# Spiritual Questioning And Its Impact On The Therapeutic Alliance: A Preliminary Study

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# SPIRITUAL QUESTIONING AND ITS IMPACT ON THE THERAPEUTIC ALLIANCE: A PRELIMINARY STUDY

by

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ABSTRACT
SPIRITUAL QUESTIONING AND ITS IMPACT ON THE THERAPEUTIC ALLIANCE: A PRELIMINARY STUDY

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A growing number of studies have found that clients would prefer to discuss spiritual and religious (S/R) concerns in psychotherapy and, notably, see it as an appropriate place to discuss these concerns. Although clients report they would prefer to discuss S/R matters with their therapist, psychologists are reluctant to do so. Lack of training may be a factor in the reluctance of psychologist to discuss spirituality and religion with their clients. In addition to the research on spirituality/religion and psychotherapy, the therapeutic alliance has been proposed as a similar component among all forms of treatment and consistently shown to be predictive of psychotherapy outcome. While the therapeutic alliance is one of the most widely investigated components in psychotherapy, no studies to date have looked at the impact of S/R querying on ratings of the alliance. This study is a first attempt towards that goal. A measure of clinician competence, the *Scale of Spiritually Conscious Care* (*SSCC*) was constructed to assess clinician awareness, knowledge, comfort, competence, and skills in addressing spirituality and religion in psychotherapy. Following creation of this measure and initial reliability investigation, clinicians were trained to administer S/R queries to their clients. Finally, the impact of this training on clinician competence and client ratings of the alliance was investigated. Results indicated the *SSCC* demonstrates adequate test-retest reliability and strong internal consistency. Although clinicians reported increased comfort and competence after the training, in addition to increased incorporation of client spirituality and religion into psychotherapy; no significant differences were found between those who attended the training and those who did not. Additionally, no significant differences in ratings of the alliance between client who discussed spirituality and religion with their clinicians and those who did not were found. The lack of significant results may be related to the small sample and low power to detect genuine differences between groups. These results are taken to be a strong first step in investigating the effect of S/R querying on ratings of the alliance and worthy of further investigation.

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## Literature Review

A large majority of Americans report believing in God or a higher power and that religion plays a significant role in their lives (Gallup & Lindsay, 1999). Additionally, a growing number of studies have found that clients would prefer to discuss spiritual and religious (S/R) concerns in therapy and, notably, see it as an appropriate place to discuss these concerns (Knox, Catlin, Casper & Schlosser, 2005; Rose, Estefeld, & Ansley, 2001). Although clients have reported that they would prefer to discuss S/R matters with their therapist, psychologists are reluctant to do so, which has been suggested to be due to a lack of training.

Additionally, an increased interest in investigating the therapeutic relationship has developed over the last 30 years, especially as the therapeutic alliance has consistently shown to be predictive of psychotherapy outcome. Although a substantial body of research on the alliance exists and the importance of discussing client's spirituality and religion has begun to be acknowledged, little research has focused on how the discussion of spirituality and religion within psychotherapy can impact the therapeutic alliance.

This study was a preliminary attempt to examine the effect of S/R querying on the alliance. A measure of self-rated competence in addressing spirituality and religion in psychotherapy, the *Scale of Spiritually Conscious Care*, was constructed, and its validity was evaluated. In addition, graduate student clinicians were trained to administer S/R queries, and the impact of that training, as measured through scores on the *Scale of Spiritually Conscious Care*, was evaluated. Finally, the impact of discussing S/R in psychotherapy on ratings of the alliance was investigated.

The following literature review focuses on the evolving body of literature on spirituality and religion and how it relates to psychotherapy. Various definitions and measurement issues are presented, and a discussion of the spiritual and religious beliefs and practices of Americans is provided. Next, the relationship between spiritual and religious beliefs and practices and psychotherapy is discussed with specific attention paid to client and therapist preferences for discussing spirituality and religion in psychotherapy and psychologist training in spirituality and religion. S/R adaptations to psychotherapy are then discussed. Finally, approaches and guidelines to discussing spiritual and religious beliefs and practices are examined. This review also covers, less extensively, the therapeutic alliance. Conceptualizations of the alliance are reviewed, followed by a discussion of the relationship between the therapeutic alliance and treatment outcome. Finally, pretreatment predictors of the therapeutic alliance are examined.

## Spirituality and Religion

Psychology and religion have had a conflicted relationship. Early theorists viewed religion in a particularly negative light. Freud (1927/1961) referred to religious views as illusions and fulfillment of the oldest, strongest, and most urgent wishes of mankind. While Freud wrote of religion with great disdain, the once negative view of spirituality and religion within the field of psychology has changed. A growing recognition of the importance of spirituality and religious issues to patients within both medical and mental health care settings is emerging (Saunders, Miller, & Bright, 2010), perhaps a result of the increasing number of studies that have documented the positive effects of spirituality and religion on physical and mental health.

This section discusses research regarding spiritual and religious beliefs and practices (SRBP). Areas that are covered include: definitions of SRBP, statistics regarding the importance of spirituality and religion to Americans, the relationship of SRBP to physical and mental health, client and therapist perspectives of the role of SRBP in psychotherapy, SRBP training as it relates to psychotherapy, and different approaches to incorporating spirituality and religion into psychotherapy.

**Definition of Spirituality and Religion**

Various definitions of spirituality and religion have been proposed and debated in the literature (Zinnbauer, Pargament, & Scott, 1999). William James defined religion as "the feelings, acts, and experiences of individual men in their solitude, so far as they apprehend themselves to stand in relation to whatever they may consider the divine" (1902/1961, p. 42). A more recent definition proposed by Richards and Bergin (1997) is "theistic beliefs, practices, and feelings that are often, but not always, expressed institutionally and denominationally as well as personally." Spirituality has also been defined in a number of different ways. Benner (1989) described spirituality as "the human response to God's gracious call to a relationship with himself" (p. 20), whereas Vaughan (1991) defined spirituality as "a subjective experience of the sacred" (p. 105). Although many researchers have attempted to define spirituality and religion, no current consensus as to how spirituality and religion should be defined exists—let alone what constitutes the boundaries of these definitions.

Recent developments in research involving the conceptualization of spirituality and religion have taken place. Zinnbauer and Pargament (2005) note that while spirituality had been undifferentiated from religion in the past, within the last several

decades it has been described as a separate construct and focus of research. Religion came to refer to a fixed system of ideas or ideological commitments, while spirituality was increasingly used to refer to the personal and subjective side of religious experience (Hill & Pargament, 2003). The separation of spirituality into a separate construct led to an unhelpful distinction between the two terms.

Pargament and colleagues (Hill et al., 2000; Pargament, 1999; Zinnbauer & Pargament, 2005) have written extensively on the potential problems of the separation of these two concepts. They argued that referring to religion as an institutional domain and to spirituality as an individual domain ignores two vital concepts: that spiritual experiences tend to evolve within a social context and that many religions are concerned with the personal lives of those who worship (Hill & Pargament, 2003). To conceptualize spirituality as a solely personal phenomenon is to ignore the cultural context in which this term was developed and to overlook that spirituality is seldom experienced in a social vacuum (Zinnbauer et al., 1999). Further, the polarization of spirituality and religion led some to view spirituality as positive and religion as negative (Zinnbauer & Pargament, 2005), which may be due in part to Western ideals of independence.

Although it would be difficult, if not impossible, to propose a definition of spirituality and religion that is beyond debate, it is helpful to define these concepts for the purposes of this paper. Spirituality is defined as "a personal or group search for the sacred" and religiousness is defined as "a personal or group search for the sacred that unfolds within a traditional sacred context" (Zinnbauer & Pargament, 2005, p. 35). In other words, religiousness is defined as a specific (traditional) form of spirituality. This conceptualization has emerged as the consensus understanding among researchers in this

area because they reflect the interconnectedness of the two constructs. As such, these two concepts will typically be referenced together.

**Spiritual and Religious Beliefs and Preferences of Americans**

It is clear that religion and spirituality are highly important to many people. A majority of Americans report believing in God or a higher power (95%), being a member of a church or synagogue (69%), and that religion plays a significant role in their lives (85%; Gallup & Lindsay, 1999). A recent public survey (Gallup Organization, 2010) found that 54% of Americans indicated that they consider religion to be "very important" in their lives and 26% indicated religion to be "fairly important" in their lives. The majority of Americans (61%) report being a member of a church or synagogue, and 39% reported attending church or synagogue in the last seven days. Additionally, a large majority (approximately 85%) of Americans describe themselves as religious or spiritual (Gallup & Lindsay, 1999; Gallup Organization, 2010). The importance of SRBP in many Americans' lives has led, in part, to an increased investigation of the impact of SRBP on physical and mental health.

**Relationship to Physical and Mental Health**

An abundance of research in recent years has documented the positive effects of SRBP on physical health. A number of researchers have demonstrated a relationship between increased religious involvement and lower mortality (McCullough, Hoyt, Larson, Koenig, & Thoresen, 2000; Powell, Shahabi, & Thoresen, 2003). Religious beliefs and activities are related to less heart disease, lower blood pressure, lower cholesterol, and better health behaviors (Koenig, 2004). Additionally, SRBP have been shown to be

protective of cardiovascular health (Powell et al., 2003) and have been related to improved physiological functioning (Seeman, Dubin, & Seeman, 2003).

Research has also demonstrated a relationship between SRBP and positive mental health, with higher religious involvement related to better mental health and wellbeing (Hackney & Sanders, 2003). Positive religious coping, or the use of one's religion to cope with stressful events, is related to spiritual growth as the result of a stressor and fewer symptoms of psychological distress (Pargament, Smith, Koenig, & Perez, 1998). People who use positive religious coping are more likely to experience less depression and anxiety, have positive affect, higher self-esteem, experience stress-related growth, and have better psychological adjustment (Ano & Vasconcelles, 2005).

In addition to the research showing a relationship between SRBP and mental health, a growing body of literature has demonstrated a connection between SRBP and mental health problems and psychopathology (Bryant & Astin, 2008; Johnson & Hayes, 2003; McConnell, Pargament, Ellison, & Flannelly, 2006). Spiritual and religious concerns are particularly prevalent in college student populations and are related to significant distress (Bryant & Astin, 2009; Johnson & Hayes, 2003). The relationship between spiritual struggles and symptoms of psychopathology (i.e. psychological distress and depression) has also been found in non-college samples (Bryant & Astin, 2009; Schnittker, 2001). A meta-analysis of 147 studies, which included more than 100,000 subjects, found an inverse relationship between religiousness and symptoms of depression (Smith, McCullough, & Poll, 2003). Substance use disorders are also related to spirituality and religion (Kendler, Gardner, & Prescott, 1997; Koenig, 2009; Saunders, Lucas, & Kuras, 2007). There is also an inverse relationship between religiousness and

drinking problems (Kendler et al., 1997) and people with drinking problems are more likely to report a disconnect between their current S/R functioning and their ideal S/R functioning (Saunders, Lucas, & Kuras, 2007).

Religious struggles are particularly prevalent for clients who suffer from serious and persistent mental illness. Persons with serious and profound mental illness are more likely to use negative religious appraisals, including viewing mental illness as a punishment from God or questioning God's power, and are more likely to report psychological distress and a greater sense of personal loss related to spirituality and religion (Phillips & Stein, 2007). Compared to the general population, persons with serious and persistent mental illness are more likely to use religious beliefs or activities to cope with their mental illness and daily difficulties (Tepper, Rogers, Coleman, & Malony, 2001). They are more likely to use religious forms of coping such as prayer, attending religious services, and worshiping God than other forms of coping, and are also more likely to use religious coping when symptoms become worse. It has been suggested that religious coping is so common among patients with mental illness because it provides a sense of meaning and purpose during difficult life circumstances (Koenig, 2009).

Due to the relatively high prevalence of spiritual struggles, and their association with symptoms of psychopathology, the Diagnosis and Statistical Manual of Mental Illness, Fourth Edition – Text Revised now contains a category to identify clients who are experiencing religious or spiritual struggles (V62.89; American Psychiatric Association, 2000). This category can be used when clients are presenting with spiritual and religious issues that are significant and need to be the focus of clinical attention. Given the relationship between spirituality/religion and mental health, researchers, and some

clinicians have recommend that clinical psychologists pay more attention to these areas of their clients' lives.

**Spirituality, Religion and Psychotherapy**

As the cultural diversity of the United States continues to grow, it is likely that mental health professionals will encounter clients with various religious and spiritual views. The religious diversity of North American contains a variety of customs, beliefs, doctrine, spiritual practices, and healing traditions (Richards & Bergin, 2000) and if psychologists are to be seen as credible and trustworthy it is important that they obtain understanding of the spiritual and religious diversity of their clients. Knowledge of SRBP and a willingness to discuss them in therapy are an important part of being a multiculturally competent therapist. The most recent version of the American Psychological Association (APA) ethics code dictates that knowledge in several multicultural areas, including religion, is essential for effective implementation of psychological services or research. If not already familiar with a multicultural area important to treatment, psychologists must obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services (American Psychological Association, 2002). As organizing bodies are now recognizing the importance of obtaining knowledge related to SRBP, researchers and clinicians have continued to investigate the importance of SRBP in clients' lives and the desire of clients to discuss their beliefs within psychotherapy.

The following section will examine client preferences for the discussion of spirituality and religion in psychotherapy, therapist preferences for the discussion of

spirituality and religion in psychotherapy, and training in incorporating clients' spirituality and religion into therapy.

**Client preferences for discussion of spirituality and religion.** Due to the high number of Americans that indicate religion and spirituality are an important part of their lives and the research documenting the beneficial contributions of religion and spirituality to physical and mental health, it should not be surprising that clients would like to discuss religion and spirituality in therapy. Although only a few small surveys of clients' preferences for discussing spirituality and religion in therapy have been conducted, the results clearly indicate that clients wish to discuss S/R matters in therapy and see it as an appropriate place to discuss these concerns (Knox, et al., 2005; Rose, et al., 2001). Knox and colleagues (2005) further note that clients are more receptive to discussing religion and spirituality when they perceived their therapist as open, accepting, and safe. However, conversations regarding SRBP were considered unhelpful when the client felt that their therapist was passing judgment on their beliefs.

**Therapist preferences for discussion of spirituality and religion.** Although most Americans indicate that spirituality and religion are a very important part of their lives, psychologists have expressed less religious affiliation than the general population (Shafranske & Malony, 1990). A recent survey of psychologists found that 48% of those surveyed reported that religion was not an important part of their lives. A little more than half of those surveyed indicated being a member of a church, synagogue or mosque, but only 33% reported attending services in the last week (Delany, Miller, & Bisono, 2007). The discrepancy between the importance of spirituality and religion to clients and therapists may impact why psychologists are less likely to discuss SRBP with their

clients. Interestingly, the majority of psychologists reported believing that religion was beneficial to mental health; yet, most psychologists do not assess religious or spiritual functioning (Hathaway, Scott, & Garver, 2004). One study found that psychologists discuss religion and spirituality with only 30% of their clients (Frazier & Hansen, 2009).

**Training in spirituality and religion.** The discrepancy between the importance that clients and therapists place on S/R concerns may help explain why psychologists are reluctant to address S/R issues in therapy. Perhaps more important, some psychologists may feel that working with religious and spiritual issues is outside of their area of expertise and therefore may see it as more appropriate to refer clients to other professionals for discussion of S/R matters (Knox et al., 2005). The reluctance to address S/R issues in psychotherapy is likely related to a lack of training and supervision in religion and spirituality and the incorporation of SRBP into psychotherapy. Although the literature regarding different ways of addressing S/R concerns in therapy has become more readily available, it is yet to be taught to clinicians in training (Bartoli, 2007). Only 13% of clinical training directors report that their programs offer a specific course unique to religion and spirituality (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002) and a majority (64.7%) of APA-accredited predoctoral internship sites offer no didactic training in addressing religion and spirituality in psychotherapy (Russell & Yarhouse, 2006).

## Religious and Spiritual Adaptations to Psychotherapy

Attempts have been made to adapt empirically-supported psychological treatments to the values and beliefs of religious clients, including Christian accommodative cognitive-behavior therapy (Pecheur & Edwards, 1984; Propst, 1980;

Propst, Ostrom, Watkins, Dean, & Mashburn, 1992), Muslim accommodative therapy for depression (Azhar & Varma, 1995a,b; Razali, Hasanah, Aminah, & Subramaniam, 1998), Muslim accommodative therapy for anxiety (Azhar, Varma, & Dharap, 1994; Razali, Aminah, & Khan, 2002; Razali et al., 1998), and Buddhist accommodative cognitive-behavior therapy for anger (Vannoy & Hoyt, 2004).

