I feel as though I have the skills to discuss my clients' religious/spiritual struggles.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

11. I am able to recognize when my clients' utilize negative religious/spiritual coping strategies (e.g. viewing the presenting issue as punishment from his/her higher power, etc.)

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

12. I know what to do when my client has religious/spiritual beliefs that I am unfamiliar with.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

13. I am comfortable discussing my clients' religious/spiritual struggles in therapy.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

Section II. Attitudes About Religious/Spiritually Integrated Practice

Please indicate with an "X" the response that best fits how much you agree or disagree with the statements regarding religious/spiritually integrated practice.

1. It is essential to assess clients' religious/spiritual beliefs in practice.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

2. Integrating clients' religious/spiritual needs during treatment helps improve client outcomes.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

3. Practitioners who take time to understand their clients' religious/spiritual beliefs show greater concern for client well-being than practitioners who do not take time to understand their clients' religious/spiritual beliefs.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

4. Integrating clients' religious/spiritual beliefs in treatment helps clients' meet their goals.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

5. I am open to learning about my clients' religious/spiritual beliefs that may differ from mine.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

6. Attending to clients' religious/spiritual needs is consistent with the principles of meeting the client where he/she is at.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

7. Sensitivity to clients' religious/spiritual beliefs will improve one's practice.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

8. I am open to referring my clients to religious or pastoral counseling.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

9. Attending to clients' religious/spiritual beliefs is consistent with my professions' code of ethics.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

10. Empirically supported religious/spiritually integrated therapies are relevant to my practice.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

11. There is a religious/spiritual dimension to the work I do.

Strongly Disagree___ Disagree___ Neutral___

Agree___ Strongly Agree___

12. I refuse to work within my clients' religious/spiritual belief system if it differs from my own.

Strongly Disagree___ Disagree___ Neutral___
Agree___ Strongly Agree___

Section III. Feasibility for You to Engage in Religious/Spiritually Integrated Practice

Please indicate with an "X" the response that best fits how much you agree or disagree with the statements regarding religious/spiritually integrated practice.

1. I have enough time to assess my clients' religious/spiritual background.

Strongly Disagree___ Disagree___ Neutral___
Agree___ Strongly Agree___

2. I have enough time to identify potential strengths or struggles related to my clients' religion/spirituality.

Strongly Disagree___ Disagree___ Neutral___
Agree___ Strongly Agree___

3. My primary practice setting does not support the integration of religion/spirituality into practice.

Strongly Disagree___ Disagree___ Neutral___
Agree___ Strongly Agree___

4. I don't have enough time to think about incorporating a religious/spiritually integrated approach into practice.

Strongly Disagree___ Disagree___ Neutral___
Agree___ Strongly Agree___

5. Given the many issues that must be addressed in treatment, I still find time to integrate my clients' religion/spirituality if they communicate a preference for this.

Strongly Disagree ___ Disagree___ Neutral___
Agree___ Strongly Agree___

6. I have been adequately trained to integrate my clients' religious/spirituality into therapy.

Strongly Disagree___ Disagree___ Neutral___
Agree___ Strongly Agree___

Section IV. How Often Do You Currently Engage in Religious/Spiritually Integrated Practice?

For this section, please indicate with an "X" the response that best fits the *frequency* with which you currently engage in religious/spiritually integrated practice.

1. I seek out consultation on how to address clients' religious/spiritual issues in treatment.

Never___ Rarely___ Some of the Time___

Often___ Very Often___

2. I read about ways to integrate clients' religious/spirituality to guide my practice decisions.

Never___ Rarely___ Some of the Time___

Often___ Very Often___

3. I read about research evidence on religious/spirituality and its relationship to health to guide my practice decisions.

Never___ Rarely___ Some of the Time___

Often___ Very Often___

4. I involve clients in deciding whether their religious/spiritual beliefs should be integrated into our work together.

Never___ Rarely___ Some of the Time___

Often___ Very Often___

5. I use empirically supported interventions that specifically outline how to integrate my clients' religious/spirituality into treatment.

