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COLLEGE OF SOCIAL AND BEHAVIORAL SCIENCES

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Sharon R. Gough

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Walden University
2009

ABSTRACT

Spiritual and Religious Diversity: Implications for Counselor Education Programs

by

Sharon R. Gough

M.A., Rollins College, 2001
B.A., State University of New York, 1989

Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy
Academic Psychology

Walden University
November 2009

ABSTRACT

The Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVC) identifies 9 core competencies for integrating spirituality/religion into practice. Previous research indicates that some mental health professionals have experienced discomfort when considering the balance between religious ideology (RI) and scientific orientation (SO) in their practice. However, no research exists assessing this potential for cognitive dissonance among mental health professionals nor has there been a test of the relative influence of RI/SO on approval of ASERVC competency integration into counselor training. Therefore, the purpose of this quantitative study was first to assess RI/SO cognitive dissonance and, second, to test RI/SO relative to ASERVC competency integration. The Religious Ideology, Scientific Orientation, Conflict Questionnaire and Core Competency Questionnaire was administered to a random sample of American Psychological Association and American Counseling Association professionals. The results from *t* tests revealed a significant difference in cognitive dissonance with higher scores on both RI/SO associated with greater dissonance. Multiple regression analysis revealed neither RI nor SO predict competency approval. Findings suggest an important social-change implication: Counselors may not perceive a conflict between RI and SO and, therefore, may be willing to accept the integration of the ASERVC competencies into their training. Implications also include changes in curricular requirements within academic programs that train counselors, social workers, and psychologists to integrate these competencies; considerations for ethical guidelines addressing religious and spiritual diversity; and the development of continuing education coursework pertaining to spiritual and religious diversity competencies.

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DEDICATION

I would like to dedicate this work to my husband, Thomas J. Gough. His love and patience provided the support needed to complete this study.

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I want to thank my dissertation chair, Alethea Baker, PhD., and my committee members, Amy Sickel, PhD., and Daniel Weigand, PhD., for their unfailing encouragement and guidance. Thank you to my colleagues who have contributed to this work throughout the past 5 years and to my children and siblings for their support. Finally, I want to express my appreciation to the staff at Gila Regional Medical Center, Padre Behavioral Hospital, and Border Area Mental Health Services.

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CHAPTER 1: INTRODUCTION TO THE STUDY

PREFACE

William James, often referred to as the Father of American Psychology, cautioned against the tendency to separate religion and the study of human behavior. In his lecture entitled "Religion and Neurology" delivered in 1902, James discussed the undermining of spiritual experiences by the "too simple-minded system of thought" he referred to as "medical materialism" (James, 1902, p. 11). As a scientist, James spent most of his life investigating the claims of religious believers and sharing his conviction that spiritual experiences ought not to be explained as pathology, but rather as something mystical that causes real effects. Through his research, James (1902) concluded that "prayer or inner communion with the spirit thereof – be that spirit 'God' or 'law'– is a process wherein work is really done, and spiritual energy flows in and produces effects, psychological or material, within the phenomenal world." (p. 359).

Introduction

A century ago James (1902) was documenting the effects of spiritual experiences in an effort to understand the relationship between the sacred and scientific psychology. Today researchers continue to examine the transcendent or spiritual states of consciousness within the framework of psychological science. Spiritual issues in psychotherapy are evolving into an integral form of spirituality embraced by an ever widening array of disciplines (Koenig, 2005; Wilber, 2000, 2005). As such, the process of integrating spirituality and religion into the counseling profession involves a variety of diversity issues (Hoffman, Cox, Ervin-Cox, & Mitchell, 2005).

Counseling psychology acknowledges spirituality and religion as an aspect of cultural diversity (American Counseling Association, 2005; American Psychological Association, 2002. 2003; Council for Accreditation of Counseling and Related Educational Programs, 2001). Contemporary society is composed of a variety of different races, ethnicities, sexual orientations, gender identities, socioeconomic levels, and religions (Hage, Hopson, Siegel, Payton, & DeFanti, 2006; Henriksen & Trusty, 2005; Singh, 2007; Sue, Bingham, Porche-Burke, & Vasquez, 1999). Diversity-competent counselors, counselor educators, and supervisors are essential if the profession is to keep pace with an ever broadening diverse client population. To accomplish this goal, the creation of specific requirements to provide both faculty and students in psychology training programs with curriculum designed to enhance spiritually and religiously diverse topics in counseling is needed (Burke et al., 1999; Cashwell & Young, 2004; Hage et al., 2006; Kelly, 1994; Miller, G., 1999; Myers & Willard, 2003; Pate & High, 1995).

Background

The relationship between spirituality, religious practices, and positive physical and mental health is evident (Kabat-Zinn, 2005; Miller & Thoresen, 2003). Koenig, McCullough, and Larson (2000) have documented how spirituality has been studied scientifically with well-established instruments demonstrating a clear link between positive health and spiritual practices (see also Hill & Pargament, 2003). This link will be further articulated in chapter 2. The popular press and peer-reviewed psychological journals are filled with research and reviews of the mind-body-spirit connection and the

role of spirituality and religion in maintaining positive mental and physical wellness. This abundance of literature is in part developments in the medical community demonstrating the connection between health, healing, and various religious and spiritual practices, including prayer and mindfulness meditation (Kabat-Zinn, 1990, 1994, 2005; Koenig, 2005; Pert, 1997; Sarno, 2006; Schwartz & Begley, 2002). Scientific evidence is affirming what spirituality researchers have been claiming for decades: faith-integrated counseling identifies multiple ways clients may actually promote health and well-being through religious and spiritual practices (Bergin, 1980, 1983, 1990; Benor, 2001; Cox, Ervin-Cox, & Hoffman, 2005; Hill & Pargament, 2003; Kass et al., 1991; Koenig, McCollough, & Larson, 2001; Koenig, 2005). The Center for Research on Religion and Urban Civil Society/Gallup Spiritual State of the Union recently revealed that faith and spirit guide the lives of three out of four American adults (University of Pennsylvania, 2003). Among the study's findings was a strong indication that the majority of Americans report an active inner life, a connection with God, divine will, or higher power. Similar findings have been established in the United Kingdom (Heelas & Woodhead, 2005) and China (Coe, 2007). Spirituality is increasingly understood as a developmental process. A review of the early (James, 1901; Jung, 1930), contemporary (Erikson, 1963; Fowler, 1981, 1991; Maslow, 1970; Rogers, 1960), and current theorists (Grof, 2001; Wilber, 2001, 2006) demonstrate an interdisciplinary searching for the psychology of spiritual development. These theories will be examined more closely in chapter 2. Understanding emotional crisis as a potentially transformative event leading to higher levels of spiritual awareness and psychological functioning is an ethical imperative. Bergin (1980)

expressed the dangers associated with inadequately prepared therapists promoting change not valued by the client or the community as “unethical or subversive” (p. 97). Current counselor education programs address spirituality and religion briefly under the multicultural competency standards of accreditation organizations (CACREP, 2001). This research will build on the growing consensus that the ethical practice of counseling psychology requires appropriate attention and training to the diversity of spirituality and religion as they pertain to psychological health.

Historically, spiritual health and wellness has been viewed as “intangible or unteachable” and in many areas continues to be viewed as “an inappropriate domain for health educators and counselors” (Chandler, Holden, & Kolander, 1992, p. 168). During the latter part of the 20th century, the emergence of spirituality, religion and health research has demonstrated the powerful and predictive relationships between these variables (Miller & Thoresen, 2003). While the foundations of psychology lie in the philosophy of the ancient Greeks, the science of psychology has pulled away from explanations of self knowledge and the soul as the central guiding force behind mystical searching for answers to life’s experiences and events. Burke and Miranti (1995) have argued that psychology has been forced to omit the spiritual dimension because it cannot be scientifically measured. However, scores of researchers have investigated the spiritual and religious factors associated with wellness and have substantiated, with empirical soundness, the benefits and clinical rationale of minding the spiritual in counseling psychology (Bellamy et al., 2007; Hill & Pargament, 2003; Hodges, 2002; Koenig, 2005; Koenig, McCollough & Larson, 2001; Kohls & Walach, 2007; Larson & Larson, 2003;

Lukoff, 2007; Miller, 1998; Miller & Thoresen, 2003; Nelson, 1994; Pargament, 1997; Pargament, Murray-Swank, & Tarakeshwar, 2005; Pargament & Saunders, 2007; Sorenson, 2004; Walker et al., 2005; Weaver et al., 2006; Zinnbauer & Pargament, 2000).

Leading researchers have articulated their concerns that unless the counseling profession compels training programs to implement educational experiences designed to develop practitioners' awareness of their own spiritual and religious subjectivity we may be hindering therapist development and the long-term effectiveness of the counseling profession (Griffith & Griffith, 2002; Sorenson, 2004; Zinnbauer & Pargament, 2000). While it is true that "religion and spirituality certainly have been a source of intolerance, bigotry, and xenophobia" (Sorenson, 2004, p. 25), it is also true that contemporary psychology is struggling to integrate spirituality, science, and mental health (Bourget, 2002) in an effort to bring back the sacred and the mystical spiritual traditions of the Good, the True, and the Beautiful articulated by the ancient Greek philosophies (Wilber, 2000).