Given the development of these therapies and the increased attention paid to incorporating SRBP into traditional psychotherapy, researchers have investigated the efficacy of these treatments. Overall, research has shown that therapies that incorporate SRBP are effective (Smith, Bartz, & Richards, 2007). When Chambless and Hollon's (1998) strict criteria for probably efficacious and well-established treatments are applied, two S/R adapted psychotherapies (i.e., 12-Step Facilitation for Alcoholism [Project Match Research Group, 1997] and Christian Accommodative Cognitive Therapy for Depression [Propst, 1980]) meet criteria for efficacy (Hook et al., 2010). Hook and colleagues (2010) note that the limited number of religious and spiritual therapies found to be efficacious is likely due to the small number of replicated, high quality, controlled outcome studies, rather than an indication that these therapies are ineffective. The authors concluded that there is evidence for the treatment of psychological problems with religious and spiritual psychotherapy, but more research, especially more methodologically rigorous research, needs to be conducted.

**Approaches and Guidelines to Incorporating SRBP into Psychotherapy**

Increasing attention is now being paid to the importance of religion and spirituality within the field of clinical psychology—both as a part of being a multiculturally competent therapist and as recognition of the potential benefits of SRBP.

Clinicians and researchers have begun calling for more attention to be paid to this area and for more information to be made available to clinicians who desire to incorporate SRBP into their assessments and therapy (e.g., Aten & Worthington, 2009; Hathaway et al., 2004).

Several approaches to incorporating SRBP into psychotherapy have been proposed by researchers in the field of spirituality and religion. These approaches are different than the treatments discussed above in that they are more general guidelines on how to incorporate SRBP into psychotherapy and not specific manualized procedures for conducting therapy. These approaches can be categorized into spiritually oriented psychotherapy, spiritually integrative psychotherapy, and spiritually conscious psychological care.

**Spiritually oriented psychotherapy.** Spiritually oriented psychotherapy refers broadly to psychotherapeutic approaches that focus on the spiritual dimensions of clients' lives (Sperry, 2003). The degree of integration of spirituality into the therapeutic process is tailored to the mutually defined goals and tasks of the treatment and in respect to the therapeutic alliance (Sperry & Shafranske, 2004). The goals of treatment vary according to the client, but may involve help with spiritual emergencies, spiritual growth, and reduction of symptomatic distress (Sperry, 2003).

Although there can be great variability in spiritually oriented psychotherapies, some general similarities between the different treatments exist. For example, spiritually oriented psychotherapy typically focuses on the clients' SRBP as the object of attention with the intent of transformation (Saunders, Miller, & Bright, 2010). Various traditional psychological approaches to treatment have been integrated with spiritual perspectives

and interventions, including psychodynamic, cognitive, rational emotive behavior therapy, interpersonal, and multicultural treatment (Richards & Worthington, 2010). One type of spiritually oriented treatment has the clinician consider the clients' relationship with God, God-image or God-representation, core psychospiritual schemas, and spiritual practices including involvement in a spiritual community (Sperry, 2004). These approaches may require the client to take part in various S/R interventions, such as reading Bible scriptures, engaging in prayer, increasing involvement with spiritual/religious community, and/or encouraging forgiveness.

**Spiritually integrated psychotherapy.** Spiritually integrated psychotherapy focuses on clients' SRBP as a way to relieve symptoms of distress and impairment (Pargament, 2007). Spiritually integrated psychotherapy differs from spiritually oriented psychotherapy in that the clients' SRBP are not focused on in order to change or improve the clients' beliefs, but to help facilitate relief of the clients' distress. Spiritually integrated psychotherapy assumes that spirituality can be a part of the solution, such as by helping relieve the client's distress, but can also be part of the problem, as the client's distress may result from maladaptive spiritual coping. A typical course of spirituality integrated psychotherapy does not exist because spirituality is expressed in different ways by different people. Examples of spiritually integrated psychotherapy could include helping clients reengage in activities they find sacred, suggesting to the client that they consider their problems within the context of their SRBP, or suggesting potentially helpful S/R beliefs and activities that are consistent with the client's faith (Saunders et al., 2010).

This approach to discussing SRBP acknowledges that clients typically bring their spirituality into the therapy room and that therapists should talk directly to their clients regarding how spirituality can be a part of the problem, solution, and also the therapeutic relationship. Pargament (2007) advocates for an explicit spiritual assessment, which involves assessing the salience of spirituality and religious affiliation to the client, as well as the salience of spirituality to the problem and to the solution. By directly addressing and assessing clients' spiritual lives, the clinician will be better able to help clients deal with their distress in a way that incorporates their spiritual beliefs.

**Spiritually conscious psychological care**. Spiritually conscious psychological care involves assessing SRBP in a respectful and sensitive manner in order to determine their general importance to a client, as well as the influence, if any, SRBP have on the presenting problem(s) and their potential as a resource to help recovery (Saunders et al., 2010). Spiritually conscious psychological care differs from the approaches discussed above in that it involves a thorough assessment of the clients SRBP, but does not involve addressing or focusing on the clients SRBP as a part of the intervention. This approach involves querying clients about their S/R life in the context of a thorough and sensitive evaluation. Querying involves assessing general beliefs and behaviors; the relationship, if any, between the problem and the client's spirituality/religion; and potential S/R resources for the client. General querying about SRBP may, or may not, lead to further queries about the clients SRBP. By assessing the client's SRBP, the therapist can better determine the impact of these beliefs on the client's current emotional distress or impairment and whether these should be addressed as part of treatment. If needed, the

psychologist can refer the client to a more appropriate services provider or religious or spiritual leader (Saunders et al., 2010).

## Therapeutic Alliance

The therapeutic alliance has been one of the most widely studied variables in psychotherapy research for the last 30 years. This section discusses historical views of the alliance, the relationship between alliance and outcome, pretreatment predictors of the alliance and the influence of client and therapist similarities. Finally, this section addresses research involving the impact of S/R discussion on ratings of the alliance.

### Historical Views

Freud was one of the first to write about the relationship between the client and therapist (Freud, 1912/1958). His writings on transference describe how the relationship between the therapist and client can have an impact on whether the client improves as a result of therapy. Freud described two types of transference: positive and negative. Negative transference refers to the client transferring their negative feelings onto the therapist (Freud, 1912/1958). Freud believed that negative transference obstructed therapeutic growth and that it was important for the therapist to help the client work through this process. Positive transference refers to the client relating to their therapist with affection and devoted dependence (Freud, 1912/1958). While negative transference has the potential to hinder therapeutic growth, Freud believed positive transference could help clients overcome their difficulties in therapy. Freud recognized the importance of his relationship with his clients and realized that the client's feelings towards the therapist are strongly related to the client progressing in therapy.

Although Freud's writings focused primarily on the client's contribution to the alliance, Rogers emphasized the therapist's role in contributing towards the therapeutic relationship. Rogers believed the primary contribution of the client-centered approach was the inquiry into therapist behaviors and the impact of therapist behaviors on psychotherapy (Rogers, 1951). Rogers held the assumption that the client has the potential for constructive change and development in the direction of a more satisfying and happy life (Rogers, 1951), which was a fundamental assumption in his theories regarding the role of the therapist within psychotherapy. Because the client has an innate capacity for growth, the role of the therapist is largely to help the client determine what is best for him/her.

Therefore, the therapist is to assume, as best as he or she is able, the internal frame of reference of the client. The therapist is to perceive the world as the client sees it, to lay aside all perceptions from an external frame of reference, and to communicate this empathic understanding to the client (Rogers, 1951). When the therapist conveys emphatic understanding, the client is better able to understand and accept herself for who she is. This is best accomplished when the therapist accepts the client for who she is, where she is, and where she is going. Rogers (1951) believed that when the counselor perceived the client from her frame of reference and accepted the client for whom she is, he allowed the client to then freely explore their life anew, and to develop new meaning and goals. The therapist must be willing to accept any choice the client makes, even if this includes choices the therapist believes will be detrimental or maladaptive.

**Bordin's Conceptualization**

Bordin's writings on the alliance have been very influential in the way researchers conceptualize and study the alliance. Bordin proposed a transtheoretical model of the therapeutic alliance (Bordin, 1979, 1994). His theory has its roots in psychoanalytic theory, but is believed to be generalizable to all forms of psychotherapy. Bordin's theory has received substantial attention in the literature and was used in the development the *Working Alliance Inventory* (Horvath & Greenberg, 1989), a commonly used measure in psychotherapy research.

Bordin asserted that the alliance consists of three parts: agreement on goals, agreement on tasks, and bond. These three components are believed to be essential to the formation of a strong therapeutic alliance. The first component, agreement on goals, refers to a careful search between the client and therapist for the change goal that most fully captures the client's struggle with the pains and frustration relative to the story of his or her life (Bordin, 1994).

The second component, agreement on tasks, refers to the specific activities undertaken to achieve these goals. While goals refers to the general ideas of what the client would like to achieve in psychotherapy, tasks refers to what the therapist and client are going to do. The therapist is the major source of selection of therapeutic tasks, but the client must understand the relevance of these tasks and believe in their potential to bring about change.

The third component, emotional bonding, grows out of the client and therapist's experience in a shared activity. This compatibility, or bonding, is expressed and felt in terms of liking, trusting, having respect for each other, and sharing a sense of common commitment to the activities in therapy (Bordin, 1994). Because of the transtheoretical

nature of Bordin's theory and the support of his conceptualization in the literature, this theory provided the framework of the therapeutic alliance for this study.

**Relationship between Therapeutic Alliance and Treatment Outcome**

A number of different meta-analytic reviews have suggested that different forms of psychotherapy produce similar results (Luborsky, Singer, & Luborsky, 1975; Smith & Glass, 1977; Wampold, et al., 1997). The findings of these meta-analyses have led researchers to look for commonalities, also referred to as common factors, among different forms of treatment that may help explain these results. As such, the therapeutic relationship has been suggested as a similar component among all forms of treatment and thought to be responsible for a significant portion of the variance in outcome. The relative efficacy of all forms of psychotherapy has led some to propose that the therapeutic relationship in general, and the alliance in particular, are the defining components shared by most psychotherapies (Horvath & Bedi, 2002).

A number of studies have linked the alliance to outcome in psychotherapy. Horvath and Symonds (1991) analyzed 24 studies on the alliance and outcome and found an average moderate effect size. Martin, Garske, and Davis (2000) conducted a similar meta-analysis of 79 studies and found that a moderate amount of the variance in treatment was uniquely related to the therapeutic alliance. Horvath and Bedi (2002) included 10 studies in a meta-analysis and found similar results. In the most up-to-date investigation on the alliance, Horvath, Del Re, Flückiger, and Symonds (2011) synthesized over 200 research reports on alliance and outcome and found an aggregated effect size of .275.

Although consistent, these results may appear to indicate that the therapeutic alliance has a somewhat small effect on treatment outcome. However, when one considers that specific therapeutic techniques, such as cognitive restructuring or pleasant activities scheduling, have been reported to account for only around 15% of the variance in treatment outcome (Lambert & Barley, 2002), the importance of the alliance emerges as even larger than these commonly used techniques. Although one may postulate that the impact of the alliance as a predictor of outcome may be stronger for certain treatment modalities, it has been found that the impact of the alliance is similar across diverse forms of psychotherapy (Horvath & Symonds, 1991; Martin et al., 2000).

**Sources of data.** Multiple measures of the alliance have been developed. These instruments reflect the authors' attempts to measure aspects of the alliance that are based on their theoretical understanding of the construct, including the *Working Alliance Inventory* (WAI; Horvath & Greenberg, 1989), the *California Psychotherapy Alliance Scales* (CALPAS; Marmar, Weiss & Gaston, 1989), and the *Vanderbilt Psychotherapy Process Scale* (VPPS; Suh, O'Malley, & Strupp, 1986). Studies using the different alliance measures report relatively similar findings, namely that the alliance is a significant contributor to positive therapeutic outcome (Horvath & Bedi, 2002; Martin et al., 2000).

Researchers have also used different sources of data, or raters, when investigating the therapeutic alliance, including client, therapist, and observer. Therapist-rated alliance has been found to be slightly less related to outcome than client or observer ratings of the alliance (Horvath & Bedi, 2002). Although slightly different, all are relatively similar in their positive findings of the relationship between the alliance and outcome.

**Timing of alliance measurement.** Alliance measured early in therapy (within the first third portion of treatment) is a consistent predictor of outcome and has been shown to be a better indicator of outcome than alliance measured later in treatment (Barber et al., 1999; Castonquay, Goldfried, Wiser, Raue, & Hays, 1996; Gaston, Thompson, Gallager, Cournoyer, & Gagnon, 1998; Sexton, 1996). While these results have led some to argue that alliance measured early in psychotherapy is the product of improvement that has already occurred in treatment, the alliance is a significant predictor of outcome even when controlling for early change in symptoms (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2009). Other research has found the alliance to be an indicator of outcome even after controlling for prior change and client characteristics (Klein et al., 2003). These findings indicate that the alliance is a significant predictor of outcome, above and beyond both improvement in treatment and client characteristics.

## Pretreatment Predictors of the Therapeutic Alliance

A number of pretreatment variables have been investigated regarding their association with the therapeutic alliance. Clients' pre-therapy severity of impairment, attachment style, and expectations for improvement have all been found to influence the alliance. Therapist characteristics and behaviors, as well as the similarities, or match, between the client and therapist have also been shown to affect the formation of the alliance.

**Client severity of impairment.** Research has generated mixed results regarding the association between the severity of clients' impairment before therapy and clients' capacity to form a strong therapeutic alliance with their therapist. Some have found pre-therapy impairment to adversely affect the alliance (Yeomans et al., 1994; Zuroff et al.,

2000), whereas others have found pre-treatment impairment to have little to no difference on alliance formation (Joyce & Piper, 1998; Paivio & Bahr, 1998). More recent research has revealed client interpersonal difficulties to negatively affect the client-therapist alliance (Dinger, Strack, Sachsse, & Schauenburg, 2009; Gibbons et al., 2003; Hersoug, Hoglend, Monsen, & Havik, 2002). Additionally, clients with certain diagnoses (e.g., personality disorders) have been shown to have a more difficult time forming an effective alliance with their therapists (Andreoli et al., 1993; Muran et al., 1995).

**Client attachment style.** An area of research that that has gained attention in recent years is the association between the client's early relational experience and the alliance within psychotherapy. Attachment theory has been proposed as a way to view the development of the alliance. Early research suggests the quality of the alliance, as reported by the client in the early stages of therapy, is affected by the quality of the client's attachment style (Joyce & Piper, 1998). Specifically, client comfort with intimacy, a factor related to secure attachment, has been found to be related to superior ratings of therapeutic alliance (Collins & Read, 1990; Kivlighan, Patton, & Foote, 1998; Mallinckrodt, Coble, & Grantt, 1995). Early parent-child relationships have also been shown to affect psychotherapy outcome (Hilliard, Henry, & Strupp, 2000), and more recent research continues to find a relationship between attachment style and alliance formation (Byrd, Patterson, & Turchik, 2010; Goldman, & Anderson, 2007).

**Client expectations for improvement.** Client expectation for improvement is also positively associated with quality of the alliance in early and middle phases of treatment (Constantino, Arnow, Blasey, & Agras, 2005), indicating that clients who expect to get better as a result of treatment are likely to form a better alliance with their

therapist. It has been proposed that clients who expect to improve in treatment are more likely to engage constructively in session and more likely to achieve symptom reduction (Meyer et al., 2002).

**Therapist characteristics and behaviors.** A number of therapist characteristics and behaviors have been identified as contributing to lower ratings of the alliance. Clients who perceive their therapists as rigid, self-focused, less involved in psychotherapy, or less understanding are likely to report lower ratings of the alliance (Marmar et al., 1989). Additionally, therapists who were characterized as exploitive, critical, moralist, defensive, and lacking warmth, respect, and confidence were likely to have lower scores on ratings of the alliance (Eaton, Abeles, & Gutfreund, 1993). Perhaps not surprisingly, Saunders (1999) found that clients' ratings of session quality were lower when the therapist was perceived as distracted, tired, and bored.

Therapist characteristics that are likely to lead to stronger alliance formation include the perception of the therapist as being trustworthy and possessing expertise (Horvath & Greenberg, 1989). Additionally, stronger alliance ratings are related to the therapist being recognized as warm, friendly, affirming, competence, confident, facilitating a greater sense of understanding, and expressing interest in the client (Bachelor, 1995; Mohl, Martinez, Tichnor, Huang, & Cordell, 1991; Najavits & Strupp, 1994; Saunders, 1999).