Never___ Rarely___ Some of the Time___

Often___ Very Often___

6. I conduct a full biopsychosocial *spiritual* assessment with each of my clients.

Never___ Rarely___ Some of the Time___

Often___ Very Often___

7. I link clients with religious/spiritual resources when it may potentially help them. (e.g. religious/spiritual reading materials, contact information to local clergy, or a prayer room/place of worship)

Never___ Rarely___ Some of the Time___

Often___ Very Often___

8. I help clients consider ways their religious/spiritual support systems may be helpful.

Never___ Rarely___ Some of the Time___

Often___ Very Often___

9. I help clients consider the religious/spiritual meaning and purpose of their current life situations.

Never___ Rarely___ Some of the Time___

Often___ Very Often___

This completes the Religious/Spiritually Integrated Practice Assessment Scale.

(Oxhandler & Parrish,2016)

APPENDIX B
DUKE UNIVERSITY RELIGION INDEX

Duke University Religion Index

1. How often do you attend church or other religious meetings?
Never___ Once a year or less___ A few times a year___
A few times a month___ Once a week___
More than once a week___
2. How often do you spend time in private religious activities, such as prayer, meditation, or Bible study?
Rarely or Never___ A few times a month___ Once a week___
Two or more times a week___ Daily___ More than once a day___
3. In my life, I experience the presence of the Divine (i.e., God).
Definitely not true___ Tends not to be true___ Unsure___
Tends to be true___ Definitely true of me___
4. My religious beliefs are what really lie behind my whole approach to life.
Definitely not true___ Tends not to be true___ Unsure___
Tends to be true___ Definitely true of me___
5. I try hard to carry my religion over into all other dealings in life.
Definitely not true___ Tends not to be true___ Unsure___
Tends to be true___ Definitely true of me___

(Koenig & Büssing, 2010)

APPENDIX C
INFORMED CONSENT

INFORMED CONSENT

The study in which you are asked to participate is designed to examine Licensed Clinical Social Worker views and behaviors pertaining to the use of religion and spirituality in clinical practice. The study is being conducted by David Drew and Jessica Banks, graduate students under the supervision of Dr. Rigaud Joseph, Assistant Professor in the School of Social Work at California State University, San Bernardino (CSUSB). The study has been approved by the Institutional Review Board Social Work Sub-committee as CSUSB.

PURPOSE: The purpose of the study is to examine the view and behaviors pertaining to the use of religion and spirituality in clinical practice.

DESCRIPTION: Participants will be asked questions about their religious beliefs and practices along with questions assessing social worker self-efficacy, attitudes, behavior and perceived feasibility related to use of client RS beliefs in practice.

PARTICIPATION: Your participation in the study is totally voluntary. You can refuse to participate in the study or discontinue your participation at any time without any consequences.

CONFIDENTIALITY: Your responses will remain confidential and data will be reported in group form.

DURATION: It will take approximately 20 minutes to complete the survey.

RISKS: Although not anticipated, there may be some discomfort in answering some of the questions. You are not required to answer and can skip the question or end your participation.

BENEFITS: There will not be any direct benefits to the participants

CONTACT: If you have any questions about this study, please feel free to contact Dr. Joseph at (909) 537- 3501

RESULTS: Results of the study can be obtained from the Pfau Library

ScholarWorks database (<http://scholarworks.lib.csusb.edu/>) at California State University, San Bernardino after July 2019.

Demographics

Age: 26-35___ 36-45___ 46-55___ 56-65___ 65 and over___

Years of practice experience: ___

(*Please answer following responses using an "X".)

Gender: Male___ Female___ Other_____

Ethnicity:

Caucasian___ African American___ Hispanic___

Asian/Pacific Islander___ American Indian/Alaskan Native___

Other_____

Political Affiliation:

Democrat___ Republican___ Independent___

Libertarian___ Other_____

Profession:

Licensed Clinical Social Worker___ Psychologist___

Psychiatrist___ Licensed Marriage and Family Therapist___

Mental Health Nurse Practitioner___ Licensed Professional Counselor___

Other_____

Religious preference:

Protestant___ Catholic___ Jewish___ Muslim___

Buddhist___ Hindu___ Spiritual___ None___

Other_____

Any courses taken as a student that focused primarily on integrating
Religion/Spirituality in practice?

Yes___ No___

Field education only___

Any prior continuing education on integrating Religion/Spirituality in practice?

Yes___ No___

Do you possess knowledge of any empirically supported treatments on
integrating Religion/Spirituality in practice?