It has been previously noted the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC), a division of the American Counseling Association, developed nine competencies in an effort to safeguard client welfare when responding to clients' spiritual issues (Miller, G., 1999). The guidelines provided that adequate mental health practitioner preparation is one which includes a comprehensive overview of the cultural similarities and differences in religion and in spiritual practices as well as an examination of the developmental stages of spiritual emergence across the lifespan. A significant consideration is for building awareness of the clinician's potential bias of his

or her own views regarding spirituality and spiritual development. Another consideration involves the ethical issues in developing and providing curriculum designed to address the issues of spiritual and religious diversity in training programs. Miller (1999) asserts the proposed changes to CACREP standards would result in very specific concerns. Those concerns will be reviewed in chapter 2. In addition, spiritual assessment and the role of spirituality on the client's ability to cope will be addressed, and finally there will be an examination of the paradigm shift that is taking place among mental health professionals. This research will contribute to ASERVIC's efforts to advance the field of psychology and to contribute to the growing body of literature promoting the necessary awareness for social change pertaining to the education and supervision of mental health professional in training programs regarding the role of spirituality and religion in therapy.

Problem Statement

Research demonstrates support for the integration of spiritual and religious diversity training in the preparation of practitioners and in their supervision; however, only a minority of counselor education programs include this type of training. Research also identifies various barriers to inclusion of this type of training, such as, concerns related to the imposition of counselor values and beliefs (Henriksen & Trusty, 2005; Plante, 2007; Steens, Engles, & Thweatt, 2006), the limitations of secular educational institutions associated with funding issues (Pate & Hall, 2005), and increased emphasis on teaching counselors in training evidenced-based techniques as managed care dictate (Sexton, 2000).

Bergin (1983) called awareness to the renewed interest and activity between psychology and religion and noted "old controversies" were beginning to resurface with new terms (p. 170). Shafranske and Malony (1985) were among the first to survey psychologists regarding their religious and spiritual orientations. These findings and the results of replications of the early studies will be thoroughly reviewed in chapter 2. Suffice to note here that the genesis for this study can be located in the early research associated with the struggle some mental health professionals have experienced over the years regarding the "alienation of therapeutic psychology from religious (and spiritual) values" (Bergin, 1980, p. 95). The dissonance evident in recent studies investigating the religiosity and spirituality of mental health professionals suggests this struggle is, in part, a result of the paradigm shift away from rigid, scientific ideologies that have dominated psychology in the past (Bathgate, 2003; Robertson, 2007; West, 2007; Wilber, 2000, 2006). This study adds to the psychological research that exists on integrating content related to spirituality and religion into the educational curriculum of the mental health professional by identifying the level of consensus among these professionals for increasing spiritual and religious diversity competencies. It considers developmental theories and stages of faith development evident in all major world religions and belief systems. Spiritual and religious issues are an integral part of human growth and development across individuals and cultures. As such, the potential impact of neglecting spirituality-related issues in psychotherapy was examined.

As a secondary issue, this study seeks to better understand the spiritual and religious dimension of human functioning, including that of the mental health

professional. It has been noted above that the behavioral sciences have been undergoing a paradigm shift in that, when surveyed, mental health professionals are increasingly reflecting the conceptual distinction between religion (identified as institutional) and spirituality (identified as personal). This research examines whether or not a discrepancy exists between psychology professionals' endorsement of their own religious ideology, scientific orientation, and their beliefs that the integration of spirituality and religion are beneficial to the mental health of the client and to the field of psychology in general. These issues are examined using Festinger's (1957) cognitive dissonance theory, specifically the degrees of dissonance between these cognitions are explored in chapter 2.

Purpose of the Study

The purpose of this study is two-fold, first, to assess cognitive dissonance, as measured by the conflict scale (the dependent variable), by comparing those who score higher versus lower on both religious ideology and scientific orientation (the independent variable). Data were gathered using the Religious Ideology, Scientific Orientation, and Conflict Questionnaire (Eckhardt et al., 1992). This was evaluated using an independent groups *t* test. Second, this study quantitatively examined the relative influence of religious ideology and/or scientific orientation on American Psychological Association (APA) and American Counseling Association (ACA) members' approval of integrating the ASERVIC core competencies into mental health professional training programs. By means of a multiple regression, the two predictor variables (religious ideology and scientific orientation) were used simultaneously to examine respondents' level of approval of the core competencies.

Research Questions and Hypotheses

The following research questions and hypotheses have been derived from a review of existing literature in the area of spiritual and religious diversity issues in mental health professional training programs. There will be a more detailed discussion of the study method in chapter 3.

Research Question.

The research questions and related hypotheses of this study are as follows:

RQ1: Will cognitive dissonance (conflict score) increase with participants who hold both religious ideology and a scientific orientation for explanations of knowledge?

Null Hypothesis 1: There will be no significant difference between those who score higher versus those who score lower on both the religious ideology scale and the scientific orientation scale on levels of cognitive dissonance (conflict scale).

Alternative Hypothesis 1: There will be a significant difference between those who score higher versus those who score lower on both the religious ideology scale and the scientific orientation scale on levels of cognitive dissonance (conflict scale).

RQ2: Does either religious ideology or scientific orientation predict respondent approval of integrating the core competency standards into current mental health professional training programs?

Null Hypothesis 2: Either religious ideology or scientific orientation predicts respondent approval of integrating the core competencies standards into current mental health professional training programs.

Alternative Hypothesis 2: Either religious ideology or scientific orientation do not predict respondent approval of integrating the core competencies standards into current mental health professional training programs. However, there is not enough evidence to suggest which would be the stronger predictor.

Definitions of Theoretical Constructs

Attempting to define spirituality, the sacred, religion, and/or religiousness generate controversy around the world. Even among those who have made the scientific study of the psychology of spirituality and religion their primary focus, the variations of definitions is vast. Throughout the research literature, the terms spirituality and religion, while not interchangeable, are typically used together and have overlapping meanings (Hage, 2006). For the purpose of researching these constructs it is important to establish a consensus regarding the definitions of the terms used in this research. To this end, the present study will use Fukuyama and Sevig's (1999) criterion that spirituality is the broader of the two terms and one's spirituality "may be experienced and expressed through religion, defined as an organized system of faith, worship, cumulative traditions, and prescribed rituals" (p.233); and the definition developed by Wuthnow (1998) that spirituality "consists of all the beliefs and activities by which individuals attempt to relate their lives to God or to a divine being or some other conception of a transcendent reality" and that "it is shaped by larger social circumstances and by the beliefs and values present in the wider culture" (p.viii).

Definition of Key Terms

Consciousness, states of consciousness: The major states of consciousness (waking, dreaming, and deep sleep) contain "a treasure trove of spiritual wisdom and spiritual awakening" as well as providing profound motivation, meaning, and drives (Wilber, 2006, p.4). Grof's (2000) explanation of the nature of the psyche and genuine spirituality as full of potential for healing is also included in this definition.

Core competencies of spirituality: The Association of Spiritual, Ethical, and Religious Values in Counseling (ASERVIC, 1998) standards for infusing spiritual and religious dimensions of client's beliefs and practices into the counseling education process provide that the competent professional counselor can:

1. Explain the relationship between religion and spirituality, including similarities and differences.
2. Describe religious and spiritual beliefs and practices in a cultural context.
3. Engage in self-exploration of religious and spiritual beliefs in order to increase sensitivity, understanding and acceptance of diverse belief systems.
4. Describe his/her religious and/or spiritual belief system and explain various models of religious or spiritual development across the lifespan.
5. Demonstrate sensitivity and acceptance of a variety of religious and/or spiritual expressions in client communication.
6. Identify limits of his/her understanding of a client's religious or spiritual expression, and demonstrate appropriate referral skills and generate possible referral sources.

7. Assess the relevance of the religious and/or spiritual domains in the client's therapeutic issues.
8. Be sensitive to and receptive of religious and/or spiritual themes in the counseling process as befits the expressed preference of each client.
9. Use a client's religious and/or spiritual beliefs in the pursuit of the client's therapeutic goals as befits the client's expressed preference.

Counseling students: For the purpose of this study, counseling students were defined as graduate and doctoral level college students majoring in psychology.

Counseling professionals: This term includes master-level and doctoral-level students, as well as master-level and doctoral-level mental health counseling professionals.

Developmental theories of spiritual development: The faith dimension is an essential feature of human experience. Stages of faith development as defined by Fowler (1981) proposes sequential changes in spiritual development from a lifespan perspective. The historical views for the psychology of spiritual development (James, 1901; Jung, 1930) are synthesized with the contemporary (Erikson, 1959, 1963, 1968; Maslow, 1964, 1968, 1971; Rogers, 1960, 1980) and post-modern views (Grof, 2001; Wilber, 2001, 2006).

Diversity: For the purpose of this study, diversity includes cultural, cognitive, existential, and transpersonal approaches to spirituality and religion that promote the use of client's spiritual beliefs, values and practices in ways conducive to mental health (Cox, Ervin-Cox, & Hoffman, 2005).

Ethical practice:. Ethical principles associated with mental health counseling involve sensitivity and training on religious-diversity-related issues (Plante, 2007). The APA (2003) set forth principles requiring psychologists to consider religion and religious issues as with all other dimensions of identity (e.g., gender, age, sexual orientation, disability, religion/spiritual orientation, educational attainment/experiences, and socioeconomic status).