A number of studies have demonstrated a connection between amount of training and ratings of the alliance (Hersoug et al., 2001; Mallinckrodt & Nelson, 1991). These results indicate that client bond with the therapist is strongly influenced by how the therapist interacts with the client and how effective the client perceives the therapist to be.

Therapist's behaviors that negatively influence the alliance include failure to structure the session, inflexibility, inappropriate use of silence, and use of superficial and destructive interventions (Eaton et al., 1993). Additionally, therapist's use of belittling, blaming, disclosure, and expression of negative sentiments regarding the client have been show to lead to poorer ratings of the alliance (Coady & Marziali, 1994). When clients perceive the therapist as trying to take charge during the early phase of therapy, as well as when clients perceive the therapist as irritable, ratings of the alliance are likely to suffer (Lichenberg et al., 1988; Sexton, 1996). Finally, inappropriate and unyielding use of transference interpretation is related to poor alliance formation (Piper et al., 1999; Ogrodniczuk, Piper, Joyce, & McCallum, 1999).

Therapist behaviors that positively influence the alliance include the therapist expressing herself well and displaying behaviors that convey an understanding and acceptance of the client (Allen et al., 1996; Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983; Saunders, Howard, Orlinsky, 1989). The therapist's use of techniques that foster greater session depth are also related to stronger alliance formation (Ackerman, Hilsenroth, Baity, & Blagys, 2000; Svenson & Hanson, 1999). Ackerman and Hilsenroth (2003) conclude that a stronger and longer lasting alliance results when the therapist applies techniques that convey support, increase the clients' understanding of their problems, and enhance the level of connectedness between themselves and the clients.

**Client and therapist match.** Researchers have also investigated the similarities, or match, between the client and therapist and its effect on treatment. The relationship between racial/ethnic match and treatment outcome has shown varying results (Jones,

1982; Sue, 1998). Some authors have found race/ethnic matching to have an influence on treatment outcome (Sue, 1998) whereas others have found no differences (Shin et al., 2005). Currently it is difficult to draw conclusions from the literature on race/ethnic match and treatment outcome as the results of research are so varying.

The relationship between gender matching and treatment outcome has also been investigated. Similar to the research on racial/ethnic matching, the research has demonstrated varying results. Although some researchers found that female clients were more satisfied with their treatment and had better outcomes when treated by a female therapist (Jones, Krupnick, & Kerig, 1987), others found gender matching had no effect on attrition rates, outcomes, or the client's perceptions of therapist empathy (Zlotnick, Elkin, and Shea, 1998). It has been suggested that while client-therapist match in gender may be related to higher client satisfaction and indirect outcomes, it does not lead to superior gains in treatment (Sue & Lam, 2002).

Little research has been conducted on the match between the client and therapist and its relationship to alliance. The research that has been conducted was related to adolescents and drug abuse. Wintersteen, Mensinger, and Diamond (2005) found that gender matching led to higher ratings of alliance and increased treatment retention for teens undergoing drug abuse treatment. Interestingly, racial/ethnic matching predicted greater treatment retention, but not client's ratings of the alliance. However, therapists who were mismatched with their clients tended to rate the alliance as lower. Given the limited population and setting, more research is needed in this area to fully understand the impact of therapist-client match on ratings of the alliance.

**Influence of S/R Discussion on Alliance**

Although an increasing amount of literature on incorporating SRBP into psychotherapy is being conducted and research consistently shows the alliance is related to outcome, little to no research has investigated the effect of S/R querying on ratings of the alliance. Guidelines have been proposed to aid clinicians in fostering a strong therapeutic alliance when working with clients who present with spiritual issues, but no empirical support is provided for their use (Young, Dowdle, & Fowers, 2009). Additionally, one attempt has been made to assess the impact of the alliance as it relates to the effectiveness of religiously tailored Christian psychotherapy as compared to non-Christian oriented psychotherapy (Wade et al., 2007). The authors used a one-item assessment of the alliance and found that clients feel equally close with therapists in Christian therapy as they do with therapists in secular therapy.

## Summary and Implications

Research has consistently demonstrated that the therapeutic alliance is related to psychotherapy outcome (Horvath et al., 2011; Martin et al., 2000). The relationship between the alliance and outcome is maintained regardless of assessment instrument used, who rates the relationship (i.e., therapist vs. client vs. observer), or when the relationship is measured (i.e., first or third session; Barber et al., 1999; Horvath & Bedi, 2002). Additionally, research on spirituality and religion has flourished over the last decade. This increased attention is likely due in part to research showing the beneficial effects of spirituality and religion on physical and mental health (Hackney & Sanders, 2003; McCullough et al., 2000). Although clients express a desire to discuss spiritual and religious concerns in psychotherapy and see therapy as an appropriate place to discuss their concerns, clinicians are reluctant to do so (Delany et al., 2007; Knox et al., 2005). It

has been suggested that clinicians may be reluctant to address S/R issues in their work with their psychotherapy clients (Knox et al., 2005).

Although lack of training is likely related to clinicians discomfort addressing S/R issues in psychotherapy, it does not excuse them from seeking training to appropriately address this area of their clients' lives. APA has stated that knowledge of multicultural matters (including SRBP) is essential for the effective implementation of psychological services and that if clinicians are not familiar with a multicultural area then it is essential for them to obtain the training and experiences necessary to ensure the competence of their services (American Psychological Association, 2002).

If clinicians are to address SRBP in their work with their clients then it is necessary for them to obtain the training to properly do so. However, there is currently limited research on training clinicians to address SRBP in psychotherapy and a lack of instruments designed to assess when clinicians have obtained the necessary levels of competence. Additionally, there is limited research addressing the influence of S/R discussion on clients' ratings of the alliance.

## Present Studies

The goals of the current studies are to conduct a preliminary investigation on S/R querying and its impact on the therapeutic alliance. The first study involved the creation and validation of an instrument to assess competence in addressing SRBP in psychotherapy.

Utilizing the measure developed in the first study, the second study evaluated whether training in addressing SRBP in psychotherapy influenced graduate students' self-

rated competence. In addition, preliminary data on the impact of S/R querying by psychotherapists on clients rating of the therapeutic alliance was collected.

The hypotheses that will be tested in the current study are as follows:

1. The *Scale of Spiritually Conscious Care* (*SSCC*) will demonstrate adequate psychometric properties. To be specific, it is predicted that each *SSCC* subscale score will demonstrate good reliability, as evidence by adequate internal consistency and test-retest reliability.
2. Prior training in SRBP will be associated with gradate students' *SSCC* scores. To be specific, students with extensive training in SRBP will have higher scores on the *SSCC* than students with little or no training.
3. Graduate student clinicians' initial *SSCC* ratings will be associated with personal SRBP. To be specific, graduate student self-rated importance of spirituality and religion in their daily life will be associated with scores on the *SSCC*.
4. Training in SRBP will lead to higher scores on the *SSCC*. Specifically, graduate student clinicians who attend training in addressing SRBP in psychotherapy will report higher *SSCC* scores following training than before training. It is also predicted that graduate student clinicians who attend training in addressing SRBP in psychotherapy will report higher *SSCC* scores at the conclusion of the study than graduate student clinicians who did not attend the training.
5. Clients who receive S/R querying will report significantly higher ratings of therapeutic alliance than clients who do not receive S/R querying. To be specific, client who report speaking with their clinicians about spirituality and religion will

report higher ratings of the alliance than clients who do not speak with their therapists about spirituality and religion.

## Method Study 1: SSCC Development

If clinicians are to obtain competence in addressing S/R issues in psychotherapy, then it is importance to develop a measure so that it can be determined when they have obtained that competence. In the first study, a questionnaire was developed to measure professional psychologists' self-rated competence in addressing clients' SRBP. This section describes the development of that measure, the *Scale of Spiritually Conscious Care* (*SSCC*), and an initial attempt to determine the psychometric properties of the instrument. Following the initial investigation of the psychometric properties of the instrument, the measure was subjected to a principal components analysis, which resulted in a revision of the instrument.

### Procedures

The study method was reviewed and approved by Marquette University's Institutional Review Board. A list of APA-accredited programs in clinical and counseling psychology located in the United States was obtained from the American Psychological Association website. Training directors were identified and contacted via email in April, 2012, and were asked to forward an email advertisement to their current students. It was not possible to identify how many training directors complied with the request.

Potential graduate student participants were told they were being asked to compete a questionnaire about their awareness and knowledge of the influence of spirituality and religion in their clients' lives. Additionally, they were told that the survey asks questions related to addressing SRBP in their work with their psychotherapy clients. Potential participants were told that their participation would be strictly anonymous and

completely voluntary. They were told they would be asked to complete the survey twice, immediately and again in one week, in order to establish the test-retest reliability of the questionnaire.

Participants created unique self-generated identification codes so that their data could be matched between the two administrations of the questionnaire while at the same time maintaining confidentiality. They were told that it would not be possible to identify them by this code. Potential participants were told that if they completed the survey one time they would be offered the opportunity to be entered into a drawing to win one of four gift certificates, and if they competed the survey a second time, their name would be entered into the drawing four times. They were told they would be provided with an email address that they could contact in order to be considered for one of the four gift certificates. Students consented by following a link to Opinio (a web-based survey software) and completing the survey. Participants that completed the survey were emailed one week later to remind them to complete the survey a second time. (See Appendix A for a copy of the email and instructions.)

**Participants**

A total of 243 students currently enrolled in APA accredited clinical and counseling doctoral psychology programs completed the survey (it is unknown if terminal master's students within doctoral programs completed the survey). Participants that responded to less than 80% of the survey ($n$ = 30) were excluded from the analyses. Of the 213 students who completed the survey once, 71 completed the survey a second time.

**Total sample.** The sample consisted of 175 females (82.5%) and 37 males (17.5%). Participant mean age was 27.9 (SD = 5.11; range = 22-50). Half of the participants were single and never married (*n* = 104, 50.2%), 71 (34.3%) were married, and 32 (15.5%) reported living with a romantic partner. Most of the participants (*n* = 183, 86.7%) reported being of Caucasian descent; of the remainder, three (1.4%) were African American, 11 (5.2%) were Asian/Pacific Islander, one (0.5%) was Native America/Native Hawaiian, and 13 (6.2%) endorsed "Other." Fourteen participants (6.6%) reported being Hispanic or Latino.

**Test-retest sample.** The sample consisted of 58 females (81.7%) and 13 males (18.3%). Participant mean age was 26.9 (SD = 3.63; range = 22-38). Half of the participants were single and never married (*n* = 39, 55.7%), 20 (28.6%) were married, and 11 (15.7%) reported living with a romantic partner. Most of the participants (*n* = 63, 90.0%) reported being of Caucasian descent; of the remainder, one (1.4%) was African American, three (4.3%) were Asian/Pacific Islander, one (1.4%) was Native American/Native Hawaiian, and two (2.9%) endorsed "Other." Two (2.8%) participants reported being Hispanic or Latino.

## Materials

Participants completed an online survey that assessed demographic information (i.e., gender, race, ethnicity, age, and marital status), general training and treatment experience, and training experiences specific to S/R issues. They also completed the *Scale of Spiritually Conscious Care*.

**Training experience**. Participants indicated their current year in their training program in addition to number of years of treatment and assessment experience attained.

Participants indicated how much training they had in SRBP by endorsing the following: (1) no training whatsoever; (2) some discussion on the topic with clinical supervisors while in training; (3) a great deal of discussion on the topic with clinical supervisors while in training; (4) one course on the topic in their training program; (5) several courses on the topic in their training program; (6) attended a seminar on the topic; (7) read articles on the topic; and (8) read a book(s) on the topic. The categories were not mutually exclusive, with the exception of "no training whatsoever."

**Scale of Spiritually Conscious Care (SSCC)**

***Theoretical considerations behind development.*** Researchers have proposed areas that should be a part of a S/R assessment. Pargament (2007) recommended conducting a S/R assessment by identifying the salience of S/R affiliation to the client, the relationship of S/R issues to presenting concerns, and the potentiality of spirituality and religion to be a resource in coping with the presenting problem(s).

In addition to addressing specific areas of SRBP, clinicians and researchers have proposed areas of competence that are necessary for clinical psychology trainees to reach so that they are able to appropriately address multicultural issues in psychotherapy. There is general agreement that each competence has three areas: beliefs/attitudes, knowledge, and skills (Sue, Arredondo, & McDavis, 1992). The first area concerns clinicians' attitudes and beliefs about ethnic minorities and the way clinicians' values may hinder counseling with clients who are of a different culture or ethnicity. Knowledge refers to clinicians' knowledge of his or her worldview and knowledge of specific cultural groups he or she will be working with. The skills component refers to specific intervention techniques and strategies needed to work with minority groups (Sue et al., 1992).

Initially, item construction and subscale organization was based upon the three areas of multicultural competence and Pargament's proposed areas of S/R assessment. After consulting the literature on multicultural competence and Pargament's proposed areas of S/R assessment, three categories were identified: clinician awareness (i.e., beliefs/attitudes), knowledge, and practice (i.e., skills). A fourth category, perceived skills, was added. It refers to clinicians' self-rated knowledge in addressing SRBP and is associated with the skills area of multicultural competence. A fifth category, comfort, was also included since research suggests that clinicians may feel uncomfortable working with religious and spiritual issues because they feel it is outside their area of expertise (Knox et al., 2005).

***Subscale construction.*** Subscales were created to evaluate the five categories that were identified as necessary for clinical psychology trainees to achieve in order to appropriately address S/R in psychotherapy. Items for each of the scales were rationally derived and reviewed with a spirituality and religion research lab. Prior to reviewing the items with the research lab, the primary investigator and faculty mentor created a list of potential items based on the categories identified by the literature search. All of the proposed items were then reviewed with the entire research lab to determine if they were easily understandable and if they fit with the conceptualization of the measure. Items included in the scale were chosen by the consensus of the research team.

The Awareness Subscale was constructed to evaluate the clinicians' attitudes and beliefs about the influence of their SRBP, or lack thereof, on the way people think, feel, and behave. This subscale contains items that assess clinicians awareness of the influence of SRBP on mental and physical health, clinicians' awareness of how counselors S/R

beliefs can influence the way they interact with their clients, in addition to clinicians' awareness of how counselors SRBP may influence the SRBP of their clients.

The Knowledge Subscale was created to evaluate the clinicians' understanding of how SRBP influence the way people think, feel, and behave. This subscale contains items that assess clinicians' understanding of how spirituality and religion impact physical and mental health, clinicians' understanding of how they may intentionally, or unintentionally, promote their own SRBP to their clients, in addition to clinicians' understanding of how their own SRBP may influence their interactions with their clients.

The next three categories concern the clinicians' skills in addressing SRBP in psychotherapy. The Comfort Subscale was created to evaluate more emotionally based aspects of addressing SRBP in psychotherapy. This subscale contains items that assess the clinician's comfort in asking their clients about their particular SRBP, their comfort in assessing the impact of their clients' SRBP on their mental health, in addition to the clinician's comfort in incorporating their clients' SRBP into treatment planning.

The Perceived Skills Subscale was constructed to measure clinicians' self-rated ability to assess their clients' SRBP and incorporate their clients' SRBP into treatment. This subscale contains items that assess the clinician's self-rated skills in asking their clients about SRBP, assessing the impact of their client's SRBP on their mental health, and incorporating their client's SRBP into treatment planning.

Finally, the Actual Practice Subscale was created to evaluate how often the clinician discusses SRBP with their clients and whether they incorporate their clients' SRBP into treatment. This subscale contains items that assess the frequency to which the clinician asks their clients about their SRBP, how often the clinician assesses the impact

of their clients' SRBP on their mental health, and how often the clinician incorporates their clients SRBP into treatment planning.

***Final version of SSCC.*** The final version of the *SSCC* consists of 44 total items and five subscales. The overall scale score contains all of the 44 items in the scale. The Awareness and Knowledge Subscales contain ten items each. The Comfort, Perceived Skills, and Actual Practice Subscales each contain eight items. Items in the Awareness, Knowledge, Comfort, and Perceived Skills Subscales are rated using a six-point Likert scale (1 = *Strongly Disagree*, 6 = *Strongly Agree*). Items in the Actual Practice Subscale are designed to assess the frequency of behavior and are rated using a six-point Liker scale (1 = *Always*, 6 = *Never*). Participants are told that the questions deal with their understanding of SRBP and how they address SRBP in their work with their psychotherapy clients. They are asked to read each of the items and rate their level of agreement or disagreement with the following statements. Participants are also told that, for the purposes of this questionnaire, Zinnbauer and Pargament's (2005) conceptualizations of spirituality and religion will be used with spirituality being defined as a personal or group search for the sacred and religiousness defined as a personal or group search for the sacred that unfolds within a traditional sacred context. The measure is scored by averaging the items within each of the subscales. Higher subscale scores indicate greater competence in that area (see Appendix B for a copy of the measure).