Yes___ No___

APPENDIX D
IRB APPROVAL FORM

CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
SCHOOL OF SOCIAL WORK
Institutional Review Board Sub-Committee

Researcher(s) David Drew & Jessica Banks
Proposal Title Religion and Spirituality in Clinical Practice:
An Exploration of Resistance Among Practitioners
SW1918

Your proposal has been reviewed by the School of Social Work Sub-Committee of the Institutional Review Board. The decisions and advice of those faculty are given below.

Proposal is:

- approved
 to be resubmitted with revisions listed below
 to be forwarded to the campus IRB for review

Revisions that must be made before proposal can be approved:

- faculty signature missing
 missing informed consent debriefing statement
 revisions needed in informed consent debriefing
 data collection instruments missing
 agency approval letter missing
 CITI missing
 revisions in design needed (specified below)



Committee Chair Signature

1/28/2019

Date

Distribution: White-Coordinator; Yellow-Supervisor; Pink-Student

REFERENCES

- Branco, F. J. N. (2016). The circle of social reform: The relationship social work—social policy in Addams and Richmond, *European Journal of Social Work*, (19)3-4, 405-419. doi: 10.1080/13691457.2015.1084272
- Canda, E. R., & Furman, L. D. (2010). *Spiritual diversity in social work practice: The heart of helping* (2nd ed.). New York: Oxford University Press.
- Campesino, M., & Schwartz, G. E. (2006). Spirituality among Latinas/os implications of culture in conceptualization and measurement. *Advances in Nursing Science*, 29(1), 69–81.
- Clore, V., & Fitzgerald, J. (2002). Intentional faith: An alternative view of faith development. *Journal of Adult Development*, 9(2), 97-107.
- Coleman-Jensen, A., Rabbit, M., Gregory, C., & Singh, A (2017). Household food security in the United States in 2016. USDA ERS. www.feedingamerica.org/research/map-the-meal-gap/overall-executive-summary.html
- Cook, G., & Krulwich, R. (2016). *The best American infographics*. Boston: Houghton Mifflin Harcourt.
- Council on Social Work Education. (2008). *Educational policy and accreditation standards (EPAS)*. Retrieved from <http://www.cwse.org>.
- Coyle, A. (2011). Critical responses to faith development theory: A useful agenda for change? *Archive for the Psychology of Religion*, 33(3), 281-298.
- Diamant, J., & Smith, G.A. (2018, May 23). Religiously, nonwhite Democrats are more similar to Republicans than to white Democrats. Retrieved from

<http://www.pewresearch.org/fact-tank/2018/05/23/religiously-nonwhite-democrats-are-more-similar-to-republicans-than-to-white-democrats/>

- Fowler, J. W. (1981). *Stages of faith: The psychology of human development and the quest for meaning*. San Francisco, CA: Haper & Row.
- Fowler, J. W. (2001). Faith development theory and the postmodern challenges. *The International Journal for the Psychology of Religion*, 11(3), 159-172.
- Fox, M. (1995). The quest for meaning: James Fowler, faith development theory, and adult religious education. *Journal of Beliefs and Values*, 16(2), 27-29.
- Gallup. (2015). *Religion*. Retrieved from <http://www.gallup.com/poll/1690/religion.aspx>.
- Gathman, A. C., & Nessian, C. L. (1997). Fowler's stages of faith development in an honors science-and-religion seminar. *Zygon: Journal of Religion & Science*, 32(3), 407.
- Hodge, D. R. (2006). A template for spiritual assessment: A review of the JCAHO requirements and guidelines for implementation. *Social Work*, 51(4), 317-326. doi:sw/51.4.317.
- Hodge, D. R. (2007). The spiritual competence scale: A new instrument for assessing spiritual competence at the programmatic level. *Research on Social Work Practice*, 17(2), 287-295. doi: 10.1177/1049731506296168.
- Hodge, D. R. (2011). Alcohol treatment and cognitive-behavioral therapy: Enhancing effectiveness by incorporating spirituality and religion. *Social Work*, 56(1), 21-31. doi:sw/56.1.21.