Mental health professional: This term refers to master-level and doctoral-level mental health counseling professionals.

Psychotherapist: This term refers to master-level and doctoral-level mental health professionals.

Religion/religiousness:. Religiosity is a complex phenomenon with multiple correlates that defy simple interpretations (Bergin, 1983). For the purpose of this research, religiousness can include "personal and institutional beliefs along with institutional practices, such as attending worship services, and usually reflects conformity and adherence to a basic set of tenets and proscribed behaviors" (Baetz, Bowen, Jones, & Koru-Sengul, 2006, p.655).

Sacred: The sacred is defined by Hill & Pargament (2003) as that which "distinguishes religion and spirituality from other phenomena. It refers to those special objects or events set apart from the ordinary" and as such are "deserving of veneration" p. 65). According to Pargament (1999) the sacred includes concepts of God, the divine, Ultimate Reality, and the transcendent, as well as any aspect of life that takes on extraordinary character by virtue of its association with or representation of such

concepts. “The sacred encompasses concepts of God, the divine, and the transcendent, but it is not limited to notions of higher powers” (Pargament, 1999, p. 12).

Spirituality: For the purpose of this research, the definition of spirituality is used as provided by the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC, 1998): Spirit may be defined as the animating life force, represented by such images as breath, wind, vigor, and courage. Spirituality is the drawing out and infusion of spirit in one’s life. It is experienced as an active and passive process. Spirituality is also defined as a capacity and tendency that is innate and unique to all persons. This spiritual tendency moves the individual toward knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, and wholeness. Spirituality includes one’s capacity for creativity, growth and the development of a value system. Spirituality encompasses a variety of phenomena, including experiences, beliefs, and practices. Spirituality is approached from a variety of perspectives, including psychospiritual, religious, and transpersonal. While spirituality is usually expressed through culture, it both precedes and transcends culture. (ASERVIC, 1998, par. 3-4).

Spiritual development:. The process of “incorporating spiritual experience that results ultimately in spiritual transformation.” (Chandler, Holden, & Kolander, 1992, p. 170). This process is strengthened as each spiritual experience is gained, not by one experience alone.

Spiritual Identity: This is defined as “a persistent sense of self that addresses ultimate questions about the nature, purpose, and meaning of life, resulting in behaviors that are consonant with the individual’s core values” (Kiesling, Sorell, Colwell, &

Montgomery, 2006, p. 1269).

Spiritual wellness: This is defined as the balance between spiritual emergence and repression similar to the theories of Rogers (1961) and Maslow (1971) outlining human self-actualizing tendencies that lead to growth, direction, and productivity.

Soul: Moore (1992) defines the soul as “not a thing, but a quality or a dimension of experiencing life and ourselves. It has to do with depth, value, relatedness, heart, and personal substance” (p. 5). As a clarification, Moore goes on to state: “I do not use the word here as an object of religious belief or as something to do with immortality” (p. 5). According to Jung (1961) there is a historical quality to the soul: “Our souls as well as our bodies are composed of individual elements which were all already present in the ranks of our ancestors (p.235). Emerson’s (1841) notion of the soul is the light that shines through humanity:

> All goes to show that the soul in man is not an organ, but animates and exercise all the organs; is not a function, like the power of memory, of calculation, of comparison, but uses these as hands and feet; is not a faculty, but a light; is not the intellect or the will, but the master of the intellect and the will; is the vast background of our being, in which they lie, an immensity not possessed and that cannot be possessed. From within or from behind, a light shines through us upon things and makes us aware that we are nothing, but the light is all (p. 135).

Emerson includes in his definition of soul the qualities that result: “When it breathes through his intellect, it is genius; when it breathes through his will, it is virtue; when it flows through his affection, it is love” (p. 135).

Theistic worldview: According to Richards and Bergin (2005) this view promotes the integration of spiritual perspectives and interventions into mainstream psychology

and "contributes important insights into previously neglected aspects of human nature, personality, therapeutic change, and the practice of psychotherapy" (p. 349).

Significance

This study contributes to the psychology of religion and spirituality, specifically in the area of counselor education. The potential benefits of identifying barriers to the integration of religion and spirituality into the core competencies of current mental health professional preparation programs are far-reaching. The diversity of religious belief and spiritual practice is recognized as a legitimate psychotherapeutic concern and a general health care issue. Understanding the process of how spiritual development is associated with quality of life and emotional well being may help to identify the relevance for religion and spirituality in these training programs. The inherent properties of the human being include spirituality and as such, the process of preparing counselors to ethically address the various expressions of religious and spiritual beliefs is essential. Exploring counselor education, supervision, and current attitudes related to spirituality and religion may contribute to an understanding of where the field of psychology presently stands and what barriers are preventing the advancement of integrating content related to spiritual and religious diversity in mental health professional training programs.

Advances in science and technology have provided evidence that strengthens the spiritual paradigm shift that has already taken place throughout various disciplines in the 20th century. Undoubtedly, the 21st century will include an even greater recognition of the effectiveness of human spirituality in protecting and restoring emotional wellness and the need for spirituality in counseling will be stronger than ever. Promoting religious

and spiritual competence for mental health professionals may result in significant public health benefits.

A review of the literature revealed over 20 years of research demonstrating the need and the support for inclusion of religious and spiritual issues in counselor education programs. National surveys of counselor education programs, members of APA and of the ACA have been invited to participate in studies concluding that practitioners, faculty/supervisors and students alike demonstrate an interest in and need for curriculum that would include religious and spiritual diversity topics. Guidelines on organizational change for psychologists and other mental health professionals acknowledge the population of the United States is increasingly racially and ethnically diverse and that various worldviews and identities are increasingly important to consider “to be competent to work with a variety of populations” (APA, 2003, p. 379). Additionally, APA principles associated with respect for others’ rights (Principle E), to be concerned to not harm others (Principle E), and to contribute to social justice (Principle F; APA, 1992) call for adequate preparation in the educational process. These guidelines are meant, in part, to improve assessment processes and reduce the misdiagnosing of the religious client. This study will help fill the gap in the literature regarding the need to integrate spiritual and religious diversity competencies into counselor educational programs.

Assumptions and Limitations

It is assumed that the willingness of participants to volunteer in this study did not bias the study, and that those individuals who might be opposed to integrating spirituality and religion into mental health professional education curriculum would not refrain from

participation. It is also assumed that the participants in the study would complete the questionnaires to the best of their ability. In addition, it is assumed that the questionnaires used are adequate instruments for gathering information and for measuring the designated variables.

There were three specific limitations to the study. The first limitation was the sampling plan, which included only participants from the APA and the ACA. This limits the generalizibility of the findings to non-APA and non-ACA members. The second limitation proved to be a poor return rate that may lower the representation of the sample and weakened the findings of the study. Finally, the majority of previous studies investigating spirituality and religion have surveyed clinical psychologists. The APA sample for this study included mental health professionals from a variety of subfields including Division 36, Psychology of Religion, and others that may report higher levels of religiosity. The ACA sample for this study included mental health professionals from its 16 divisions including ASERVIC, which may report higher levels of religiosity. It was important to be mindful of these differences when studies were compared.

Summary

There is broad evidence in the research literature demonstrating the relationship between spirituality and religious practices as a dimension of human behavior that contributes to physical and emotional well-being. (Koenig, McCollough, & Larson, 2001; Plante & Sherman, 2001; Pargament, 1992, 1999, Plante, 2007; Richards & Bergin, 2000, 2004, 2005; Shafranske & Malony 1985, 1990; Shafranske, 2000, 2001; Sperry & Shafranske, 2005). In addition, the most current research suggests a growing interest on

the part of the client for addressing spiritual and/or religious issues with their mental health professional (Movic et al., 2006; Pargament et al., 2005; Pargament & Saunders, 2007). The efficacy of spiritually sensitive psychotherapy is proving to impact a variety of treatment issues, including eating disorders, addictions, and coping with life-threatening illness (Baetz et al. 2006). Relational spirituality has been found to be an effective protective factor against depression in adolescent girls, survivors of intimate partner violence, obsessive compulsive disorder, and anxiety disorders. Spiritually oriented interventions are demonstrating effectiveness in promoting change within the individual, most notably in changing self-schema from self-destructive to self-accepting (Beck, 2003; Bono & McCullough, 2006).

The field of psychology is in the midst of a paradigm shift. Mental health professionals must acknowledge the importance of the spiritual dimension of psychological problems, establish adequate training about supervision of these issues, and encourage the further exploration of this aspect of psychotherapy in research and practice. The advances in the scientific study of religion and spirituality have heightened awareness of this shift and may hasten the integration of these dimensions to promote wellness. Current training programs briefly address spirituality and religion within the multicultural core competency standard. The present study seeks to identify what issues may be hindering a more fully developed integration of spirituality and religion into the educational programs that prepare today's mental health professional. In addition, this study builds on the growing consensus that the ethical practice of counseling psychology

requires appropriate attention and training regarding the diversity of spiritual and religious issues.