## Results Study 1: SSCC Development

### Psychometric Properties of the SSCC

Initial psychometric data (means, standard deviation, range) for the *SSCC* are provided in Table 1.

Table 1

*Psychometric Properties of the SSCC: Mean, Standard Deviation, and Range*

| | *M* (SD) | Range |
|---|---|---|
| **Awareness Subscale** | | |
| 1. I am aware that S/R beliefs and practices impact a person's worldview. | 5.72 (.60) | 2-6 |
| 2. I am aware that spirituality and religion impact physical health. | 4.74 (1.03) | 1-6 |
| 3. I am aware that spirituality and religion impact mental health. | 5.28 (.87) | 1-6 |
| 4. I am aware that different S/R groups (e.g., Jewish, Catholic, Hindu, etc.) have different S/R beliefs and practices. | 5.77 (.58) | 2-6 |
| 5. I am aware that a counselors S/R beliefs and practices might affect their clients. | 5.25 (.86) | 2-6 |
| 6. I am aware that counselors might unintentionally promote their own S/R values to their clients. | 5.17 (.91) | 2-6 |
| 7. I am aware that even non-S/R counselors can affect the S/R beliefs and practices of their clients. | 5.10 (.93) | 2-6 |
| 8. I am aware that my own attitudes towards S/R might affect my clients. | 5.10 (1.02) | 1-6 |
| 9. I am aware that my background and experiences have influenced my attitudes | 5.22 (.97) | 1-6 |

| | | |
|---|---|---|
| towards my clients' S/R beliefs and practices. | | |
| 10. I am aware that my reactions to my clients might be based on stereotypes about their S/R beliefs and practices. | 4.91 (1.15) | 1-6 |
| **Knowledge Subscale** | | |
| 11. I understand how S/R beliefs and practices impact a person's worldview. | 5.01 (.88) | 2-6 |
| 12. I understand how spirituality and religion impact physical health. | 4.17 (1.17) | 1-6 |
| 13. I understand how spirituality and religion impact mental health. | 4.68 (1.04) | 1-6 |
| 14. I can identify the differences in S/R beliefs and practices among different S/R groups (e.g., Jewish, Catholic, Hindu, etc.). | 4.60 (1.04) | 2-6 |
| 15. I understand how counselors might impose their own S/R values upon their clients. | 4.85 (.92) | 1-6 |
| 16. I understand how counselors might unintentionally promote their own S/R values to their clients. | 4.91 (.90) | 2-6 |
| 17. I understand how even non-S/R counselors can affect the S/R beliefs and practices of their clients. | 4.79 (.95) | 2-6 |
| 18. I understand how my own attitudes towards S/R might affect my clients. | 4.83 (1.01) | 1-6 |
| 19. I understand how my background and experiences have influenced my attitudes towards my clients' S/R beliefs and practices. | 4.91 (1.05) | 1-6 |
| 20. I understand how my reactions to my clients might be based on stereotypes about their S/R beliefs and practices. | 4.81 (1.02) | 1-6 |
| **Comfort Subscale** | | |
| 21. I am comfortable asking my clients whether they are S/R. | 5.00 (1.10) | 2-6 |
| 22. I am comfortable asking my clients about | 4.90 (1.13) | 1-6 |

| | | |
|---|---|---|
| their particular S/R affiliation. | | |
| 23. I am comfortable asking my clients about their particular S/R beliefs. | 4.84 (1.08) | 1-6 |
| 24. I am comfortable asking my clients about their particular S/R practices. | 4.81 (1.08) | 1-6 |
| 25. I am comfortable assessing the impact of my clients' S/R beliefs and practices on their mental health. | 4.46 (1.14) | 1-6 |
| 26. I am comfortable asking my clients if their S/R beliefs and practices are a part of their presenting problem(s). | 4.22 (1.24) | 1-6 |
| 27. I am comfortable asking my clients if their S/R beliefs and practices can be a resource in helping them cope with their problem(s). | 5.23 (.92) | 2-6 |
| 28. I am comfortable incorporating my clients' S/R beliefs and practices into treatment planning. | 4.45 (1.18) | 1-6 |
| **Competence Subscale** | | |
| 29. I know how to ask my clients whether they are S/R. | 4.69 (1.14) | 1-6 |
| 30. I know how to ask my clients about their particular S/R affiliation. | 4.55 (1.16) | 1-6 |
| 31. I know how to ask my clients about their particular S/R beliefs. | 4.38 (1.18) | 1-6 |
| 32. I know how to ask my clients about their particular S/R practices. | 4.36 (1.15) | 1-6 |
| 33. I know how to assess the impact of my clients' S/R beliefs and practices on their mental health. | 3.80 (1.17) | 1-6 |
| 34. I know how to ask my clients if their S/R beliefs and practices are a part of their presenting problem(s). | 3.82 (1.23) | 1-6 |
| 35. I know how to ask my clients if their S/R beliefs and practices can be a resource in | 4.72 (1.03) | 2-6 |

| | | |
|---|---|---|
| helping them cope with their problem(s). | | |
| 36. I know how to incorporate my clients' S/R beliefs and practices into treatment planning | 3.89 (1.16) | 1-6 |
| **Practice Subscale** | | |
| 37. I ask my clients whether they are S/R. | 3.73 (1.50) | 1-6 |
| 38. I ask my clients about their particular S/R affiliation. | 3.49 (1.47) | 1-6 |
| 39. I ask my clients about their particular S/R beliefs. | 3.20 (1.33) | 1-6 |
| 40. I ask my clients about their particular S/R practices. | 3.15 (1.30) | 1-6 |
| 41. I assess the impact of my clients' S/R beliefs and practices on their mental health. | 3.06 (1.20) | 1-6 |
| 42. I ask my clients if their S/R beliefs and practices are a part of their presenting problem(s). | 2.41 (1.17) | 1-6 |
| 43. I ask my clients if their S/R beliefs and practices can be a resource in helping them cope with their problem(s). | 3.53 (1.33) | 1-6 |
| 44. I incorporate my clients' S/R beliefs and practices into treatment planning. | 2.88 (1.24) | 1-6 |

Note. S/R = Spiritual and Religious

**Internal Consistency of the SSCC**

Internal consistency for the instrument was computed using Cronbach's coefficient alpha based on data collected during the first administration of the measure. The internal consistency for the overall scale (44 items) was strong ($\alpha = .96$, $n = 188$). Internal consistency for the subscales was also strong: Awareness Subscale (ten items, $\alpha = .91$, $n = 207$), Knowledge Subscale (ten items, $\alpha = .90$, $n = 207$), Comfort Subscale

(eight items, $\alpha = .91$, n = 211), Perceived Skills Subscale (eight items, $\alpha = .93$, n = 206), and Actual Practice Subscale (eight items, $\alpha = .93$, n = 205). Cronbach's alpha at or above 0.90 is considered to be an excellent indication of internal consistency (George & Mallery, 2003).

**Correlation Between Subscales of the SSCC**

The relationships between subscales of the measure were computed using correlation coefficients (two-tailed) based on data collected during the first administration of the measure. Results are shown in Table 2. The Awareness and Knowledge Subscales were more strongly related to each other than the scales related to addressing SRBP in psychotherapy. Furthermore, the Comfort, Perceived Skills, and Actual Practice Subscales were more strongly related to each other than with the Awareness and Knowledge Subscales.

Table 2

*Correlations Between SSCC Subscales*

| | Awareness Subscale | Knowledge Subscale | Comfort Subscale | Perceived Skills Subscale |
|---|---|---|---|---|
| Awareness Subscale | ___ | | | |
| Knowledge Subscale | .67** | ___ | | |
| Comfort Subscale | .36** | .48** | ___ | |
| Perceived Skills Subscale | .33** | .59** | .71** | ___ |
| Actual Practice Subscale | .23** | .36** | .61** | .61** |

** $p < .01$ (2-tailed). N = 213 (N = 206 for Actual Practice Subscale).

**Test-Retest of the SSCC**

The test-retest reliability of the *SSCC* was evaluated using correlation coefficients (which was evaluated using two-tailed test of significance with an alpha level set at .05) between the two administrations of the scale. Participants completed the second administration of the measure one-week following the initial completion of the measure. Preliminary analyses were performed to ensure no violations of the assumptions of normality, linearity and homoscedasticity. The one-week retest reliability coefficient of the total item score was, $r = .90$, n = 72, $p < .001$. The one-week retest reliability coefficients for the five subscales were (Awareness Subscale: $r = .66$, n = 71, $p < .001$; Knowledge Subscale: $r = .62$, n = 71, $p < .001$; Comfort Subscale: $r = .79$, n = 71, $p$

< .001; Perceived Skills Subscale: $r$ = .85, n = 70, $p$ < .001; Actual Practice Subscale: $r$ = .84, n = 71, $p$ < .001).

**Association of S/R Training with SSCC**

The sample included 51 (24.2%) first-year students, 66 (31.3%) second-year students, 43 (20.4%) third-year students, 24 (11.4%) fourth-year students, 18 (8.5%) fifth-year students, five (2.4%) sixth year students, and four (1.9%) seventh year or more students.

The average number of years of treatment experiences for the group was 2.99 (SD = 1.80) and average number of years of assessment experiences was 2.38 (SD = 1.60). Thirty-eight (17.8%) students reported receiving no training in SRBP, 132 (62.0%) reported some discussion with clinical supervisors while in training, seven (3.3%) reported a great deal of discussion with clinical supervisors while in training, 23 (10.8%) reported taking one course on the topic, nine (4.2%) reported taking several courses on the topic, 38 (17.8%) reported attending a seminar on the topic, 113 (53.1%) reported reading articles on the topic, and 34 (16.0%) reported reading books on the topic. Year in training program was re-categorized into two groups (first, second, and third years students in one group and fourth, fifth, sixth, and seventh year and beyond students in another group). The majority of participants (n = 160, 75.8%) were in the first three years of their training program.

Training experiences were re-categorized into four groups according to level of training, using the method devised by Saunders, Petrick and Miller (in press). In addition to a “no training” group, those with some training were categorized into three subgroups: 112 (52.6% of total sample) participants who discussed S/R issues with a clinical

supervisor to "some extent" and/or read or books on the topic and/or read articles on the topic were included in the "some training" group, 50 (23.5%) participants who attended a seminar and/or had one course were included in the "moderate training" group, and 13 (6.1%) participants who discussed S/R issues with a clinical supervisor to a "great extent" and/or had taken several courses were included in the "extensive training" group.

Level of S/R training experience was not associated with year in training program ($x^2$ [df = 3, $n$ = 211] = 6.47, $p$ = .091).

The association of S/R training experiences with total *SSCC* score was investigated to see if subjects with more S/R training reported higher scores on the *SSCC*. A one-way between-groups analysis of variance was conducted to explore the impact of S/R training on total SSCC score (higher scores indicating higher self-rated competence). There was a statistically significant difference (setting alpha at .05) in total SSCC score for the four S/R training groups: $F$ (3, 209) = 13.44, $p$ < .001. Post-hoc comparisons using the Tukey HSD test indicated that the mean score for the group with "no training" ($M$ = 175.68, 95% CI [165.76, 185.60]) was significantly lower than all of the other groups: "some training" ($M$ = 195.96, 95% CI [191.27, 200.65]), $p$ < .001; "moderate training" ($M$ = 204.80, 95% CI [197.00, 212.60]), $p$ < .001; and "extensive training" ($M$ = 222.62, 95% [206.21, 239.02]), $p$ < .001. Additionally, the mean score for the group with "extensive training" ($M$ = 222.62, 95% [206.21, 239.02]) was significantly higher than the group with "some training" ($M$ = 195.96, 95% CI [191.27, 200.65]), $p$ = .004.

**Principal Components Analysis of SSCC**

Following the initial investigation of the psychometric properties of the *SSCC*, the 44 items of the instrument were subjected to principal components analysis (PCA) with

an Oblimin rotation. The items were analyzed using a two, three, and five factor solution. An inspection of the screeplot revealed a clear break after the third component. Additionally, the three-factor solution was determined to be the best fit with prior conceptualization.

Four items ("I am aware that S/R beliefs and practices impact a person's worldview;" "I am aware that different S/R groups [e.g., Jewish, Catholic, Hindu, etc.] have different S/R beliefs and practices;" "I am comfortable incorporating my client's S/R beliefs and practices into treatment planning;" "I know how to incorporate my client's S/R beliefs and practices into treatment planning") were eliminated from the measure following the PCA as they did not load onto any of the factors or they were associated with more than one of the three factors.

The three factors resulting from the analysis were labeled Awareness/Knowledge, Comfort/Perceived Skills, and Behavior (see Table 3). Revised subscales were created to reflect the results of the PCA and the factors identified. (The SSCC-Revised was used in the subsequent study.)

Table 3

*Summary of Items and Structure Coefficients from PCA with Oblimin Rotation of SSCC*

| Item | Structure Coefficients | | |
|---|---|---|---|
| | Factor 1 | Factor 2 | Factor 3 |
| 1. I am aware that S/R beliefs and practices impact a persons' worldview. | **.41** | **.52** | |
| 2. I am aware that spirituality and religion impact physical health. | .44 | **.62** | |
| 3. I am aware that spirituality and religion impact mental health. | .43 | **.64** | |
| 4. I am aware that different S/R groups (e.g., Jewish, Catholic, Hindu, etc.) have different S/R beliefs and practices. | | | |
| 5. I am aware that a counselors S/R beliefs and practices might affect their clients. | | **.74** | |
| 6. I am aware that counselors might unintentionally promote their own S/R values to their clients. | | **.80** | |
| 7. I am aware that even non-S/R counselors can affect the S/R beliefs and practices of their clients. | | **.77** | |
| 8. I am aware that my own attitudes towards S/R might affect my clients. | | **.85** | |
| 9. I am aware that my background and experiences have influenced my attitudes towards my clients' S/R beliefs and practices. | | **.78** | |
| 10. I am aware that my reactions to my clients might be based on stereotypes about their S/R beliefs and practices. | | **.80** | |
| 11. I understand how S/R beliefs and practices impact a persons' worldview. | **.59** | .41 | |
| 12. I understand how spirituality and religion impact physical health. | **.61** | .46 | |

| | | | |
|---|---|---|---|
| 13. I understand how spirituality and religion impact mental health. | **.64** | .48 | |
| 14. I can identify the differences in S/R beliefs and practices among different S/R groups (e.g., Jewish, Catholic, Hindu, etc.). | **.50** | | |
| 15. I understand how counselors might impose their own S/R values upon their clients. | .50 | **.71** | |
| 16. I understand how counselors might unintentionally promote their own S/R values to their clients. | .50 | **.79** | |
| 17. I understand how even non-S/R counselors can affect the S/R beliefs and practices of their clients. | .47 | **.79** | |
| 18. I understand how my own attitudes towards S/R might affect my clients. | .51 | **.83** | |
| 19. I understand how my background and experiences have influenced my attitudes towards my clients' S/R beliefs and practices. | | **.72** | |
| 20. I understand how my reactions to my clients might be based on stereotypes about their S/R beliefs and practices. | | **.78** | |
| 21. I am comfortable asking my clients whether they are S/R. | **.78** | | .43 |
| 22. I am comfortable asking my clients about their particular S/R affiliation. | **.75** | | .45 |
| 23. I am comfortable asking my clients about their particular S/R beliefs. | **.78** | | .43 |
| 24. I am comfortable asking my clients about their particular S/R practices. | **.79** | | .46 |
| 25. I am comfortable assessing the impact of my clients' S/R beliefs and practices on their mental health. | **.68** | | |
| 26. I am comfortable asking my clients if their S/R beliefs and practices are a part of their presenting problem(s). | **.61** | | .42 |

| | | | |
|---|---|---|---|
| 27. I am comfortable asking my clients if their S/R beliefs and practices can be a resource in helping them cope with their problem(s). | **.52** | | |
| 28. I am comfortable incorporating my clients' S/R beliefs and practices into treatment planning. | **.53** | | **.50** |
| 29. I know how to ask my clients whether they are S/R. | **.79** | | .44 |
| 30. I know how to ask my clients about their particular S/R affiliation. | **.81** | | .46 |
| 31. I know how to ask my clients about their particular S/R beliefs. | **.83** | | .44 |
| 32. I know how to ask my clients about their particular S/R practices. | **.84** | | .46 |
| 33. I know how to assess the impact of my clients' S/R beliefs and practices on their mental health. | **.71** | | .43 |
| 34. I know how to ask my clients if their S/R beliefs and practices are a part of their presenting problem(s). | **.63** | | .47 |
| 35. I know how to ask my clients if their S/R beliefs and practices can be a resource in helping them cope with their problem(s). | **.62** | | .46 |
| 36. I know how to incorporate my clients' S/R beliefs and practices into treatment planning. | **.63** | **.42** | **.54** |
| 37. I ask my clients whether they are S/R. | .40 | | **.77** |
| 38. I ask my clients about their particular S/R affiliation. | .40 | | **.84** |
| 39. I ask my clients about their particular S/R beliefs. | .44 | | **.85** |
| 40. I ask my clients about their particular S/R practices. | .41 | | **.87** |
| 41. I assess the impact of my clients' S/R beliefs and practices on their mental health. | .49 | | **.70** |
| 42. I ask my clients if their S/R beliefs and practices are a part of their presenting problem(s). | .44 | | **.66** |
| 43. I ask my clients if their S/R beliefs and practices | .41 | | **.78** |

| | |
|---|---|
| can be a resource in helping them cope with their problem(s). | |
| 44. I incorporate my clients' S/R beliefs and practices into treatment planning. | **.75** |

Note. Factor 1 = Awareness/Knowledge; Factor 2 = Comfort/Perceived Skills; Factor 3 = Behavior; S/R = Spiritual and Religious. Boldface values indicate major loadings. Loadings less than .40 are not shown. $N = 213$

**Awareness/Knowledge Subscale.** The Awareness/Knowledge Subscale contains 14 items from the original Awareness and Knowledge Subscales. These items assess the respondents' understanding of how clinicians' background and S/R beliefs can influence their relationship with their client. This revised subscale is consistent with the prior formulation of competence in that it assesses the need of clinicians to be aware of how their values may hinder their ability to counsel clients from different cultural backgrounds as well as knowledgeable of the groups they will be working with.