- Hodge, D. R. (2015). Spirituality and religion among the general public: Implications for social work discourse. *Social Work, 60*(3), 219-227.
doi:sw/swv021
- Jardine, M. M., & Viljoen, H. G. (1992). Fowler's theory of faith development: An evaluative discussion. *Religious Education, 87*(1), 74-85.
- Jones, T. P. (2004). The basis of James W. Fowler's understanding of faith in the research of Wilfred Cantwell Smith: An examination from an evangelical perspective. *Religious Education, 99*(4), 345-357.
- Jones, Jeffrey. (2016, February 3). Red states outnumber blue for the first time in Gallup tracking. Retrieved from <https://news.gallup.com/poll/188969/red-states-outnumber-blue-first-time-gallup-tracking.aspx>
- Joseph, R., & Macgowan, M. J. (2019). The theory evaluation scale: An epistemological tool for analyzing social work theories. *Social Work Education, 38*(2), 269-281.
- Kirst-Ashman, K. K., (2017). *Introduction to social work and social welfare: Critical thinking perspectives*. Boston, MA: Cengage Learning.
- Koenig, H. G. (2012). Religion, spirituality, and health: The research and clinical implications. *ISRN Psychiatry, 2012*, 278730.
<http://doi.org/10.5402/2012/27873>.
- Koenig, H. G., & Bussing, A. (2010). The Duke University Religion Index (DUREL): A Five-Item Measure for Use in Epidemiological Studies. *Religions, 1*, 78-85.

- Lace, J. W., & Handal, P. J. (2018). Confirming the tripartite structure of the Duke university religion index: A methodological approach. *Journal of Religion and Health* 57, 704-716.
- Larsen, K. M. (2011). How spiritual are social workers? An exploration of social work practitioners' personal spiritual beliefs, attitudes, and practices. *Journal of Religion and Spirituality in Social Work: Social Thought*, 30, 17-33.
- Leitz, C. A., & Hodge, D. R. (2013). Incorporating spirituality into substance abuse counseling: Examining the perspectives of service recipients and providers. *Journal of Social Service Research*, 39, 498-510.
- Lucchetti, G., Lucchetti, A. L. G., Peres, M. F., Leão, F. C., Moreira-Almeida, A., & Koenig, H. G. (2012). Validation of the duke religion index: DUREL (Portuguese version). *Journal of religion and health*, 51(2), 579-586.
- McDargh, J. (2001). Faith development theory and the postmodern problem of foundations. *The International Journal for the Psychology of Religion*, 11(3), 185-199.
- National Association of Social Workers. (2008). *Code of Ethics of the National Association of Social Workers*. Retrieved from <http://www.socialworkers.org/pubs/code/code.asp>.
- Ouwehand, Eva. (2018). Sweet delight and endless night: A qualitative exploration of ordinary and extraordinary religious and spiritual experiences in bipolar disorder. *International Journal for the Psychology of Religion*, 28(1), 31-55.

- Oxhandler, H. K., & Pargament, K. I. (2014). Social work practitioners' integration of clients' religion and spirituality in practice: A literature review. *Social Work, 59*(3), 271-279.
- Oxhandler, H. K., Parrish, D. E., Torres, L. R., & Achenbaum, W. A. (2015). The integration of clients' religion and spirituality in social work practice: A national survey. *Social Work, 60*(3), 228-237. <https://doi.org/10.1093/sw/swv018>.
- Oxhandler, H. K., & Parrish, D. E. (2016). The development and validation of the religious/spiritually integrated practice assessment scale. *Research on Social Work Practice, 26*(3) 295-307.
- Oxhandler, H. K., Ellor, J. W. (2017). Christian social workers' views and integration of clients' religion and spirituality in practice. *Journal of the North American Association of Christians in Social Work, 44*(3), 3-24.
- Oxhandler, H. K., & Parrish, D. E. (2017). Integrating clients' religion/spirituality in clinical practice: A comparison among social workers, psychologists, counselors, marriage and family therapists, and nurses. *Clinical Psychology, 74*(7), 680-694. Wileyonlinelibrary.com/journal/jclp.
- Parker, S. (2011). Spirituality in counseling: A faith development perspective. *Journal of Counseling & Development, 89*(1), 112-119.
- PEW Research Center. (2014). Fewer Hispanics are Catholic, so how can more Catholics be Hispanic? Retrieved from <https://www.pewresearch.org/fact-tank/2014/05/07/fewer-hispanics-are-catholic-so-how-can-more-catholics->

be-hispanic/

PEW Research Center. (2014). Religious landscape study. Retrieved from

<http://www.pewforum.org/religious-landscape-study/#religions>

PEW Research Center. (2016). Democrats maintain edge as party 'more

concerned' for Latinos, but views similar to 2012. <http://www.pew>

[hispanic.org /2016/10/11/democrats-maintain-edge-as-party-more-](http://www.pewhispanic.org/2016/10/11/democrats-maintain-edge-as-party-more-concerned-for-latinos-but-views-similar-to-2012/)