Chapter 2 addresses a review of the existing literature and a presentation of how the most recent research demonstrates the association between spiritually-integrated psychotherapy and physical/emotional wellness. The chapter begins with a description of the rationale for the integration of spirituality and religion into the mental health professional education process, a theoretical basis for spirituality as an integral dimension, and a discussion of the nature of spirituality and religion and the paradigm shift in the field of psychology. An overview of spiritual identity and development throughout the lifespan will include the theories of Erikson, Fowler, and Wilber. Chapter 2 will also include a discussion of literature that challenges the integration of spirituality and religion into the process of psychotherapy. Finally, a review of religious and spiritual experiences among mental health professionals will be examined within the framework of cognitive dissonance theory.

Chapter 3 describes the methodology used to study the research questions. This chapter will discuss the use of a quantitative research design as a valid means to analyze the gathered data. The chapter will include a description of the sample population, procedures, ethical considerations, measures, and analysis of the data.

Chapter 4 describes the results of the study and the findings as they relate to the two hypotheses. It includes a discussion of the research tools and data analysis.

Chapter 5 summarizes the research that has been conducted in the past and discusses the conclusions that may be drawn from the present research. In addition, the

limitations of the present study will be discussed, along with recommendations for the use of the present study and a discussion of what futures studies need to be conducted to advance this area of study.

CHAPTER 2: LITERATURE REVIEW

Introduction

Relevant theoretical and empirical studies reported in the professional literature pertaining to the core constructs of the present study are presented in this chapter. Principle areas of specific importance include literature focused on the integration of spiritual and religious diversity into mental health professional education and supervision, a review of the theories supporting spirituality as an inherent human dimension, spiritual development and identity across the lifespan, the concerns associated with integration of spirituality and religion, and the literature related to mental health professional's spiritual and religious experiences. The evidence for a shifting paradigm within psychology will be reviewed in the context of dissonance theory.

Throughout the course of this research, several databases were searched (Academic Search Premier, PsycINFO, PsycARTICLES, ERIC, Medline). The keywords included mental health professional, psychologist, counseling, spirituality, religion, and combinations of those terms. In addition, mental health and spirituality, emotional wellness, religion and science, spirituality and science, counseling psychology and science were used to gather literature. All of the major theorists in this research were independently entered to review their relevant works and analysis of their works by others.

Background

In 1995, the Summit on Spirituality was held as members of the American

Counseling Association as well as members of the Association of Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) interested in infusing spirituality into counseling began to collaborate (Miller, G., 1999). The summit produced a draft that was subject to many revisions and which ultimately provided a working definition of spirituality. Within the definition was the view of human spirituality as unique to the individual. A significant component of the Summit's recommendation was associated with the growing concern related to counselor awareness of diversity and developmental processes that are involved in spiritual identity. The draft also outlined the nine core competencies considered essential for addressing spirituality and religion which were subsequently recommended for inclusion to the Counsel for Accreditation of Counseling and Related Educational Programs (CACREP) accreditation standards for training programs (Burke et al., 1999).

Over a decade later, this recommendation has not been accepted. Young, Wiggins-Frame, and Cashwell (2007) conducted a national survey addressing the issue by asking a random sample of 505 American Counseling Association members to rate the importance of the nine competencies. The researchers found 68% of the participants indicated a need for developing curricular and training guidelines while 43.5% of the participants indicated they lacked the ability to practice psychology in accord with the ASERVIC competencies. This study was the first to ask counseling professionals to evaluate the ASERVIC competencies. The findings documented the shifting opinion among clinicians in favor of the relevance of spiritual and religious issues in clinical work (Young et al., 2007).

An earlier study by Young, Cashwell, Wiggins-Frame, and Belaire (2002) surveyed 94 CACREP program directors and found that 69% of the respondents indicated their programs addressed spirituality and religion, but only 46% felt prepared or very prepared in their ability to integrate material related to spirituality and religion into their teaching and supervision of counseling students. The authors noted a limitation of the study was their failure to gather information as to how spirituality and religion were being addressed in the programs surveyed. However, 80% of the respondents who indicated they were very unprepared also indicated that curriculum guidelines were needed. In addition, 85% of the respondents who were unprepared indicated additional training in addressing issues of spirituality and religion in counseling was needed. The Young et al. (2007) study affirmed and articulated the struggle of many spirituality researchers: "the conflict between the scientific, objective perspective of psychology and the transcendent, subjective aspects of religion" (p. 47). Despite the hundreds of reviews and research studies investigating and demonstrating the positive relationship between spiritual and religious practice and good health, these conflicts persist (Koenig, McCollough, & Larson, 2001; Larson, 2003).

In a recent survey of APA-accredited doctoral programs, Russell and Yarhouse (2007) found nearly 65% of the responding training directors reported they did not provide training in religion/spiritual issues as a major content area. Of the 139 predoctoral internship sites responding, only 49 sites reported didactic training within the area of religion/spirituality. Of those sites, nearly 50% reported the trainings were offered only once a year; nearly 20% reported the trainings were offered once a semester and

6.6% were offered on a monthly basis. These findings indicate little or no formal training for this sample of psychology interns on the issues of religion and spirituality. Russell and Yarhouse note that only 2% of the internship sites provided access to spirituality and religion training materials despite the abundance of scholarly books and articles available to educators on the integration of spirituality and religion into internship training and supervision.

The implications of neglecting the spiritual dimension in counselor training are far reaching. Bergin (1980, 1990, 1991, 1994) cautioned the counseling profession to recognize the effect of religious values in the alienation of therapeutic psychology and to begin to "include religion more systematically in theories, research, and techniques, especially as they bear on personality and psychotherapy" (Bergen, 1980, p. 95). Bergin's commentary on the developing zeitgeist recognized in the late 1970s initiated the current clamor for the proper recognition of spiritual and religious consciousness in human functioning. Much of Bergin's work revolved around dispelling the notion that religiosity was antithetical to positive mental health (1983) and to clarifying the importance of therapist's personal religious values (1980).

Bergin was one of the earliest to write extensively on secular psychotherapy and the religious dimension, urging the profession to recognize the cultural context of clients' religious world view and to challenge the professional tradition of dismissing religiosity as insignificant or even harmful to the therapeutic process. While warning that it is unethical to "trample on the values of clients" and unwise to "focus on value issues when

other issues may be the nucleus of the disorder," Bergin (1991, p. 399) also maintained it was important to recognize that

> many clients are not treated within a congenial values framework because so many clinicians do not understand or sympathize with the cultural context of their clients' religious world views but instead deny their importance and coerce clients into alien values and conceptual frameworks. Psychologists' understanding and support of cultural diversity has been exemplary with respect to race, gender, and ethnicity, but the profession's tolerance and empathy has not adequately reached the religious client. As the helping professions change to better meet the needs of the public, more tolerance will allow clients and counselors to freely pursue their spiritual values (p. 399).

Bergin has consistently called upon the mental health professional to acknowledge that a spiritual orientation should not be dismissed as "regression to religious dogmatism or primitive supernaturalism… [but viewed as] empirical, eclectic, and ecumenical" and as a legitimate source of knowledge (Bergin, 1991, p. 399).

Attention to the religious and spiritual issues clients bring to therapy is increasingly considered a valid aspect of counseling psychology (Kelly, 1994; Pargament, 1997, 1999; Pargament & Saunders, 2007; Richards & Bergin, 2000; Shafranske & Malony, 1985, 1990). The efforts many have made and are continuing to make to promote the integration of curriculum in counselor education to prepare clinicians in addressing spiritual and religious diversity has not been completely ineffective. While no formal curriculum changes have been mandated to date, independent studies and continuing education offerings are being accessed increasingly (Russell & Yarhouse, 2006) and counseling professionals are acknowledging the need for including this dimension in therapy and counselor preparation programs (Bergin & Jensen, 1990; Delaney, Miller, & Bisono, 2007; Maxie, Arnold, & Stephenson, 2006;

Pate & High, 1995; Smith & Orlinsky, 2004).

In addition to the multiple scholarly textbooks available for integrating spirituality and religion in the counseling education process (Miller, 2003; Miller, 1999; Richards & Bergin, 2000, 2005; Shafranske, 1996; Sperry & Shafranske, 2005), several excellent models for increasing curriculum content in this area have been developed (Briggs & Rayle, 2005; Burke et al., 1999; Curtis & Glass, 2002; Fukuyama & Sevig, 1997; Ingersoll, 1997; Leseho, 2007; Myers, Mobley, & Booth, 2003; Pate & Hall, 2005; Zinnbauer & Pargament, 2000). Clearly, the foundations for integrating spirituality and religion into the clinical practice of counseling psychology have been established. Moreover, the evidence for the benefits of including this dimension can no longer be dismissed as empirically weak or insignificant (Koenig, McCollough, & Larson, 2001). The recognition that spirituality and religion are factors in mental health was finally acknowledged by the American Psychiatric Association when the 1994 edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*) included religious or spiritual problems as a valid focus of clinical attention (p. 685).

Historical Context

There is an abundance of literature related to the history and evolution of the current support for integrating spiritual and religious diversity into counselor education programs. Appendix A provides a discussion of the historical context, as well as a discussion related to spirituality and religion in the context of specific religious belief systems, and the application of spirituality and religion to specific populations. While the literature pertaining to these issues is related to the present research, its content is distal in

relationship to the immediate questions and problems identified by current investigations into this issue. Appendix A is an effort to include a more complete picture of how the field of psychology has evolved to its present state concerning spirituality and religion.