**Comfort/Perceived Skills Subscale.** The Comfort/Perceived Skills Subscale contains 18 items from the original Knowledge, Comfort, and Perceived Skills Subscales. These items assess the clinicians' self-rated ability to address SRBP in their work with their clients. This revised subscale is consistent with the prior formulation of competence in that it is necessary for clinicians to be comfortable speaking with their clients about SRBP and also have the knowledge to properly assess their clients' SRBP.

**Behavior Subscale.** The Behavior Subscale contains the eight items from the Actual Practice Subscale. These items assess the frequency with which the clinician addresses SRBP with their clients. This subscale is consistent with the prior formulation of competence in that clinicians must demonstrate that they are actually discussing SRBP with their clients.

**Psychometric properties of the revised subscales.** Internal consistency for the revised overall scale and three subscales was computed using Cronbach's coefficient alpha. The internal consistency for the new (after removing the four items) overall scale (40-items) was strong ($\alpha = .96$, n = 191). Internal consistency for the new subscales was also strong: Awareness/Knowledge Subscale (14 items, $\alpha = .94$, n = 208), Comfort/Perceived Skills Subscale (18 items, $\alpha = .94$, n = 202), and Behavior Subscale (eight items, $\alpha = .93$, n = 205).

## Method Study 2: SCPC Training and Alliance

The second study was a pilot project that evaluated the impact of training graduate student clinicians to evaluate clients' S/R backgrounds and current practices. Graduate students were administered the *SSCC-Revised* prior to training and again at the conclusion of the study.

It was hypothesized that clinicians would report higher scores on the *SSCC-Revised* after attending the training than before the training. It was also hypothesized that clinicians who attended the training would report higher scores on the *SSCC-Revised* at the conclusion of the study than clinicians who did not attend the training. Finally, it was hypothesized that clinicians' ratings of the significance and importance S/R issues in their own lives and their treatment experience would be associated with their self-competence ratings on the *SSCC-Revised*.

Preliminary data on the impact of S/R querying on clients' ratings of the therapeutic alliance was also collected. Clients seen at the Center for Psychological Services at Marquette University were administered measures of the therapeutic alliance and a measure of self-rated religious importance and attitudes toward discussing SRBP in psychotherapy. It was hypothesized that clients who received S/R querying would report higher ratings of the alliance than those who did not received S/R querying.

### Procedures

The study method was reviewed and approved by Marquette University's Institutional Review Board.

**Study site.** The Center for Psychological Services (CPS) is the primary on-site training facility for students in the clinical psychology graduate problem. While training at CPS, students provide psychological assessment and treatment under the supervision of the clinical psychology program faculty, who are licensed clinical psychologists. Graduate student clinicians typically see three to five therapy clients in any given week.

The following procedures are typically followed when a client is brought into the system at CPS. When a person calls the clinic looking for psychological services, one of the clinic staff will collect basic demographic information and a brief summary of the presenting problem(s). The staff member will answer any questions about procedures, fees, policies, and directions to the clinic. If the caller is in need of emergency services at that time, the staff member will refer them to an appropriate agency. If necessary, the clinic director will conduct a follow-up phone interview to determine if the clinic is the most appropriate facility for the client to obtain psychological services. The clinic director will assign the client's case to a supervision group (a collection of graduate student trainees receiving supervision under a particular supervisor any given year). The clinical supervisor will then assign the client's case to a graduate student clinician. The graduate student will call the client to schedule an intake appointment at a mutually agreed upon time. The clinic administrative assistant then assigns the client a clinic number and prepares the client's chart.

When the client arrives for the initial appointment, he or she is asked to complete a number of forms. These forms ask questions related to the client's demographics and symptoms. Once the client has completed the forms, the clinician takes the client to one of the private therapy rooms. The clinician explains the policies and procedures of the

clinic, discusses confidentiality and limits of confidentiality, and obtains informed consent for psychological treatment. The clinician then conducts the initial interview.

**Research protocol.** These procedures were added to the typical data collection that clients undergo as a part of their routine care at CPS.

***Recruitment of and data collection from CPS clients and clinicians.*** Undergraduate research assistants (UGAs) approached clients in the clinic waiting room before they met with their clinicians for their second appointment. UGAs asked clients if they could briefly tell them about a study being conducted at the center. Those clients that consented to being informed about and invited to the study were taken to a research room at the CPS. The UGAs then provided each client with a brief explanation of the study, including its potential risks and benefits, confidentiality, and anonymity. Clients were told that they would be involved in research that is investigating clinical assessment and its influence on different components of psychotherapy. The UGAs explained what would be required of the client and that there was no penalty if they did not wish to participate in the study. After the UGAs obtained informed consent and the client completed the Marquette University *Authorization to Use or Disclose Protected Health Information in Research Form*, the client was escorted back to the waiting room. Clients were approached following their third session at CPS and asked to complete the *Working Alliance Inventory-Short Form* in addition to questions related to their SRBP and incorporation of SRBP into their work with their clinician.

Doctoral students (2nd year and above) in the clinical psychology program at Marquette University were sent an email inviting them to participate in a study investigating the effects of training on student's ability to ask S/R queries during intake

sessions (see Appendix C for a copy of this email). They were told they were being offered the opportunity to complete two sets of online questionnaires about their SRBP and their ability to incorporate their clients' SRBP into psychotherapy. Students were informed that if they completed the first set of questionnaires they would receive a $10 gift certificate to either Amazon.com or Starbucks. Upon completion of the second set of questionnaires, the students were informed they would receive a $20 gift certificate to either Amazon.com or Starbucks.

Students were told that their responses on these questionnaires would be anonymous and that it would not be possible to identify their responses from the email address they used to receive the gift certificate. Students were instructed on how to create unique, self-generated ID numbers so that their data could be connected between the two sets of questionnaires but could not be connected to them. In addition to the questionnaires, students were offered the opportunity to take part in a one-time training on integrating S/R into intake interviews. They were told it was not necessary to complete the questionnaires in order to take part in the training and it was not necessary to participant in the training in order to complete the questionnaires. A link to the survey was provided in the email. Students consented by completing the survey by following a link to Opinio. A reminder email was sent one week after the initial email.

Potential participants were emailed two months after the initial email inviting them to participate in the follow-up survey (see Appendix D for a copy of this email). They were thanked for their participation in the first survey. They were reminded that they would receive a $20 gift certificate if they completed the follow-up survey. Participants were also reminded that their responses were anonymous and that they would

re-create their self-generated ID number so that their data could be connected between the two sets of questionnaires. A link to the follow-up survey was provided in the email. Students consented to the follow-up survey by following the link to Opinio.

***S/R querying training.*** The graduate student clinicians in this study were invited to attend a one-time training on asking clients about SRBP during intake interviews. They were informed that the training would take an hour to complete. Additionally, they were told attendance would not be taken during the training, but that they would be asked to complete self-generated ID numbers so that participant data on the questionnaires could be connected with training attendance. Two trainings dates were provided to students to facilitate participation. Dr. Stephen Saunders conducted the training.

The training consisted of a brief overview of the relationship between spirituality/religion and psychotherapy, including definitions, associations with physical and mental health, client preferences for discussing spirituality and religion in psychotherapy, and therapist attitudes and behaviors towards discussing spirituality and religion in psychotherapy. Clinicians were then provided an overview of Spiritually Conscious Psychological Care (SCPC), an approach to addressing spirituality and religion in psychotherapy. SCPC consists of assessing the relevance and affiliation of spirituality and religion in clients' lives, in addition to the potential association between clients' spirituality and religion and their presenting problems. Additionally, SCPC involved assessing the potential of spirituality and religion as a resource, or hindrance, in helping clients cope with their presenting problems. (See Saunders, Miller and Bright [2010] for additional information on SCPC.) The PowerPoint slides from the training can be found in appendix E.

## Participants

Participants included graduate students training towards their Ph.D. in Clinical Psychology at Marquette University and clients self-referred to the CPS.

**Clinicians.** A total of 24 students currently enrolled in Marquette University Clinical Psychology Program completed the survey during the first administration. Of the 24 students who completed the survey during the first administration, 18 (75%) completed the follow-up survey. The sample, those who completed the survey twice, consisted of 15 females (83.3%) and three (16.7%) males. Participant mean age was 26.28 (SD = 1.9; range = 23-31). Almost half of the participants were single and never married (*n* = 8, 44.4%); of the remainder, six (33.3%) were married, and four (22.2%) lived with a romantic partner.

**Clients**. A total of 12 clients seen at CPS consented to take part in the study and completed the measures. The sample consisted of eight females (66.7%) and three (25.0%) males. One participant (8.3%) did not report his or her gender. Participant mean age was 27 (SD = 12.48; range = 19-64). Over half of the participants were single and never married (*n* = 9, 75.0%), one (8.3%) reported living with a romantic partner, and two (16.7%) were separated or divorced. Most of the participants (*n* = 7, 58.3%) reported being of Caucasian descent; of the remainder, thee (25.0%) reported being Black/African American, one (8.3%) reported being Asian/Asian America/Pacific Islander, and one (8.3%) reported being Mexican/Mexican American. Two (16.7%) participants indicated graduating from high school, two (16.7%) indicated some college experience, two (16.7%) indicated obtaining a two-year college degree, four (33.3%) indicated obtaining a four-year college degree, and two (16.7%) indicated some graduate school. Three

(25.0%) participants reported being employed full time, four (33.3%) indicated being employed part time, one (8.3%) reported being disabled, two (16.7%) reported being unemployed, and two (16.7%) did not indicate employment status.

## Materials

**Demographic questionnaire.** Clients and graduate student clinicians completed questionnaires that assessed demographic information (i.e., gender, race, ethnicity, age, and marital status).

**Personal SRBP of participants.** Clients and graduate student clinicians completed a series of questions about their personal SRBP. Participants were asked to indicated which of the following best describes them at the present time: "I believe in God," "I believe we can't really know about God," "I do not believe in God," or "I don't know what to believe about God." Participants were then asked to rate how spiritual they considered themselves to be. The five response options ranged from "Extremely spiritual" to "Not at all spiritual." Participants then rated how religious they completed themselves to be. The five response options ranged from "Extremely religious" to "Not at all religious." Participants also indicated if they were members of a S/R community. Finally, participants rated how important their spirituality and religion is in their daily life and how important their SRBP are in making decisions regarding career, family or health. Response options for these two questions ranged from "Extremely important" to "Not at all important."

**SRBP and mental health.** Clients were asked to indicate how much the problems for which they were currently seeking treatment affected their S/R life, in addition to how much their SRBP have been involved in the way they have coped with the problems for

which they are seeking treatment. The response options for the two questions ranged from "To a great extent" to "Not at all." Participants were then ask to rate how much members of their S/R community were a potential resource for them in trying to cope with the problems for which they were seeking treatment. Response ranged from "I don't have a spiritual or religious community" to "To a great extent."

**Opinion regarding incorporation of SRBP into psychotherapy.** Clients were asked two questions regarding their opinion of incorporating S/R into psychotherapy. They were asked to indicate their opinion regarding whether a mental health profession should ask about religious and spiritual beliefs. The three response options were that a mental health profession should "never," "sometimes," or "always" ask about religious or spiritual beliefs. Participants were also asked how often they would have liked to speak with their current mental health professional about spirituality and religion. The five response options ranged from "Every session" to "Not at all."

**Discussion of S/R issues in current treatment.** Clients were asked a series of questions regarding the discussion of spirituality and religion in their current treatment. Participants were asked whether or not their mental health professional at the CPS had asked them about spirituality and religion. Response options included "I don't remember," "No," or "Yes." If the participant indicated, "Yes" to the previous question, they were then asked to answer two questions about their comfort speaking with their mental health professional about SRBP and the helpfulness of speaking with them about their SRBP. The response options ranged from "Very uncomfortable/unhelpful" to "Very comfortable/helpful."

**Working Alliance Inventory – Short Form (WAI-S).** Clients completed the *WAI-S* (Tracey & Kokotovic, 1989). The *WAI-S* is a 12-item, shortened version of the original *Working Alliance Inventory* (*WAI*; Horvath & Greenberg, 1989), which has client, therapist, and observer versions. The *WAI-S* consists of three scales of four questions each. Participants rate each item on a 7-point scale ranging from 0 (Never) to 7 (Always). Items on each subscale are summed to provide total sores for each subscale. The subscales of the *WAI* and *WAI-S* are based on Bordin's conceptualization of the working alliance and address agreement on the goals of therapy, agreement about the tasks of therapy, and the bond between the client and therapist. The *WAI* and *WAI-S* have similar factor structures. The *WAI-S* subscales have demonstrated high internal consistency (Cronbach's αs) ranging from .83 to .98. The *WAI-S* and *WAI* have been shown to be highly correlated, have similar subscale intercorrelations, and are both moderately predictive of therapy improvement (Busseri & Tyler, 2003). Internal consistency for the current sample was $\alpha = .86$ (total scale), $\alpha = .19$ for the Goals Subscale, $\alpha = .79$ for the Task Subscale, and $\alpha = .80$ for the Bond Subscale.

**Scale of Spiritually Conscious Care-Revised.** The revised version of the *Scale of Spiritually Conscious Care* (*SSCC-Revised*) was administered to graduate student clinicians. The *SSCC-Revised* is a 40-item measure of clinician competence in addressing SRBP in psychotherapy. The measure contains three subscales: Awareness/Knowledge, Comfort/Perceived Skills, and Behavior. The Awareness/Knowledge Subscale contains 14 items and assesses clinicians' awareness and knowledge of the influence of SRBP on mental and physical health and how counselors' SRBP can influence their work with their clients. The Comfort/Perceived Skills Subscale contains 18 items and assesses

clinicians' comfort discussing SRBP with their clients and clinicians' self-rated ability in discussing SRBP with their clients. The Behavior Subscale contains eight items and assesses the frequency to which the clinician asks their clients about their SRBP in addition to how often the clinician assesses the impact of their clients' SRBP on their mental health. Items in the Awareness/Knowledge and Comfort/Perceived Skills Subscales are rated using a six-point Likert scale (1 = *Strongly Disagree*, 6 = *Strongly Agree*). Items in the Behavior Subscale are rated using a six-point Likert scale (1 = *Always*, 6 = *Never*). The *SSCC-Revised* subscales and total score all demonstrate high internal consistency (above .90).

## Results Study 2: SCPC Training and Alliance

### Clinician Prior Training in S/R

The sample included three (16.7%) second-year students, five (27.8%) third-year students, three (16.7%) fourth-year students, three (16.7%) fifth-year students, three (16.7%) sixth year students, and one (5.6%) seventh year or beyond student.