[concerned-for-latinos-but-views-similar-to-2012/](http://www.pewhispanic.org/2016/10/11/democrats-maintain-edge-as-party-more-concerned-for-latinos-but-views-similar-to-2012/)

PEW Research Center. (2018). What unites and divides urban, suburban and

rural communities. Retrieved from [http://www.pewsocialtrends.org/2018/05/](http://www.pewsocialtrends.org/2018/05/22/what-unites-and-divides-urban-suburban-and-rural-communities/)

[22/what-unites-and-divides-urban-suburban-and-rural-communities/](http://www.pewsocialtrends.org/2018/05/22/what-unites-and-divides-urban-suburban-and-rural-communities/)

PEW Research Center. (2018). When Americans say they believe in God, what

do they mean? Retrieved from <http://www.pewforum.org/2018/04/25/when>

[Americans-say-they-believe-in-god-what-do-they-mean/](http://www.pewforum.org/2018/04/25/when-Americans-say-they-believe-in-god-what-do-they-mean/)

PEW Research Center. (2018). Wide gender gap, educational divide in voters'

party identification. Retrieved from <http://www.people-press.org/2018/03/20/>

[wide-gender-gap-growing-educational-divide-in-voters-party-identification/](http://www.people-press.org/2018/03/20/wide-gender-gap-growing-educational-divide-in-voters-party-identification/)

Post, B. C., & Wade, N. G. (2014). Client perspectives about religion and

spirituality in group counseling. *The Counseling Psychologist*, 42, 601-627.

<https://doi.org/10.1177/0011000014524601>

Salsberg, E., Quigley, L., Mehfoud, N., Acquaviva, K., Wyche, K., Sliwa, S.

(2017). *Profile of the Social Work Workforce*. Retrieved from

<https://www.cswe.org/Centers-Initiatives/Initiatives/National-Workforce->

Initiative/SW-Workforce-Book-FINAL-11-08-2017.aspx

- Senreich, E. (2013). An inclusive definition of spirituality for social work education and practice. *Journal of Social Work Education, 49*(4), 548-564.
- Sheridan, M. (2009). Ethical issues in the use of spiritually based interventions in social work practice: What we are doing and why. *Journal of Religion and Spirituality in Social Work, 28*(2), 99-126.
- Stanley, M. A., Bush, A. L., Camp, M. E., Jameson, J. P., Philips, L. L., Barber, C. R., Zeno, D., Lomax, J. L., & Cully, J. A. (2011). Older adults' preferences for religion/spirituality in treatment for anxiety and depression. *Aging and Mental Health, 15*, 334-343.
- Streib, H. (2005). THEORY: " Faith development research revisited: Accounting for diversity in structure, content, and narrativity of faith". *The International Journal for the Psychology of Religion, 15*(2), 99-121.
- Substance Abuse and Mental Health Administration (SAMHSA). (2010). *Mental Health, United States, 2008*. Rockville, MD: Center for Mental Health Services.
- Summermatter, A., & Kaya, C. (2017). An overview of spiritually oriented cognitive behavioral therapy. *Spiritual Psychology and Counseling, 2*(1), 31-53. doi:10.12738/spc.2017.1.0017.
- U.S. Department of Labor, Bureau of Labor and Statistics. (2018). Labor force statistics from the current population. *Occupational outlook handbook*. Retrieved from <https://www.bls.gov/cps/cpsaat11.htm>

- Vieten, C., Scammell, S., Pierce, A., Pilato, R., Ammondson, I., Pargament, K. I., & Lukoff, D. (2016). Competencies for psychologists in the domains of religion and spirituality. *Spirituality In Clinical Practice*, 3(2), 92-114.
doi:10.1037/scp0000078.
- Webster, D. H. (1984). James Fowler's theory of faith development. *British Journal of Religious Education*, 7(1), 14-18.
- Zastrow, C. H. and Kirst-Ashman, K. K. (2016). *Understanding Human Behavior and the Social Environment*. Boston: Cengage Learning.

ASSIGNED RESPONSIBILTIES

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