The Relationship Between Spirituality, Religious Practices, and Mental Health

There is broad evidence in the research demonstrating the relationship between spirituality and religious practices as a dimension of human behavior that contributes to physical and emotional well-being. The *Handbook of Religion and Health* by Koenig, McCullough, and Larson (2000), documented the largest body of scientific research on the interaction of spiritual/religious processes and health. Regarded as a seminal contribution to the field, addressing the methodological quality and strength of results, the text critiques over one thousand separate studies and discusses the principal topics including the positive and negative effects of religion on mental health, physical disorders, and disease prevention.

Miller and Thoresen (2003) discussed the relevance of spiritual and religious factors in health and further dispel the assumptions that spirituality can not be studied scientifically. Miller and Thoresen identify the investigation of these factors as a genuine frontier and suggest operational definitions to distinguish between the terms *spirituality* and *religion*, identify methods for establishing levels of evidence, and approaches for interpreting the scientific literature related to spirituality, religion and health.

As an effective form of coping with emotional illnesses, spiritual exploration promotes self awareness and a way of making sense of personal experiences. For example, the universal concept of forgiveness can be found in nearly all religious

teachings as a process to reduce suffering and resentments, and to increase intolerance of others (Cosgrove & Konstam, 2008; Larson & Larson, 2003; Miller & Thoresen, 2003).

Baetz et al. (2006) confirmed a positive relationship between spiritual values, higher worship frequency, and lower odds of current and past depression, current and past mania, current personality disorders, and current social phobias. The researchers suggest that while association between spiritual values and mood disorders, anxiety, and addictive disorders is complex, the relationships suggest the use of spirituality to reframe life difficulties, including mental health disorders, could enhance coping skills by increasing access to spiritual resources.

Bussema and Bussema (2007) examined the role of spirituality in recovery from mental illness ($N = 58$) and found 71% of the participants reported spirituality played a significant role in their recovery by providing a sense of purpose, peace, and comfort. The researchers also concluded religious faith provided hope for the future (78%), were more likely to experience joy in their faith lives (81%), and were significantly more likely to report feeling fulfilled and spiritually alive. The role of spirituality and religious practices were indicated by the majority of the participants of this study as factors that serve as an effective buffer against despair. Religious and/or spiritual coping can also provide a community where one can experience support, fellowship, and comfort.

Larson and Larson (2001) discuss the quantitative research linking spiritual and religious practices and beliefs and beneficial mental health outcomes. The authors note the client's spiritual dimension had been recognized as a focus of clinical care as evidenced by the international move toward developing sensitivity among psychiatry's

professional associations. This development was attributed to the number of studies demonstrating the positive associations between spirituality and the prevention of depression and addiction, and in helping clients cope with severe physical and/or mental illness diagnoses. The researchers note the lack of knowledge among mental health professionals regarding the growing body of research findings in the following areas: (a) prevention, coping, and recovery from depression; (b) suicide prevention; (c) substance abuse prevention and treatment; (d) adolescent and adult health risk reduction; (e) coping with surgery and severe medical illness; (f) potential harmful aspects of spiritual/religious problems; and (g) religious/ spiritual links with longevity (Larson & Larson, 2001, p. 2).

In a follow-up work, Larson and Larson (2003) review longitudinal studies of community samples concluding spiritual/religious involvement is associated with increased chances for living longer, enhanced coping resources, improvements in pain management, and protective against depression, substance abuse, and suicide. However, the review also revealed spirituality and religion can cause distress and "may serve as a source of conflict linked with poorer health outcomes" (p. 37). Whether as potentially helpful or harmful, Larson and Larson recommend clinicians respectfully ask clients about the role spirituality and/or religious beliefs and practices play in their daily lives in an effort to provide spiritual support or to address spiritual distress that may be occurring.

Pargament, Murray-Swank, and Tarakeshwar (2005) offer an empirically-based rationale for the importance of a spiritually-integrated psychotherapy as a means of addressing psychological problems. The researchers assert four reasons to include the

spirituality dimension based on areas of research that have been conducted: (a) spirituality can be part of the solution to psychological problems, (b) spirituality can be a source of problems in and of itself, (c) people want spirituality sensitive help, and (d) spirituality cannot be separated from psychotherapy. While cautioning clinicians to avoid imposing spiritual values and trivializing spirituality as a mere tool for coping, the authors assert that to neglect the spiritual dimension in psychotherapy is “perhaps the greatest danger” (p. 155).

The connection between religious faith and individual well-being has been investigated in multiple studies (Koenig, McCollough, & Larson, 2001) in an effort to demonstrate the importance of spirituality as a “core element that affects people’s beliefs about themselves and others, their values and practices, and their understanding of their lives” (Ellis, 2005, p. 9). Indeed, the integration of spiritual and psychological growth has been shown to be a powerful transformative path to understanding the meaning and purpose of life. Yalom (2008) addresses the universal fear of death and urges the recognition that life is finite and that a deeply spiritual and meaningful life cannot develop without compassion for oneself and for others.

Spirituality as a factor in coping with symptoms of mental illness was investigated by Bellamy et al (2007). Their findings indicated two-thirds of the participants (N = 1835) reported spirituality was important in their lives, 62% engaged in public spiritual activities (church attendance, bible study groups), and 26% engaged in private activities (prayer, reading the Scriptures, and meditation). The authors concluded aspects of spirituality and religiosity, such as reciprocity (mutual support, giving back), and social

support (sense of community, fellowship) contribute to the faith and hope essential for recovery and quality of life.

Marks (2005) discusses the three dimensions of religious experience (religious practices, spiritual beliefs, and faith community) within the three dimensions of health (biological, psychological, and social). Using this biopsychosocial model as a framework, Marks's review of the available research indicates a "predominantly positive relationship" between these dimensions including well being, physical health, mental health, and psychological coping (p. 183).

In another biopsychosocial model of recovery, Chattopadhyay (2005) presented a paper in India on the Indian concepts of mental health. Acknowledging the strong social "taboo" associated with mental illness among this cultural group, Chattopadhyay asserts the ancient themes related to spiritualism (traditional shamanism) are being transformed to modern, more acceptable concepts (neo-shamanism). He identifies the Hindu philosophy and practices of experiencing joy through the worship of Gods and Goddesses: "It releases one of stress due to complete submission of one's soul onto the feet of the God and then waiting for the next year with a lot of expectations to beget it as other shock-absorbing phenomena" (p. 15). Among the strategies within a biopsychosocial model of recovery suggested by Chattopadhyay, are training primary health care staff (doctors, nurses), throughout their undergraduate and postgraduate training, how to adopt and practice spiritual therapy to individuals; training of priests, pastors, and local leaders in assisting individuals and their families; establishing counseling programs in the temple, mosque, church, or monastery, and providing value-

related therapy, in that, the use of holy books would be balanced with the bio-psycho-social aspects of psychopathology and modern medical techniques. Along with medical attention, traditional methods, such as confession, prayer, protecting objects such as Amulets, and participating in religious practices are suggested.

Theoretical Bases for Spiritual Seeking as a Human Dimension

William James (1902) was one of the earliest to offer a scientific basis for the importance of individual sacred experiences. James established the first laboratory for experimental psychology in America and interviewed hundreds of individuals regarding their religious beliefs and experiences. For James, to understand the psychology of religion and heal the sick soul required one to “be willing to forget conventionalities, and dive below the smooth and lying official conversational surface” (James, 1902, p.109). James viewed religious-seeking as essential to psychological health, resulting in intellectual right-mindedness and the ability to discern truth (Pajares, 2002). Perhaps most significantly, as a professor of physiology at Harvard University, he “sounded a sober and penetrating defense of religious conviction,” at a time when no scientist had “entered more deeply or respectfully into the inner life of the faithful” (Loconte, 2003, p. 2). While James was a contemporary of Freud, he did not view psychological functioning as abstract theory only; in James’ view, the philosophical and religious beliefs that influence human experience deserved more prominence in the understanding of the psychology of human functioning (Lesser, 1999).

While James remained deeply spiritually all of his life, he was acutely aware of the challenge of spiritual and religious issues within psychological science. He

acknowledged that involvement in religious matters was not always beneficial. James notes the complex differences between the religion of "healthy-minded consciousness" versus the "sick soul" of morbid-mindedness including insecurity, perceptions of failure, pathological unhappiness, religious melancholy and the like (James, 1902, p. 96-117).

Jung (1933) viewed the nature and functioning of the human psyche as the struggle that exists for the self to emerge, to individuate, and integrate consciousness with unconsciousness. Jung states: "Science employs the term 'the unconscious,' thus admitting that it knows nothing about it, for it can know nothing about the substance of the psyche when the sole means of knowing anything is the psyche" (1961, p. 336). With extensive knowledge of mythology, religion, and philosophy, Jung proposes a psychology focused on the depth of unconscious experiences. His writings express the belief that the soul is of an "unimaginable complexity and diversity" (Jung, 1961, p. 399). Navigating the shadow (unconscious) "requires considerable moral effort" and this effort may result in self-knowledge, but only following "much painstaking work extended over a long period" (Jung, 1951, as cited in Singer, 1972, p. 165). Genuine spirituality becomes possible when the relationship between the conscious self and the unconscious forces of the personality are able to be integrated openly, according to Jung.