The average number of years of treatment experience for the group was 3.5 (SD = 1.98) and the average number of clients seen for psychotherapy was 38.78 (SD = 51.8). Four (22.2%) students reported receiving no training whatsoever in SRBP, 12 (66.7%) reported some discussion with clinical supervisors while in training, one (5.6%) reported a great deal of discussion with clinical supervisors while in training, eight (44.4%) reported attending a seminar on the topic, eight (44.4%) reported reading articles on the topic, and two (11.1%) reported reading books on the topic.

### Clinician and Client SRBP

The frequencies for clinician and client responses to questions of SRBP are listed in Table 4.

Table 4

*Clinician and Client SRBP*

| | Clinician Total (%) | Client Total (%) |
|---|---|---|
| Belief in God | | |
| Believe in God | 10 (55.6%) | 7 (58.3%) |
| Do not believe in God | 3 (16.7%) | 2 (16.7%) |
| Cant really know about God | 3 (16.7%) | 0 (00.0%) |
| Don't know what to believe | 2 (11.1%) | 3 (25.0%) |
| Self-rated Spirituality | | |
| Not Spiritual | 1 (5.6%) | 3 (25.0%) |
| Slightly Spiritual | 8 (44.4%) | 2 (16.7%) |
| Moderately Spiritual | 7 (38.9%) | 5 (41.7%) |
| Very Spiritual | 2 (11.1%) | 2 (16.7%) |
| Self-rated Religiousness | | |
| Not Religious | 7 (38.9%) | 8 (66.7%) |
| Slightly Religious | 8 (44.4%) | 2 (16.7%) |
| Moderately Religious | 3 (16.7%) | 1 (8.3%) |
| Very Religious | 0 (00.0%) | 1 (8.3%) |
| Member of Religious Community | 10 (55.6%) | 4 (33.3%) |
| Importance of SRBP in Daily Life | | |
| Not Important | 6 (33.3%) | 4 (33.3%) |
| Slightly Important | 8 (44.4%) | 4 (33.3%) |
| Moderately Important | 4 (22.2%) | 3 (25.0%) |
| Very Important | 0 (00.0%) | 1 (8.3%) |
| Importance of SRBP in Making Decisions | | |
| Not Important | 4 (22.2%) | 4 (33.3%) |
| Slightly Important | 11 (61.1%) | 1 (8.3%) |
| Moderately Important | 2 (11.1%) | 6 (50.0%) |
| Very Important | 1 (5.6%) | 1 (8.3%) |

Clinician N = 18; Client N = 12.

## Client SRBP and Psychotherapy

**Clients' attitude regarding being asked about SRBP.** The responses to the question regarding whether a mental health professional should ask clients about their SRBP were as follows: "should always ask" (*n* = 7, 58.3%) and "should sometimes ask" (*n* = 5, 41.7%). Regarding how often participants would like to speak with their mental health professionals about S/R issues: two (16.7%) participants reported some sessions, six (50.0%) few sessions, and four (33.3%) not at all.

**Client S/R coping and psychotherapy.** Regarding whether their presenting problems have affected their S/R life: one (8.3%) participant reported to a great extent, two (16.7%) reported somewhat, two (16.7%) reported very little, and seven (58.3%) reported not at all. Three (25.0%) participants reported using their S/R a great extent to cope with their presenting problems, one (8.3%) reported somewhat, two (16.7%) reported very little, and six (50.0%) reported not at all.

The majority of participants (*n* = 5, 50%) reported their S/R community is not a resource in coping with their presenting problems; of the remainder, one (8.3%) stated somewhat, one (8.3%) stated very little, and four (33.3%) participants reported not being a member of a S/R community.

**Clients' experiences discussing S/R in psychotherapy.** Four (33.3%) participants stated they spoke with their mental health professional about spirituality and/or religion, seven (58.3%) indicated they did not speak with their mental health professional about spirituality and/or religion, and one (8.3%) indicated they did not remember. Of the four participants who indicated they spoke with their mental health

professional about spirituality and/or religion, two (50.0%) reported being very comfortable with the conversation, one (25.0%) reported being moderately comfortable with the conversation, and one (25.0%) reported being very uncomfortable with the conversation. One (25.0%) participant reported it was very helpful speaking with their mental health professional about spirituality and religion, one (25.0%) reported it was slightly helpful, one (25.0%) reported it was slightly unhelpful, and one (25.0%) reported it was moderately unhelpful.

**Association of Clinician SRBP with Initial SSCC-Revised Ratings**

The association of clinician SRBP with initial ratings of the *SSCC-Revised* was investigated by computing correlation coefficients (which was evaluated using two-tailed test of significance with an alpha level set at .05). Clinician self-rated S/R significance and importance was correlated with scores on the *SSCC-Revised* (Total score, Awareness/Knowledge Subscale, Comfort/Perceived Skills Subscale, and Behavior Subscale). There were no statistically significant correlations found between any of the variables (see Table 5 for results).

Table 5

*Correlations Between Self-rated S/R Significance and Importance and Initial SSCC Scores*

| | Scale of Spiritually Conscious Care | | | |
|---|---|---|---|---|
| | Awareness/ Knowledge Subscale | Comfort/Perceived Skills Subscale | Behavior Subscale | Total Score |
| Spiritual Significance | .34 | .15 | .26 | .28 |
| Religious Significance | .03 | -.18 | -.10 | -.12 |
| S/R Importance in Daily Life | .31 | .02 | .12 | .14 |
| S/R Importance in Making Decisions | .28 | -.05 | .05 | .10 |

Note. S/R = Spiritual and Religious. N = 24 (N = 23 for Behavior Subscale).

**Association of Program Training with Initial SSCC Ratings**

The association of prior program training with initial ratings of the *SSCC-Revised* was investigated by computing correlation coefficients. Clinician current year in program, number of years of treatment experiences, and number of clients seen for psychotherapy were correlated with total score on the *SSCC-Revised* and subscale scores (see Table 6 for results).

Current year in program and number of years of treatment experience were strongly positively correlated. Due to the strong positive correlation between these items, only the number of years of treatment experience is described in this section. Prior

psychological treatment experience was significantly correlated with the *SSCC* total score, Comfort/Perceived Skills Subscale, and Behavior Subscale.

Table 6

*Correlations Between Prior Training Experience and Initial SSCC Scores*

| | Scale of Spiritually Conscious Care | | | |
|---|---|---|---|---|
| | Awareness/ Knowledge Subscale | Comfort/Per ceived Skills Subscale | Behavior Subscale | Total Score |
| Current Year in Program | -.13 | .47* | .58** | .41* |
| Years of Treatment Experience | -.13 | .52* | .61** | .45* |
| Number of Clients Seen for Psychotherapy | -.22 | .32 | .34 | .21 |

* $p < .05$, ** $p < .01$. N = 24 (N = 23 for Behavior Subscale).

**Impact of SCPC Training on SSCC Scores**

The average scores of participants separated by participation in training and initial versus follow-up administration of the *SSCC-Revised* are show in Table 7.

Table 7

*Average SSCC Subscale Scores – Separated by Training Attendance and Initial vs. Follow-up*

| | Training Initial *M* (SD) | Training Follow-up *M* (SD) | No Training Initial *M* (SD) | No Training Follow-up *M* (SD) |
|---|---|---|---|---|
| Awareness/Knowledge Subscale | 5.05 (.66) | 4.93 (.70) | 4.76 (.94) | 4.86 (.79) |
| Comfort/Perceived Skills Subscale | 3.88 (.61) | 4.55 (.53) | 4.36 (1.05) | 4.55 (1.05) |
| Behavior Subscale | 2.03 (.75) | 2.73 (.82) | 2.85 (1.40) | 3.01 (1.22) |

Note. Numbers reported are average item scores for the subscales. For the Awareness/Knowledge Subscale and Comfort/Perceived Skills Subscale 1 = Strongly Disagree; 2 = Moderately Disagree; 3 = Disagree; 4 = Agree; 5 = Moderately Agree; 6 = Strongly Agree. For the Behavior Subscale 1 = Never; 2 = Rarely; 3 = Some of the time; 4 = Often; 5 = Most of the time; 6 = Always. Total N = 18 (8 Training); N = 17 for Behavior Subscale (8 Training).

To examine the hypothesis that clinician participants would demonstrate differences in scores on the *SSCC-Revised* after training in Spiritually Conscious Psychological Care, four mixed between-within analysis of variance analyses (ANOVAs) were conducted. Scores on the *SSCC-Revised* (Total score, Awareness/Knowledge Subscale, Comfort/Perceived Skills Subscale, and Behavior Subscale) served as the dependent variables. For the independent variables, training was utilized as the between groups factor and administration of the measure (initial vs. follow-up) was utilized as the within groups factor.

For the *SSCC-Revised* total score, there was no significant interaction between time and training, Wilks Lambda = .96, $F$ (1, 16) = .72, $p$ = .409, partial eta squared = .04. There was not a substantial main effect for time, Wilks Lambda = .82, $F$ (1, 16) = 3.54, $p$ = .078, partial eta squared = .18, with neither group showing an increase in scores across the two time points. The main effect comparing the training was not significant, $F$ (1, 16) = .10, $p$ = .761, partial eta squared = .006, suggesting no difference in the effect of training on the two scores.

For the Awareness/Knowledge Subscale, there was no significant interaction between time and training, Wilks Lambda = .98, $F$ (1, 16) = .25, $p$ = .622, partial eta squared = .02. There was not a substantial main effect for time, Wilks Lambda = 1.00, $F$ (1, 16) = .00, $p$ = .984, partial eta squared = .00, with neither group showing an increase in scores across the two time points. The main effect comparing the training was not significant, $F$ (1, 16) = .33, $p$ = .571, partial eta squared = .02, suggesting no difference in the effect of training on the two scores.

For the Comfort/Perceived Skills Subscale, there was no significant interaction between time and training, Wilks Lambda = .87, $F$ (1, 16) = 2.37, $p$ = .144, partial eta squared = .13. There was a substantial main effect for time, Wilks Lambda = .68, $F$ (1, 16) = 7.49, $p$ = .015, partial eta squared = .32, with both groups showing an increase in scores across the two time points. The main effect comparing the training was not significant, $F$ (1, 16) = .41, $p$ = .534, partial eta squared = .03, suggesting no difference in the effect of training on the two scores.

For the Behavior Subscale, there was no significant interaction between time and training, Wilks Lambda = .81, $F$ (1, 15) = 3.53, $p$ = .08, partial eta squared = .19. There

was a substantial main effect for time, Wilks Lambda = .62, $F$ (1, 15) = 9.27, $p$ = .008, partial eta squared = .38, with both groups showing an increase in scores across the two time points. The main effect comparing the training was not significant, $F$ (1, 15) = 1.14, $p$ = .303, partial eta squared = .07, suggesting no difference in the effect of training on the two scores.

**Comparison of CPS Sample and Internet Sample on SSCC Scores**

Independent-samples t-tests were used to examine any differences on the *SSCC-Revised* between the Internet sample collected during the first study and graduate student sample collected during the second study. Scores on the *SSCC-Revised* (Total score, Awareness/Knowledge Subscale, Comfort/Perceived Skills Subscale, and Behavior Subscale) served as the dependent variables, and group membership served as the independent variable. Significant differences between the two groups were found on the Behavior subscale (see Table 8 for results).

Table 8

*T-tests Comparing Means for Internet and CPS Samples*

| | National Sample *M* (SD) | CPS *M* (SD) | *t* |
|---|---|---|---|
| Awareness/Knowledge Subscale | 4.98 (.75) | 5.04 (.80) | -.35 |
| Comfort/Perceived Skills Subscale | 4.55 (.78) | 4.25 (.92) | 1.81 |
| Behavior Subscale | 3.19 (1.07) | 2.64 (1.18) | 2.30* |
| Total Score | 4.41 (.68) | 4.18 (.77) | 1.53 |

Note. Numbers reported are average item scores for the subscales. * $p < .05$. N = 213 for the internet sample; N = 24 for the CPS sample).

**Exploratory Analysis of Impact of S/R Querying on Client Ratings of the Alliance**

An exploratory analysis of the relationship between S/R querying and client ratings of the alliance was conducted. Independent-samples t-tests were used to examine the association between clinician S/R querying and clients' ratings of the therapeutic alliance. Scores on the *WAI-S* (Total score, Goals Subscale, Task Subscale, and Bond Subscale) served as the dependent variables, and S/R querying served as the independent variable. No significant differences between the two groups were found (see Table 9 for results).

Table 9

*T-tests Comparing WAI-S Scores for Querying and Non-querying Groups*

| | Querying *M* (SD) | No Querying *M* (SD) | *t* |
|---|---|---|---|
| WAI-S Total | 59.00 (24.86) | 66.86 (10.43) | .52 |
| WAI-S Goals | 19.25 (9.95) | 21.43 (4.08) | .75 |
| WAI-S Task | 18.50 (9.75) | 21.86 (5.37) | .94 |
| WAI-S Bond | 21.25 (5.56) | 23.57 (2.76) | .75 |

N = 11 (4 Querying)

## Discussion

The present studies investigated the psychometric properties of a new instrument designed to assess clinician competence in addressing SRBP in psychotherapy (the *Scale of Spiritually Conscious Care*) and provided preliminary information on the impact of S/R querying on clients' ratings of the alliance. Overall, the *Scale of Spiritually Conscious Care* (*SSCC*) demonstrated strong internal consistency and test-retest reliability, and it was also able to distinguish between those with prior training in SRBP and those with no training whatsoever in SRBP. Following the initial investigation into the validity of the *SSCC*, a factor analysis was conducted on the *SSCC.*

The instrument was revised based on the results of the factor analysis. Graduate student clinicians reported higher scores on the Comfort/Perceived Skills and Behavior subscales of the *SSCC-Revised* after training in Spiritually Conscious Psychological Care (SCPC) than before training. No significant differences in *SSCC-Revised* scores were found between those who attended the training and those who did not. Finally, this investigation failed to find significant differences in client ratings of the therapeutic alliance between those who received S/R querying and those who did not.

### SSCC Validation

As predicted, all subscales and the overall *SSCC* score demonstrated strong reliability with high levels of internal consistency and test-retest reliability. *SSCC* subscale scores, in addition to total score, demonstrated Cronbach's coefficient alpha at or above the 0.90 level, an excellent indicator of internal consistency. Furthermore, all

subscales and the *SSCC* total score demonstrated test-retest reliability, as evidenced by significant correlations between administrations at two time points one-week apart.

All subscales did not demonstrate the same level of reliability across administrations. Scores on the Comfort, Perceived Skills, and Actual Practice subscales had stronger correlations ($r$ = .79-.85) across administrations than scores on the Awareness and Knowledge ($r$ = .62-66) subscales. It may be that by asking participants to answer questions about the relationship between spirituality/religion and psychotherapy they will naturally become more aware of the connection between these two concepts and feel they have a greater understanding of how SRBP can influence the way people think, feel, and behave, resulting in lower correlations on the Awareness and Knowledge subscales across the two time-points. The subscales related to skills in addressing SRBP in psychotherapy are likely to remain more stable across a short time span, as the probability of clinicians obtaining additional training in SRBP in the week between administrations was small.

The *SSCC* demonstrated validity in that it was able to differentiate between students with varying levels of prior training in SRBP. Participants who reported no prior training in SRBP had significantly lower *SSCC* scores than participants with some, moderate, and extensive levels of prior training in SRBP. Additionally, participants who reported extensive prior training in SRBP had significantly higher *SSCC* scores than participants with only some training in SRBP. These results demonstrate that the instrument is able to distinguish between those with varying levels of training in SRBP, an indication that scores on the *SSCC* increase as participants have more training in SRBP.

Although a number of instruments have been designed to measure multicultural competence (Gamst et al., 2004; D'Andrea, Daniels, & Heck, 1991; Sodowsky, Taffe, Gutkin, & Wise, 1994), this study is the first attempt to develop a measure designed specifically to assess competence in addressing SRBP in psychotherapy. The results of the current study lend support for the use of the *SSCC* as an instrument for measuring competence in addressing SRBP in psychotherapy.

**SSCC Revision**

Following the initial investigation into the psychometric properties of the *SSCC*, the measure was subjected to a PCA with Oblimin rotation in order to determine the factor structure of the instrument. The items were analyzed using a two, three, and five solution. The three-factor solution resulted in the clearest extraction and was in line with the prior conceptualization. The three factors identified (Awareness/Knowledge, Comfort/Perceived Skills, and Behavior) reflect areas of importance clinicians should obtain competence in if they are going to appropriate address SRBP in their work with their clients. In addition to the three factors identified, four of the items were eliminated from the measure after the results of the PCA, as they were not associated with one of the factors or were associated with more than one factor.