Jungian psychology has been characterized as an inherently spiritual discipline (Corbett & Stein, 2005). In this way, Jung maintained that even the psychopathology religiosity or spirituality may reveal in the individual, there is an element of the sacred to be found and to potentially be fully integrated into the individual's lived experience. As contemporary Jungian analysts Corbett and Stein assert, these numinous experiences can

readily be dismissed as defensive coping or the result of an overactive imagination by the therapist untrained in spiritual matters. For clinicians educated in the Jungian approach to spiritually-oriented psychotherapy, matters of the sacred are the most significant aspects of treatment.

As the turbulent and transformative 1960s approached, existential theories were gaining momentum. By 1970, Frankl (1959, 1969) had developed the theory that there is meaning in all experiences, even the most dehumanizing, and the growth of one's soul progresses through these events. He identified the human condition as a persistent neurotic anxiety he referred to as the "existential vacuum" or meaninglessness (Hodges, 2002). Frankl's personal experiences in the Nazi concentration camps coupled with his scientific training as a neurologist and psychiatrist, offered a significant contribution to psychological thought. In *Man's Search for Meaning*, Frankl (1959) articulated his observations that as prisoners were able to dwell in the "spiritual domain" they were somewhat insulated from the severe realities of their daily lives: "Spiritual life strengthened the prisoner, helped him adapt, and thereby improved his chances of survival" (p. 123). Frankl's scientific training and personal experiences reaffirmed his belief that finding meaning in the events of one's life is a primary motivational force.

The works of May (1950, 1953, 1956) and Tillich (1952, 1957) marked the emerging awareness of existential psychological thought in America. The notion of transcendence as a spiritual dimension is fundamental to these theorists (Hodges, 2002). While May (1953) wrote about the disintegration of modern man's sense of self and the subsequent abandonment of spiritual searching he nevertheless endorsed belief

in the power of love: "For every act of love and will – and in the long run they are both present in each genuine act – we mold ourselves and our world simultaneously. This is what it means to embrace the future" (May, 1969, p. 322). Existential theory invited the exploration of deeper spiritual issues in psychotherapy that had not previously been developed. The works of Yalom (1989, 2005, 2008) have been, and continue to be, invaluable guidance for counseling professionals interested in learning effective methods of assisting their clients explore the spiritual dimension of life.

The work of Rogers (1942, 1951, 1960) further legitimized the need to recognize and honor clients' spiritual leanings. He emphasized a therapeutic orientation which valued the deepest aspects of the individual, and as a result increasing self-acceptance became the motivation for change: "the urge (toward self-actualization) is evident in all organic and human life – to expand, extend, become autonomous, develop, mature…" (1960, p. 35). Rogers viewed consciousness to be "a richly varied society of impulses and feelings and thoughts, which prove to be very satisfactorily self-governing when not fearfully or authoritatively guarded" (p. 203). These views were in stark contrast to the Freudian notions that consciousness was the "watchman over a dangerous and unpredictable lot of impulses, of which few can be permitted to see the light of day" (Rogers, 1960, p. 203). Rogers contributed to the humanistic movement by increasing the credibility of existential concepts, such as living in the here and now, with accurate perception of individual experience. He emphasized the fully functioning individual is one who is able to demonstrate responsibility for experiential freedom which requires self-awareness and self-acceptance, both highly spiritual qualities.

In a paper Rogers presented to an APA convention in 1972, he identifies his concerns about "our very sick society… and the near fatal illnesses of our culture" (Rogers, 1980, p. 235). Rogers challenged psychology as a science and a profession to move forward by breaking down the scientific barriers that had long been outdated. In this, Rogers was referring to his belief that if psychology is to become a science useful to humanity it will need to

> become a science based on careful observation of inner cognitive processes… it will involve the exploration of inner, personal, emotionalized meanings… and be based upon understanding the phenomenological world of man [sic], as well as his external behavior and reactions (Rogers, 1980, p. 239).

These challenges remain relevant and unanswered. Rogers's assertion that as a profession, psychologists did not dare to investigate the mysterious, they preferred to rely on "a security blanket of observable behaviors only" (p. 257). Yet he was optimistic that future generations of psychologists would be unencumbered by outdated scientific traditions and explore the lawful reality not readily observable by our five senses and where there is an intermingling of past, present, and future (p. 256). According to Bergin (1980), this unobservable reality Rogers refers to are the "spiritual forces" which are potentially "at work in human behavior" (p. 96). In this radical approach to psychology, Rogers was able to open a pathway for spirituality to be considered in mainstream psychology during the early 1970s.

Similarly, Maslow (1948, 1968) asserted the hierarchy of need gratification motivates individuals toward self-actualization. The tendency toward becoming fully human was to Maslow the process of overcoming fears and developing a "superior perception of reality" (1968, p. 32). He discusses the core-religious experience as being

known historically as a "private, lonely, personal illumination, revelation, or ecstasy of some acutely sensitive prophet or seer"; these "peak-experiences" Maslow contends, were not extraordinary at all (Maslow, 1970, p. 19). Rather, what had previously been described in supernatural terms regarding religious experience, were to Maslow able to be examined in "all its facets and in all its meanings in a way that makes it (religion) a part of science rather than something outside and exclusive of it" (1970, p. 20). He asserts the knowledge gained in terms of self-validating insights and revelations during peak experiences are sufficient to alter the individual's perception of reality with such positive force that self-destructive behaviors may be prevented: "a single glimpse of heaven is enough to confirm its existence even if it is never experienced again. It is my strong suspicion that even one such experience might be able to prevent suicide… and perhaps many varieties of slow self-destruction…" (Maslow, 1970, p. 75).

According to Maslow (1970), the shifting of attention that takes place during peak experience result in an altered consciousness he terms "the falling of the veils" (p. 77) and he suggests this new perception empowers the individual and helps to reduce existential meaninglessness. The cognitive shifts that take place during the peak experience were, in Maslow's view, consciousness-expanding events leading to higher levels of reality, transcendence, and ultimately, self actualization.

Psychological Interventions That Disrupt Spiritual or Religious Functioning

As evidenced by past and current studies, an individual's spiritual and/or religious beliefs and practices contribute to positive psychological functioning. While it has been acknowledged that in some cases religion can disrupt healthy psychological functioning,

the negative aspects of religiosity are outweighed by the feelings of connection and comfort gained by attending to the spiritual. It should be noted however, there are interventions that can disrupt one's spiritual or religious functioning.

The misinterpretations of psychological symptoms are, according to transpersonal psychology, the result of an absence of the spiritual dimension (Cortright, 1997; Grof, 2000). Spiritual emergencies are profound psychological experiences that are potentially transformative. These spiritual events involve non-ordinary experiences that are frequently perceived as pathological but, according to Grof (2000), "if they are correctly understood and supported, these psycho-spiritual crises can result in emotional and psychosomatic healing, remarkable psychological changes, and consciousness evolution" (p.137). Mental health professionals who lack even the most basic understanding of nonordinary states of consciousness, or spiritual emergencies, are likely to misinterpret and misdiagnose these experiences as pathological. If Maslow (1971) was correct, we are all born with a longing for transcendent experiences, and this deserves clinical care.

Emergent Theoretical Bases of the Integration of Spirituality into Counseling

Overall, some of the most significant contributors to contemporary psychology have endorsed the importance of the spiritual experience to positive psychological functioning. Whether these experiences are referred to as numinous experiences (Jung, 1933), religious seeking (James, 1902), or peak experiences (Maslow, 1964), the emphasis is clearly related to the shift in consciousness that occurs when individuals encounter the unobservable reality which expands their previous understanding of themselves and their existence.

More recently psychologists and psychiatrists are able to incorporate the findings of modern physics into their arguments for the importance of attending to the spiritual aspects of human functioning. Miovic (2004) discusses the evidence for a neurophysiological model which explains mystical and spiritual experiences as consciousness that is now scientifically observable. Indeed, medical journals contain multiple empirically sound studies demonstrating the efficacy of spiritually-based interventions such as distant healing (Koopman & Blasband, 2002) and remote intercessory prayer on outcomes in patient care (Palmer, Katerndahl, & Morgan-Kidd, 2004), as well as evidence of correlated functional magnetic resonance imaging (fMRI) detailing signals between distant human brains (Achterberg et al., 2005). In addition, the medical evidence for mindfulness meditation as a healing force has been growing since the mid 1980s (Kabat-Zinn et al., 1985; Kabat-Zinn et al., 1992; Kabat-Zinn, 2005; Miller, Fletcher, and Kabat-Zinn, 1995).

Ellis et al. (2002) conducted a qualitative study using semistructured interviews of 13 family physicians regarding their comfort and practice of addressing spiritual issues with their patients. The results indicated that 6 of the participating physicians reported comfort in addressing spiritual issues with their patients on a regular basis. These participants cited their own spiritual development and the scientific evidence correlating spirituality with positive health outcomes as justification for their interventions. Barriers to spiritual assessment, by participants reporting they do not regularly address spiritual issues, were identified as lack of comfort or training, lack of spiritual awareness or inclination, and fear of inappropriately influencing patients.

Ellis (2002) asserts there is a scientific tunnel vision at work that is hindering the advancement of spiritual health research. As a physician, he identifies and disagrees with, the attitudes within his profession and common within all scientific communities that "what we cannot measure, we cannot know, and therefore is unworthy of our observation…" (Ellis, 2002, p.259). However, religion and spirituality are proving to be clinically relevant both in medicine and in mental health (Koenig, McCollough, & Larson, 2001; Larson, 2003; Plante & Sherman, 2001). As modern medicine contends with the emerging scientific evidence for their own paradigm shift related to spirituality, the profession has been responding by implementing curriculum to educate medical students with courses addressing spirituality and religion in an effort to reduce the perceived barriers (Larson, Lu, & Swyers, 1996; McCarthy & Peteet, 2003; Puchalski, Larson, & Lu, 2000).

A review of the literature related to the theoretical basis for spiritual seeking as a human dimension leads to the following conclusions: (a) many of the major contributors within psychological theory have advanced beliefs related to the importance of spiritual experience in positive mental health, (b) the development of existential and transpersonal psychological theories have contributed broader acceptance of spiritual emergence as a clinical concern, (c) neurophysiological studies have demonstrated the scientific evidence for mystical and spiritual experiences that commonly occur within human functioning, and (d) medical training programs have recognized the need to include curriculum addressing the spiritual and religious needs of patients when addressing physical presentations. As Grof (2000) claimed, "more and more people seem to realize that

genuine spirituality based on profound personal experience is a vitally important dimension of life" (p. 138). Indeed, and as this dimension is acknowledged, awareness of how the various stages of spiritual development proceeds becomes crucial.

Theories of Spiritual Identity and Development

A significant aspect of building awareness of the need for spiritual and religious diversity curriculum in counselor education programs, is the acknowledgement of how spiritual development proceeds. Developmental theorists emphasize clear stages of cognitive processes and subsequent capacities for interpretation and behavior within a given environment. Among the many theoretical models of human personality and development, Jung's (1933) psychodynamic theory, Maslow's (1968) hierarchy of needs, and Rogers's (1961) growth motivation are perhaps the most congruent with contemporary spirituality development theories. Erikson (1959) and Kohlberg (1981) also contribute to the model of spiritual development briefly proposed here. These well established theories will be synthesized with more contemporary works including Fowler's (1981, 1996) theory of faith development and Wilber's (2000, 2006) integral spirituality model.

Spiritual experiences are among the most transformative events human beings can know. Spiritual development involves intrapersonal integration which Tan (1996) defined as "a person's own appropriation of faith and integration of psychological and spiritual experience" (p. 377). Tan notes the spiritual development of the therapist is seen as a crucial component for effective integration. Hamman (2001) suggests therapists consciously, or perhaps unconsciously, enter into the therapeutic profession in an effort to

heal their own wounds and to develop, through spiritual seeking, a sense of "wholeness, health, and holiness" (p. 343). Understanding the process by which individuals, including therapists, develop the capacities for spiritual growth is paramount to ethical treatment (Myers, Mobley, & Booth, 2003; Plante, 2007; Shimabukuro, Daniels, & d'Andre, 1999).

Addressing a client's spiritual and religious concerns requires not only self awareness and knowledge of diversity issues on the part of the clinician; it also requires an accurate assessment of what level of spiritual development the client has been able to achieve (Miller, 2003). There is ample evidence in the literature for the appropriate assessment of spiritual and religious views of clients as proficiency in assessment reduces the tendency to misdiagnose individuals (Miller & Thoresen, 2003; Richards & Bergin, 1997; Walker et al, 2004). Knowledge of spiritual or faith development is indicated to facilitate a variety of treatment issues including loss, depression, anxiety, and recovery from addictions (Miller, 1999).

The previous review of the approaches of Jung, Rogers, and Maslow demonstrated the emphasis each of these theorists placed on the importance of spiritual growth and development. Each articulated his belief that the process of integrating the unconscious materials of soul into the lived experience of conscious existence involves effort. For Jung, it is painstaking and extensive; Rogers's soul work could be spontaneous if fear and external controls are minimized; and Maslow's peak experiences could result in advances of soul work that could otherwise take years. In all of these psychologies, the common factor is that without the recognition of the stages of development, stagnation would occur and enlightened consciousness, or transcendence, would remain elusive.

Jung's view of spiritual development involved the individualization of the self. This concept runs throughout Jungian theory and is one of his basic concepts: The process of becoming whole is the "conscious realization and integration of all the possibilities contained within the individual" (Singer, 1972, p. 134). In *The Undiscovered Self*, Jung (1957) articulates his beliefs that only when the individual is willing to accept the conflicts and the demands of "rigorous self-examination and self-knowledge" will he or she make progress toward his or her unconscious the "only accessible source of religious experience" (p. 89). For Jung, it is the exploration of our own souls together with the integration of lived experience that leads to higher levels of spiritual development.

Similarly, Humanistic approaches to spiritual development involve rigorous self-examination and the integration of lived experiences; Rogers's (1961) and Maslow's (1968, 1964, 1971) self-actualization theories stress transcendence as the mechanism for spiritual change and promote here-and-now peak experiences. These experiences, if correctly interpreted, lead to progress in spiritual development. Benjamin and Looby (1998) discuss the nature of spirituality in the context of Rogers's and Maslow's theories. Claiming there is a potential for a spiritual awakening when the counseling professional is able to recognize the divine in their clients, Benjamin and Looby asserted

> The most powerful component in counseling one human being helping another – is the spiritual connections between counselor and client. This then is the essence of the spiritual awakening, which follows when the counselor sees in the client the reflection of God or a Higher Power, and in turn the client experiences and acknowledges the same spiritual feature in the counselor. No longer is the counselor on a pedestal but made of the same clay, sharing the same spirit, and reflecting the same light (p. 99).

Benjamin and Looby hypothesize the client's spiritual journey can begin with this awakening if the counseling professional is able to conceptualize spirituality as "universal in nature and as manifesting many different and conflicting forms (p. 99).

Spiritual transformation is achieved in the context of Rogers's and Maslow's self-actualization theories through transcendence, a quality characterized by a natural tendency or the development of synergy or cooperative action (Maslow, 1971). It is the role of the counselor to "help (the) client to unfold, to break through the defenses against his own self-knowledge, to recover him or herself, and get to know him or her self" (Maslow, 1971, p. 50). This is the essence of spiritual development from the Humanistic perspective.

Erikson's (1950, 1959, 1968) psychosocial theory of human lifespan development is an important one to consider in any review of spirituality development theories. Kiesling et al. (2006) propose a definition of spiritual identity based on Erikson's assertion; in general, a sense of identity develops through the individual's interaction with his or her social experiences and the "persistent sameness" of the individual's characteristics (Erikson, 1950, p. 109). According to Kiesling et al, spiritual identity is forged in much the same way, in that there develops a "persistent sense of self that addresses ultimate questions about the nature, purpose, and meaning of life, resulting in behaviors that are consonant with the individual's core values (p. 1269). Erikson (1963) proposed individuals are able to continually revise and transform their experiences, integrate them and, if there is sufficient freedom, will "adapt to the triumphs and disappointments inherent to being" (p. 268). In this explanation, spiritual

development proceeds through the chronological progression of stages through crisis, doubt, within the specific cultural contexts, and among the ongoing experiences of the individual.

Wink and Dillon (2002) examined spiritual development across the lifespan with participants aged early 30s through mid-70s. Their findings indicate spirituality increased significantly during the second half of life. Changes in spirituality across the course of adulthood were varied based on gender and cohort. In addition, the experience of negative life events in early adulthood was a powerful predictor of a turning toward spiritual interests and practices in later life and early religious involvement tends to predispose individuals toward spiritual seeking. Wink and Dillon suggest the experience of adversity facilitated spiritual development in their sample. The ability to transform loss, pain, and disappointment into personal growth and spiritual awareness indicate a quality these researchers refer to as cognitive commitment:

> The fact that spiritual development tends to occur in individuals who are psychologically minded, invested in the world of ideas, and who tend to experience adversity in their lives raises the issue of the relation between spiritual development, wisdom, and postformal stages of cognitive development, because all of these constructs have been associated with similar personal life event antecedents and characteristics associated with the development of wisdom (p. 93).

The midlife transcendence evident in the findings of this research suggests spiritual development is enhanced by adversity as well as cognitive readiness.

Ingersoll (1998) surveyed 12 participants representing 11 different spiritual traditions in an effort to examine how individuals experience spirituality and various dimensions of spiritual wellness (conception of the absolute or divine, meaning,

connectedness, mystery, sense of freedom, experience-ritual, forgiveness, hope, knowledge-learning, and present-centeredness). The findings suggest there are universals in the spiritual experience and a transcendence of particular religious creeds. Ingersoll asserts the spiritual dimensions are helpful when working with clients who have had negative religious experiences and can help clients acknowledge their spirituality.

Fowler (1981) articulates the stages of faith development in his psychology of human development model. Through his research with hundreds of subjects, Fowler described an overview of six distinct stages an individual may experience during the course of spiritual identity development.

The first stage occurs approximately between the ages of 3 to 7 years and is known as the intuitive-projective faith stage. This stage is fantasy-filled and children can be affected by the beliefs and values of the adults they closely relate to.

The second stage, known as mythic-literal faith stage, occurs from age 7 to adult. This stage is marked by the emergence of story, drama, and myth as a means of finding meaning. People internalize the beliefs of those around them in a literal manner.