The measure was revised so that the subscales reflected the factors identified in the PCA. The Awareness/Knowledge Subscale contains items that assess the respondents' understanding of how clinicians' background and S/R beliefs can influence their relationship with their clients. This scale addresses issues identified in the literature on multicultural competence; namely that clinicians need to be aware of how their own

views may hinder their work with clients who are of different cultural backgrounds (Sue et al., 1992).

The Comfort/Perceived Subscale contains items that assess the clinicians' self-rated ability to address SRBP in their work with their clients. This scale is also inline with the multicultural competence literature that states clinicians need to have the skills and abilities to work with clients of different cultural backgrounds (Sue et al., 1992). Additionally, this scale also addresses literature suggesting clinicians may feel uncomfortable working with religious and spiritual issues because they feel it is outside of their area of expertise (Knox et al., 2005).

The Behavior Subscale contains items that assess the clinicians' self-rated ability to address SRBP in their work with their clients. This scale reflects that it is not only sufficient for clinicians to feel capable of addressing SRBP with their clients, but they need to actually discuss SRBP with their clients.

The final measure contains 40 items and scoring includes an overall score and three subscale scores: Awareness/Knowledge, Comfort/Perceived Skills, and Behavior. The internal consistency of the revised instrument, as measured by Cronbach's coefficient alpha, was higher than prior to the modification. The revised measure, *SSCC-Revised*, was used in the subsequent study.

**Association of Clinicians' Personal SRBP and Prior Training with Initial SSCC Scores**

As predicted, prior program training—before receiving training in addressing SRBP in psychotherapy—was related to clinician's *SSCC-Revised* scores in the second study. Training experience was positively correlated with scores on the

Comfort/Perceived Skills Subscale, Behavior Subscale, and total score. These results may reflect that as graduate student clinicians progress in their training programs they are likely to obtain more exposure to training in SRBP, feel more competent in discussing S/R issues with their clients, and are more likely to address SRBP with their clients.

Contrary to prediction, the self-rated significance and importance of spirituality and religion to clinicians was not related to scores on the *SSCC-Revised*. This finding is somewhat surprising given research showing therapist S/R values can influence views on mental health and the practice of psychotherapy (Grimm, 1994). It is noted that the sample size in this study was 24. Future research should continue to explore the relationship between SRBP and scores on the *SSCC-Revised,* and would benefit from obtaining larger samples.

**Influence of SCPC Training**

Mixed results were found when investigating the impact of training in SCPC. It was initially predicted that participants who took part in SCPC training would report significantly higher scores across all *SSCC-Revised* subscales after training as compared to before training. The current study failed to find significant differences over time on the Awareness/Knowledge Subscale of the *SSCC-Revised*. These results indicate that neither those who attended SCPC training nor those who did not attend the training reported significantly higher ratings on the Awareness/Knowledge Subscale over time. It is possible that the measure lacked the sensitivity or precision to detect meaningful changes over time. Additionally, scores on the Awareness/Knowledge Subscale were already relatively high and it is likely they were not likely to go any higher. Comparison of the Internet sample and CPS sample indicated participant's scores were all similar.

Significant differences over time were found on the Comfort/Perceived Skills and Behavior subscales. Although differences in participants' scores were found over time on the two subscales, no significant differences were found between those who did and did not receive training. These results indicate that, in this small sample, S/R training had no significant impact on clinicians' self-rated ability to address SRBP in their work with their psychotherapy clients or increase the frequency of clinicians discussing SRBP with their clients.

Even though the current study failed to detect significant differences between those who attended the training and those who did not attend the training, the use of training to improve multicultural competence has support from the literature. D'Andrea, Daniels, and Heck (1991) found that students' scores on an instrument designed to measure multicultural competence were significant higher following participation in a multicultural counseling training course. Future studies should continue to investigate the impact of S/R training on competence in addressing SRBP in psychotherapy.

The lack of significant differences between groups may also be due to differences in the graduate student clinicians who self-selected to attend the training and those who did not. Evaluation of the mean scores of those who attended training and those who did not attend training showed that participants who attended the training had lower initial scores on the Comfort/Perceived Skills Subscale and Behavior Subscale than those who did not attend training. These results may indicate that those who chose to participate in training may have felt they were more in need of training in addressing SRBP with their clients than those who chose not to attend the training. Those who did not attend the training may have already felt competent in addressing SRBP with their clients.

Additionally, the small sample size in the current study may have made it difficult to detect true differences between groups. Future studies could replicate the procedures from the current study with a larger sample, increasing the likelihood of detecting true differences.

Finally, the absence of supervision specifically related to addressing spirituality and religion in psychotherapy following the training may have contributed to the lack of significant differences between the two groups. No supervision or consultation was offered to the graduate student clinicians after participating in the training. The one-time training in addressing SRBP in psychotherapy may not have been sufficient enough to alter the graduate student clinician's behavior or attitudes. The graduate student clinicians may still have felt they lacked the competence to address SRBP following the training. The addition of ongoing supervision and consultation would have addressed these issues by providing training attendees further support and encouragement in addressing SRBP with their clients.

**Impact of S/R Querying on Client Ratings of the Alliance**

Contrary to prediction, no significant differences in ratings of the alliance were found between clients who were asked S/R queries and those who were not. These results may indicate that discussion of spirituality and religion during intake sessions has no impact on ratings of the therapeutic alliance. However, the results of the current study are surprising given reports that therapists who are knowledgeable about and sensitive to the cultural worlds of their clients do a better job of engaging and retaining clients and achieve better outcomes (Blow, Sprenkle, Davis, 2007). Although this study failed to

detect significant differences between the two groups, it is likely that the small number of participants in each group made it difficult to detect true differences.

Furthermore, this study was unable to determine the effectiveness to which clinicians addressed spirituality and religion in their work with their clients, as it was outside the scope of this project to monitor clinician administration of S/R queries or to identify which clients were asked S/R queries by clinicians who had attended training in SCPC. It is possible that those clinicians who discussed SRBP with their clients did not attend training in SCPC and were therefore not as competent in addressing SRBP with their clients—an important consideration in light of research indicating clients' reaction to discussing SRBP can vary widely depending on the way in which the topic is approached by the therapist (Cragun & Friedlander, 2012). Monitoring clinician administration of S/R queries, as well as controlling for clinician attendance at SCPC training, are important considerations for future studies.

**Limitations**

Several limitations of the current studies should be noted. First, due to the low number of graduate student clinician and client participants in the second study, the likelihood of committing a Type II error, failing to detect true differences, was increased. Additionally, the low sample size in both groups could have led outlying values in each group to skew the data, potentially inflating or deflating the chance of significant results. Increased numbers of participants would help addresses these issues.

Second, the clients who were recruited to participate in the second study may not be representative of all those who seek psychological services. Marquette University is a Jesuit institution, and though the Center for Psychological Services is not a religiously

affiliated clinic, it may be perceived to be by clients who seek services there. Clients who self-select to seek services at the Center for Psychological Services may have certain expectations regarding the incorporation of S/R into their treatment.

Third, while the graduate student clinicians in the study had varying levels of experience, they are all novel therapists comparatively. More experienced clinicians may be better able to take advantage of the training in addressing SRBP in psychotherapy and may also be able to form more effective working relationships with their clients. Prior research has indicated more experienced clinicians are able to form better alliances with their clients (Mallinckrodt & Nelson, 1991). Additional studies could investigate the impact of training in addressing SRBP with clinicians of varying levels of experience to see if level of experience influences ratings of the alliance above and beyond the influence of S/R querying.

Finally, the lack of monitoring of clinician discussion of SRBP with clients is a major limitation of the current study. This study was unable to determine the effectiveness to which clinicians discussed spirituality and religion with their clients. There was no way to determine how clinicians approached the topic of spirituality and religion with their clients, whether clinicians appeared open to the topic of spirituality/religion, if they appeared accepting of their clients' SRBP, and how they incorporated their clients' SRBP into psychotherapy. The lack of monitoring of clinicians' discussions of SRBP with their clients limits the interpretation of the current results. Future studies could address these issues by video recording or in-person monitoring of client-therapist interactions.

**Future Directions**

The results of the current studies reveal several possibilities for future research. Future studies should continue to evaluate the relationship between the *SSCC* and training in SRBP. Although the current study found the *SSCC* was able to distinguish between those with varying levels of experience, more investigation is needed to determine how well the SSCC is able to detect training and competence in addressing SRBP. Future studies should also evaluate the differences in *SSCC* scores between different training programs.

Additionally, future studies should continue to investigate the impact of training in addressing SRBP in psychotherapy. With the ever-increasing cultural diversity in the United States, it is likely that mental health professionals will continue to encounter clients with various customs, beliefs, and spiritual practices (Richards & Bergin, 2000). The importance of having the skills to properly address client's SRBP in psychotherapy has been acknowledge by the American Psychological Association and has been mandated as a necessary requirement of providing ethical care for clients (American Psychological Association, 2002). Future research could investigate the impact of training in S/R with both graduate student clinicians and licensed psychologists.

Finally, researchers should continue to examine the influence of S/R discussion on ratings of the alliance. The alliance continues to be one of the best predictors of psychotherapy outcome (Horvath et al., 2011), and any attempt to improve the strength of the relationship between the client and therapist should be pursued. Future research could replicate the procedures from this study with a larger sample, in other treatment settings, and with clinicians of varying levels of experience. As stated before, future studies would benefit from improved monitoring of clinician discussion of SRBP. Improved monitoring

could be accomplished by audio or video recording intake sessions by independent evaluators. Recording sessions would allow researchers to confirm which clinicians spoke to their clients about SRBP and the quality of these discussions.

**Conclusion**

In conclusion, results of first study indicate the *SSCC* demonstrates strong reliability and is able to distinguish between those with prior training in SRBP and those with no prior training. The second study failed to detect significant differences between graduate student clinicians who attended training in SCPC and those who did not, in addition to failing to detect significant differences in clients' ratings of the alliance after discussion of SRBP in this small sample. Although the hypotheses in the second study were not supported, the execution of the current project indicates the study design is feasible and worthy of replication with a larger sample. As the cultural diversity of the United States continues to grow, it will be important for clinicians to gain competence in addressing SRBP in psychotherapy. Clinicians are likely to be viewed more favorably and seen as more trustworthy if they are able to discuss SRBP with their clients and able to convey understanding of their clients' experience. It will be necessary to develop training that teaches clinicians the skills to properly address SRBP in psychotherapy, in addition to assessment measures that can determine when clinicians have achieved necessary levels of competence.

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Appendix A

## Email to Potential Participants in SSCC Survey

### Research Opportunity

Researchers at Marquette University are conducting an on-line survey of clinician's attitudes towards addressing spirituality and religion in psychotherapy. The survey asks questions about your awareness and knowledge of the influence of spirituality and religion in your client's lives. Additionally, the survey asks questions related to addressing spirituality and religion in your work with your psychotherapy patients. Demographic information (such as your age, marital status, education, ethnicity, etc.) will also be collected. Most people are able to complete the survey in less than 10 minutes.

The survey will be completely anonymous. You will not be asked to disclose any information that might be used to identify you. Your responses will NEVER be connected to you.

We are recruiting 100 respondents. We ask that each respondent complete the survey twice – both immediately and one week from now – in order to establish the "test-retest reliability" of the questionnaire. In order to match your two responses, you will generate a unique ID code. It will not be possible to identify who you are by this code. If you complete the survey, we will offer you the opportunity to be entered into a drawing for the chance to win one of four $25 gift certificates to Amazon.com. If you complete the survey a second time, we will enter you into the drawing four times for the chance to win one of the four gift certificates. At the end of the survey we will provide an email address that you can contact in order to be considered for one of the four gift certificates.

The survey has been approved by Marquette University's Institutional Review Board (IRB). A certificate of the approval can be provided if you would like. If you have any questions, please contact Dr. Saunders via email at Marquette University (Milwaukee, Wisconsin) at: stephen.saunders@marquette.edu

Whether or not you complete this survey, thank you for considering it.

To participate in this survey simply click on the survey link below and follow the on-screen instructions. If for some reason you are unable to connect by simply clicking on this link, please copy the entire line of text and paste it into your Web browser.

http://survey.marquette.edu/opinio/s?s=3913

APPENDIX B

## Scale of Spiritually Conscious Care

**Directions:** The following items deal with your understanding of spiritual and religious (S/R) beliefs and practices and how you address S/R beliefs and practices in your work with your psychotherapy clients. Please read each item and indicate your level of agreement or disagreement with the following statements. For the purpose of this questionnaire spirituality is defined as *a personal or group search for the sacred* and religiousness is defined as *a personal or group search for the sacred that unfolds within a traditional sacred context* (Zinnbauer & Pargament, 2005).

- Please rate your disagreement or agreement with the following statements

| | **Strongly Disagree** | **Moderately Disagree** | **Disagree** | **Agree** | **Moderately Agree** | **Strongly Agree** |
|---|---|---|---|---|---|---|
| **The following questions deal with your awareness of the influence of spiritual and religious (S/R) beliefs and practices on the way people think, feel, and behave.** | | | | | | |
| 1. I am aware that S/R beliefs and practices impact a person's worldview. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 2. I am aware that spirituality and religion impact physical health. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 3. I am aware that spirituality and religion impact mental health. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 4. I am aware that different S/R groups (e.g., Jewish, Catholic, Hindu, etc.) have different S/R beliefs and practices. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |

| | | | | | | |
|---|---|---|---|---|---|---|
| 5. I am aware that a counselors S/R beliefs and practices might affect their clients. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 6. I am aware that counselors might unintentionally promote their own S/R values to their clients. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 7. I am aware that even non-S/R counselors can affect the S/R beliefs and practices of their clients. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 8. I am aware that my own attitudes towards S/R might affect my clients. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 9. I am aware that my background and experiences have influenced my attitudes towards my clients' S/R beliefs and practices. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 10. I am aware that my reactions to my clients might be based on stereotypes about their S/R beliefs and practices. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| **The following questions deal with your <u>understanding of how</u> spiritual and religious (S/R) beliefs and practices influence the way people think, feel, and behave.** | | | | | | |
| 11. I understand how S/R beliefs and practices impact a person's worldview. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 12. I understand how spirituality and religion impact physical health. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |

| | | | | | | |
|---|---|---|---|---|---|---|
| 13. I understand how spirituality and religion impact mental health. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 14. I can identify the differences in S/R beliefs and practices among different S/R groups (e.g., Jewish, Catholic, Hindu, etc.). | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 15. I understand how counselors might impose their own S/R values upon their clients. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 16. I understand how counselors might unintentionally promote their own S/R values to their clients. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 17. I understand how even non-S/R counselors can affect the S/R beliefs and practices of their clients. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 18. I understand how my own attitudes towards S/R might affect my clients. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 19. I understand how my background and experiences have influenced my attitudes towards my clients' S/R beliefs and practices. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 20. I understand how my reactions to my clients might be based on stereotypes about their S/R beliefs and practices. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |

| **The following questions deal with how <u>comfortable</u> you are addressing spiritual and religious (S/R) beliefs and practices in your work with your psychotherapy clients.** | | | | | | |
|---|---|---|---|---|---|---|
| 21. I am comfortable asking my clients whether they are S/R. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 22. I am comfortable asking my clients about their particular S/R affiliation. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 23. I am comfortable asking my clients about their particular S/R beliefs. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 24. I am comfortable asking my clients about their particular S/R practices. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 25. I am comfortable assessing the impact of my clients' S/R beliefs and practices on their mental health. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 26. I am comfortable asking my clients if their S/R beliefs and practices are a part of their presenting problem(s). | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 27. I am comfortable asking my clients if their S/R beliefs and practices can be a resource in helping them cope with their problem(s). | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 28. I am comfortable incorporating my clients' S/R beliefs and practices into treatment planning. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |

| **The following questions deal with your competence in address spiritual and religious (S/R) beliefs and practices in your work with your psychotherapy clients.** | | | | | | |
|---|---|---|---|---|---|---|
| 29. I know how to ask my clients whether they are S/R. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 30. I know how to ask my clients about their particular S/R affiliation. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 31. I know how to ask my clients about their particular S/R beliefs. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 32. I know how to ask my clients about their particular S/R practices. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 33. I know how to assess the impact of my clients' S/R beliefs and practices on their mental health. | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 34. I know how to ask my clients if their S/R beliefs and practices are a part of their presenting problem(s). | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 35. I know how to ask my clients if their S/R beliefs and practices can be a resource in helping them cope with their problem(s). | **SD** | **MD** | **D** | **A** | **MA** | **SA** |
| 36. I know how to incorporate my clients' S/R beliefs and practices into treatment planning | **SD** | **MD** | **D** | **A** | **MA** | **SA** |

| **The following questions deal with <u>how often you address</u> spiritual and religious (S/R) beliefs and practices in your work with your psychotherapy clients.** | | | | | | |
|---|---|---|---|---|---|---|
| | **Always** | **Most of the time** | **Often** | **Some of the time** | **Rarely** | **Never** |
| 37. I ask my clients whether they are S/R. | **A** | **M** | **O** | **S** | **R** | **N** |
| 38. I ask my clients about their particular S/R affiliation. | **A** | **M** | **O** | **S** | **R** | **N** |
| 39. I ask my clients about their particular S/R beliefs. | **A** | **M** | **O** | **S** | **R** | **N** |
| 40. I ask my clients about their particular S/R practices. | **A** | **M** | **O** | **S** | **R** | **N** |
| 41. I assess the impact of my clients' S/R beliefs and practices on their mental health. | **A** | **M** | **O** | **S** | **R** | **N** |
| 42. I ask my clients if their S/R beliefs and practices are a part of their presenting problem(s). | **A** | **M** | **O** | **S** | **R** | **N** |
| 43. I ask my clients if their S/R beliefs and practices can be a resource in helping them cope with their problem(s). | **A** | **M** | **O** | **S** | **R** | **N** |
| 44. I incorporate my clients' S/R beliefs and practices into treatment planning. | **A** | **M** | **O** | **S** | **R** | **N** |

APPENDIX C

**Email Advertising S/R Querying Study to Graduate Students**

Dear all:

Thanks to all for their help in the first part of the CPS study. The second part is set to begin immediately.

Time 1 Questionnaire: Any clinical program student who is willing can take the questionnaires online (between 15-20 minutes to complete). If you complete the questionnaire, we will send a **$10** gift certificate to either Amazon.com or to Starbucks. (Instructions are described on the last page of the questionnaire). This part of the study is *open right now*. It will close next Thursday (February 7th).

Time 2 Questionnaire: *In 8 weeks*, we will again invite any clinical program student who is willing to complete the online questionnaire a second time (which will be shorter than the first). For that, we will send a **$20** gift certificate to Amazon.com or to Starbucks.

Your responses on these questionnaires will be anonymous. We will **NOT** be able to connect your email address to your responses. Students will create self-generate ID numbers so that we are able to connect their data on the two sets of questionnaires.

Training. The training about integrating spiritual and religious (S/R) queries into intake interviews is open to all students. The training will take about 1 hour and can be applied towards MAPIP requirements.

We will **NOT** be taking attendance during the training. However, in order to see whether the training has an effect (i.e., to connect participant responses to participation in the training), we will ask students to provide their self-generated ID numbers.

PLEASE NOTE THAT it is **not** necessary to complete the questionnaires in order to take part in the training. It is likewise **not** necessary to do the training in order to complete the questionnaires.

The survey can be found by following this link:
https://survey.marquette.edu:443/opinio/s?s=4290

Please let me know if you have any questions about the study.

Whether or not you choose to participate, thank you for considering this.

APPENDIX D

**Follow-up Survey to Graduate Students**

Dear all:

Thanks to all who completed the Time 1 Questionnaire as well as to those who attended the training on asking patients about their spiritual and religious beliefs and practices. The follow-up questionnaire is now ready to complete.

The follow-up questionnaire is open to any clinical program student who completed the first questionnaire. It is significantly shorter than the first. For your participation, we will email a **$20** gift certificate to Amazon.com or Starbucks. Instructions on how to receive the gift card are listed at the end of the survey.

As a reminder, your responses on these questionnaires will be anonymous. We will **NOT** be able to connect your email address to your responses. Students will create self-generate ID numbers so that we are able to connect their data on the two sets of questionnaires.

PLEASE NOTE THAT it is **not** necessary to have attended the training in order to complete the questionnaires.

The follow-up survey can be found by following this link:
https://survey.marquette.edu:443/opinio/s?s=4302

Please let me know if you have any questions about the study.

Whether or not you choose to participate, thank you for considering this.

# APPENDIX E

## Slides of Spiritually Conscious Psychological Care Training

8/5/13

**Asking Patients About Spiritual and Religious Beliefs and Practices:**

**The Practice of Spiritually Conscious Psychological Care**

**Stephen M. Saunders, Ph.D.**
**Professor of Psychology**
**Marquette University**

**February 27 & 28, 2013**

### Preview

- Background
  - Definitions
  - Associations
  - Prevalence(s)
  - Preferences
  - Therapist attitudes vs. behaviors
- Spiritually Conscious Psychological Care

### Background

### Definitions

- Spirituality: thoughts, feelings and behavior that entail a search or a striving for understanding and relatedness to the transcendent (often, but not always, God).
- Religiousness: spiritually-related thoughts, feelings, beliefs, values, and behaviors that are specifically related to an organized religion.

### Associations: Spirituality, Religion and Health

- Physical Health
  - Religious involvement associated with better health outcomes
    - Greater longevity
    - Better coping skills
    - Better quality of life in patients with terminal illness

Cornah, 2006

- Mental Health
  - positive association between measures of spirituality and mental health
    - anxiety, depression, suicide, substance abuse
    - increased hope, well being, optimism
    - enhanced capacity to cope with stress

Exline & Rose, 2005
Pargament et al., 1998
Rew & Wong, 2006

## Conclusion

- Many studies have found that measurs of S/R are associated with measures of physical and emotional health.
- Why?
  - Dunno
- And ....
  - Nothing
  - Psychologists do NOT promote religion.

- S/R Issues Within Mental Illness
  - can be associated with or part of problems
    - increased guilt, anxiety, religious obsessions/ compulsions
    - negative religious coping
  - extremely relevant to practice of clinical psychology
    - indicative of severe MI
    - still do not focus on S/R as an aspect of treatment

Exline & Rose, 2005
Pargament et al., 1998
Rew & Wong, 2006

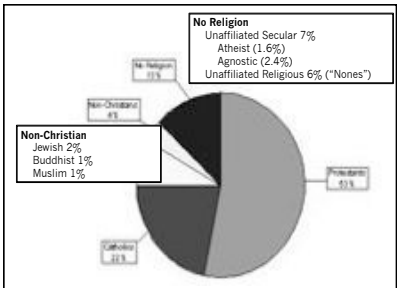
## Prevalence(s)

(Meaning how many do what.)

## Spirituality and Religion in America

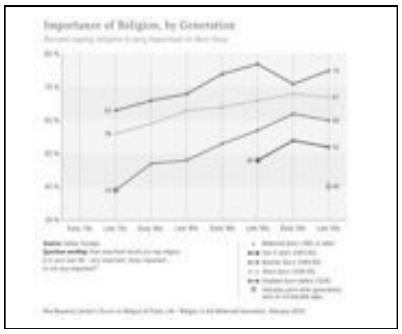
- America is a highly spiritual and religious country
  - 85% describe selves as religious or spiritual
  - 95% report believing in God or higher power
  - 69% are member of church or synagogue
  - 85% "Religion plays a significant role in my life"

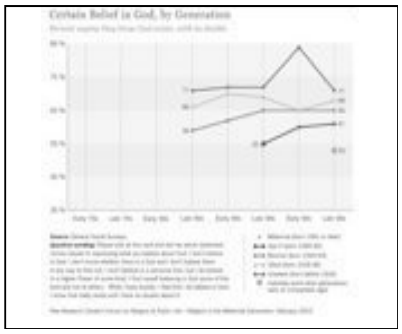
Gallup & Lindsay, 1999
Gallup Organization, 2010

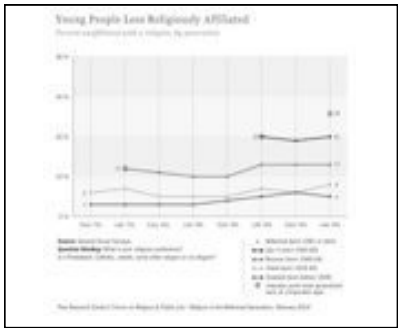


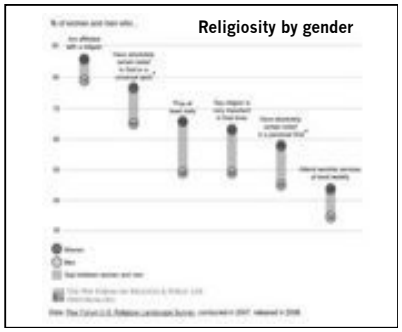

## Pew Surveys

- The U.S. Religious Landscape Survey
  - telephone interviews
  - nationally representative sample
  - 35,556 adults in continental U.S.
- Religiosity by age
- Religiosity by gender
- Religiosity by ethnicity



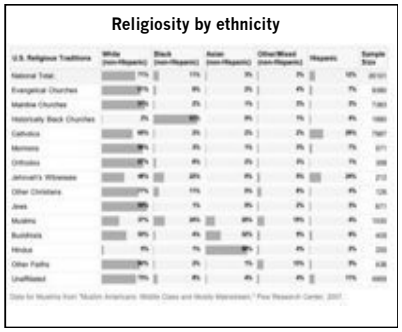



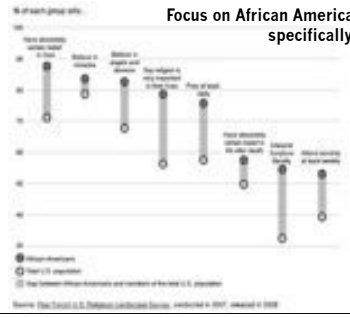




## Pew Surveys

- Religiosity by ethnicity
- Results show that competence in S/R issues is an aspect of multicultural competence.



**Focus on African Americans specifically …**



## In conclusion

- It's complicated
- For example
  - "Importance of religion" AND belief in God relatively independent
  - Growth of "nones"
  - Belief in angels and demons not necessarily associated with religion

## Preferences

## Patient Preferences

- Most say they would like to discuss spiritual and religious concerns in therapy
- Some are hesitant to seek mental health treatment out of fear that their SRBP would not be respected

American Association of Pastoral Counselors, 2005
Rose, Westefeld, & Ansley, 2001

## Historical Conceptions and Misconceptions

- Common perception that psychologists are disinterested in and, perhaps, contemptuous of religiousness and spirituality.
- This perception has some legitimacy.

"(Religion is) a universal obsessional neurosis . . . infantile helplessness . . . a regression to primary narcissism." Freud (1959). Civilization and its Discontents.

"Religiosity is in many respects equivalent to irrational thinking and emotional disturbance." (Albert Ellis)

"(Religion is) a temporal lobe dysfunction."
Mandel (1980). In *The Psychobiology of Consciousness*.

## Therapist Attitudes vs Therapist Behaviors

## Therapist Attitude vs. Behavior

- Psychologists recognize importance of S/R, but…
  - Only discuss S/R with 30% of clients
  - Less than half ask about S/R during intake

(Frazier & Hansen, 2009; Hathaway, Scott, & Garver, 2004)

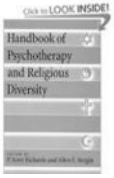
## Therapist Reluctance

- Lack of Training
  - Doctoral Programs
  - Pre-doctoral Internship
- Concerns about undue influence
  - If patients indicate that they are not interested, the subject of personal religion or faith should not be pursued

Post et al. (2000). Ann Intern Med,132.

## Therapist Reluctance

- Bad advice
  - "Spiritually expert psychotherapy"




## A look inside …

- "This book provides readers with the information needed to increase their competency in working sensitively with members of each of the major faith communities in North America."

## I don't think so.

Catholic Church
The Latin Church
Eastern Catholic Churches
Other churches
Independent (self-identified as Catholic)
Eastern Orthodox Church
Other orthodox
Oriental Orthodox
Church of the East
Pre-Lutheran Protestants
Lutheranism
Anglicanism
Anglican Communion
Other Anglican Churches
Calvinism
Continental Reformed churches
Presbyterianism
Congregationalist Churches

**And many more!**

Anabaptists
Brethren
Methodists
Pietists and Holiness Churches
Baptists
Spiritual Baptist
Apostolic Churches – Irvingites
Neo-Charismatic Churches
African Initiated Churches
United and uniting churches
Religious Society of Friends (Quakers)
Stone-Campbell Restoration Movement
Southcottites

8/5/13

## Therapist Reluctance

- Bad advice
  - "Spiritually oriented psychotherapy"
    - "Want to help you become more Christ-like." (Tan et al.)
    - Help patients preserve or transform their beliefs.


## Summary

- Over 90% clients have spiritual/religious beliefs, most have some practices.
- S/R issues are relevant to health, including mental health.
- Clients desire that their S/R be addressed respectfully.
- Psychologists want to address it, but the existing advice really stinks.

## An Emerging Issue

- Joint Commission on the Accreditation of Healthcare Organizations (2008)
  - Recommended inclusion of questions during assessments to identify religious/spiritual beliefs and practices that are important to the patient
  - Determine impact, if any, on treatment

## A Proposed Solution

Evaluate spiritual/religious topics in the same manner as other sensitive issues.

- With sensitivity
- Conduct spiritually conscious psychological care

Spiritually Conscious Psychological Care

## Spiritually Conscious Psychological Care

Three parts

- Relevance (and affiliation)
- Association with problems
- Actuality or potentiality as resource (or a hindrance)

## Relevance (and affiliation)

- Hodge (2006) cautioned to obtain client's consent to a spiritual assessment
  - Some may be reluctant to share their private beliefs about religion with a stranger who they suspect may not be accepting or understanding.
- Hathaway, Scott, and Garver (2004) suggested use of simple preliminary probes
  - Do more detailed assessment with clients who give an affirmative response

## Relevance (and affiliation)

- Assess whether client identifies self as Spiritual or Religious
  - That is, determine if this is a relevant topic that should be further pursued
  - If not, **move on** to something else.
- If "Yes"
  - Ask about S/R affiliation

## Relevance/Affiliation questions

- Relevance
  - Are you a religious or spiritual person?
  - How important is spirituality or religion in your daily life? Has spirituality or religion been important to you in your life?
  - Are there things in your life that are sacred to you?
  - Do you believe in a higher power?
- Affiliation
  - Are you part of a spiritual or religious community?
  - Are there spiritual or religious practices that you follow regularly?

## Association with problem

- Assess whether S/R is associated with problem in either direction
  - Conflicts with S/R
  - S/R beliefs/practices causing problems
  - Problems causing issues with S/R

## Association with problem

- Beliefs and (perhaps "versus") practices that might contribute to problems
  - Doctrine about premarital sex, masturbation, homosexuality, abortion, birth control, female submission/male dominance, gender role expectations
- Disagreements about religious practices and beliefs can lead to discord with family members
  - 20-25% teens hold significantly different religious beliefs than parents
- Disappointing or abusive experiences with church leaders or members

## Association with problem

- S/R beliefs causing/exacerbating problems
  - Scrupulosity; guilt; delusions
    - Depression as punishment for sin
  - This will usually become evident quickly when ask about S/R (i.e., client will volunteer information as part of presenting problem)
  - Are your spiritual or religious beliefs important to this problem?

## Association with problem

- Problem causing issues with S/R
  - Has your current problem affected your relationship with your higher power?
  - Has the problem for which you are seeking help affected your religious or spiritual life?

## Actual or Potential Resource (or Hindrance)

- Are S/R beliefs and practices a resource (or a potential resource)?
- Are S/R beliefs and practices (and affiliations) a hindrance?

## Resource?

- Has your religion or spirituality been involved in your attempts to deal with this problem?
- Are members of your spiritual or religious community (such as a spiritual leader) a potential resource for you in trying to deal with this problem?
- Is there someone you can talk to about spiritual or religious matters as they relate to this problem?

## Hindrance?

- Are you worried about possible conflicts between your beliefs and your treatment?
- Do members of your (faith community) know you are here? Would they approve?
- Are you able to talk to those in your (faith community) about having problems or about seeking treatment?

## Spiritually Conscious Psychological Care


Continuum of spiritual care in psychotherapy.

## Moving Forward

MHPs are trained to address the personal, individualistic, and idiosyncratic needs of their clients.

We strive to do so with full awareness of differences between ourselves and our clients, related to ethnic/racial, sexual, social, religious/spiritual, and socioeconomic diversity.

Patients can and should expect caregivers to respect their beliefs and to talk about spiritual concerns in a respectful and caring manner.