The third stage, the synthetic-conventional stage, begins to occur during adolescence through adulthood, but many adults do not proceed through it and the stage becomes permanent. Interpersonal faith provides a basis for identity, but emphasis is given to the values and beliefs of those in authority or significant others.

The fourth stage, the individuative-reflective stage, typically begins to occur in young adulthood, but Fowler (1981) qualifies that many do not advance to this stage, or only partially obtain it. It is a stage marked by a critical awareness of the beliefs,

values, symbols, and meanings adopted from one's childhood and social class. A new identity emerges that is differentiated from others, demythologized, and more complex.

The fifth stage, the conjunctive faith stage, is characterized by the striving to integrate one's past with the emerging deeper self. Persons in this stage are aware of paradox and distortion while exerting one's self according to their beliefs.

The sixth and final stage of spiritual development is referred to as the universalizing faith stage. Fowler (1981) notes the universalizing stage of development is exceedingly rare. Persons who have embodied this stage of development include Gandhi, Mother Teresa, Martin Luther King, Jr., and Thomas Merton. These individuals hope to transform the world through love and are often viewed as subversive to the very structures they hope to change presumably because of their unwavering integrity. There is no specific religious faith associated with this level of spiritual development.

Faith development theory, according to Fowler (1996), is a functionalist approach to understanding behavior: "The functionalism of faith development theory is much more related to individual's ways of construing and interpreting experience than it is to the energy and motivation for action they engender" (p. 179). In addition to the faith stages, Fowler defines what he considers the conversion process, which can occur during any of the various faith stages. Conversions can occur that do not lead to a change of faith stage, but a change in the content of one's faith. Other conversions can precipitate a faith stage change and may result in a reworking of commitments and lifestyle.

Integrating Fowler's stages of faith development into counselor preparation programs would not only provide clinicians with a more comprehensive educational

experience as it relates to counseling, but would also provide a framework for a deeper exploration of their own spirituality and faith development. Erwin (2001) argues for more counselor education regarding issues of spirituality and suggests the integration of Fowler's stages of faith into counseling programs. As a means of complementing counseling student's professional development, Erwin applies Fowler's stages to counseling supervision. Erwin maintains that a closer examination of personal spiritual development would encourage a deeper awareness and heightened sensitivity to the spiritual experiences of their clients, and would provide a means of helping clients develop coping skills, meditation and prayer practices, and for making meaning in their lives.

Cartwright (2001) provides a review of cognitive developmental theory and spiritual development. The sequence of spiritual understanding may be affected by the individual's level of cognition, and asserting cognitive development is not "domain-general" (p. 213). Cartwright maintains neo-Piagetian and postformal theories suggest higher levels of cognitive development depend upon individual experience over the course of the lifespan. Cartwright presents Fowler's comprehensive lifespan perspective on spiritual development and notes one of the formal mechanisms for spiritual change in adulthood, according to Fowler (1981), is conflict:

> When individuals are faced with circumstances that are not consistent with their current conception of the world, they must look beyond their own constructions of reality to 'make sense' of the available information (p. 217).

Cartwright reasons that the ability to consider alternative views is more likely when unconstrained by a culturally transmitted framework and when the individual is able to

operate at the postformal level of cognitive development. At this level, abstract principles are understood as unifying forces "in the vast connectedness between self, others, and a Higher Power" (p. 218).

Thus far, this review has encompassed theories that are frequently cited in the spirituality and counselor education literature. The works of Jung, Rogers, Maslow, and Fowler are traditional in any review of spiritual development and identity. However, the works of Wilber and Grof are less common in this literature and less frequently suggested for integration into counselor education programs. Grof (1996, 2000) asserts that the doorway to spiritual and transpersonal experiences is associated with the reliving of biological birth. Wilber (1996, 2000, 2006), prolific in his explanations of stages of spiritual development, offers a blending of psychological theories of personality and spiritual development.

One of the key concepts in understanding Grof's (2000) psychology is that human consciousness is not limited to the confines of the materialistic worldview of Western science. Grof's clinical observations, with thousands of subjects, resulted in his certainty that "human consciousness is a part of, and participates in, the larger universal field of cosmic consciousness that permeates all of existence" (p. xi). As such, the process of psychotherapy is at once excruciatingly difficult and liberating. The advanced therapist is knowledgeable about the various states of consciousness, spiritual emergencies, and the crisis of transformation. Grof (1996) discusses his theory of consciousness evolution and the distinction between mystical states (temporary experiences) and various psychotic states (associated with more permanent structures):

> It is important to take into consideration the overall context, the person's experiential style, and his or her ability to integrate the experiences into everyday life. In addition, the belief system of the surrounding culture and of the professionals treating the individuals involved should not be underestimated as factors that play a paramount role in shaping the nature of this process and its outcome (p. 20).

Grof argues the recognition of these differences is crucial in providing effective therapy.

Among Grof's many controversial assertions is his belief that the path to spiritual development and consciousness evolution is to be understood through holotropic states of consciousness. According to this view, consciousness develops on a continuum, a continuous range or states of being. Through these holotropic states, individuals can being to experience what Jung (1933) referred to as the collective unconscious, a domain inclusive of mythological figures (see also Campbell, 1949) which can provide deep insights leading to transformation and transcendence. The exploration of these states and stages of spiritual development is, according to Grof, not merely advantageous, but critical for survival of mankind (Grof, 2000). He maintains psychotherapists must recognize the basic tenet of holotropic therapy: "symptoms of emotional and psychosomatic disorders represent an attempt of the organism to free itself from old traumatic imprints, heal itself, and simplify its functioning" (p. 179).

Certainly requiring counseling students to gain a basic level of familiarity with the theories of Grof and other transpersonal psychologies would promote the possibility of a "deep emotional and spiritual transformation of humanity," that in Grof's view, we must achieve if we are to reach the level of consciousness evolutionarily necessary for our survival. Such training would not only develop skills and techniques for validating client

spiritual experiences, but would, according to Grof, help to develop in the client and clinician alike a "new appreciation for existence and reverence for all life" (2000, p. 318).

Similarly, Wilber (2000) maintains the process of spiritual development involves the ability to integrate states of consciousness. While the structures of these various states are highly complex in Wilber's model, the four basic areas, or quadrants of consciousness, include the inner, outer, the collective, and the individual. Wilber also subscribes to the transpersonal view that consciousness is a continuum, a continuous whole and individuals proceed through such stages as egocentric, ethnocentric, and worldcentric (p. 6). Wilber borrows from Kohlberg's (1981) moral development, Piaget and Inhelder's (1966) cognitive development, and Maslow's (1968, 1971) hierarchy of needs development for his typology. His perspective is unique in that it unifies these various theories and offers a comprehensive psychology in which to integrate the self.

Wilber's focus on developmental stage conceptions combine the ideas contained in Eastern religions, Western science, and Jungian individuation. Bidwell (1999) outlines Wilber's transpersonal psychology and suggests his contribution is significant for its blending of ancient religious traditions and contemporary psychologies. Bidwell also notes the integrative approach Wilber (2000) brings to the understanding of pathology is particularly useful as it frames the developmental stages of the self, or the "general self-sense" (p. 91) as moving through clear fulcrums or levels of differentiation-and-integration processes (p. 93). The various *types* of pathologies, such as phobias, anxiety, and depression can be addressed through psychological and spiritual therapies based on Wilber's model which help to identify the various *levels* of pathology, such as neurotic,

borderline, and psychotic disorders. In simpler terms, Wilber states that

> each level of self development has different types of defenses. The self, at every level, will attempt to defend itself against pain, disruption, and ultimately death, and it will do so using whatever tools are present at that level (p. 94).

The goal of human life, according to Wilber, is spiritual growth or the process of moving through levels of consciousness, ultimately to transcendence. Bidwell's review of Wilber's model includes the therapeutic approaches that have been successful in addressing the process of uncovering and reintegration the self or ego. These therapies include classic psychoanalysis, Gestalt psychology, Jungian therapy, and self psychology.

Rowan (2007) provides a discussion related to psychospiritual development and identifies ways of merging Wilber's ideas into the frameworks of humanistic theory. Rowan notes Wilber's work extends Maslow's hierarchy of needs theory and suggests the triangle or pyramid traditionally used to represent Maslow's model is insufficient. Rowan asserts self-actualization is not the final stage of development and provides examples in Wilber's articulation of what lies beyond Maslow's model. For instance, the self-actualization stage is renamed by Wilber and others (see Wade, 1996) as the Centaur or Authentic level and beyond that is the Subtle stage, where we gain access to the Divine through symbols and images as suggested by previous human consciousness experts such as Assagioli (1975), Campbell, (1959, 1990), Hillman, (1997), Jung (1964), and May (1991). Developing next is the Causal stage where the use of symbols are no longer necessary and we reach the region of mysticism that Buddhists refer to as *Dharmakaya* (Rowan, 2007). Beyond this level there is disagreement with Wilber's stages among humanistic theorists, including Rowan: "the whole idea of a set of levels becomes

ridiculous or at least unnecessary" (p. 74).

Wilber has been referred to as a "kind of mad classifier" (Handler, 2007), and indeed, a review of his works reveal countless stages and levels of human consciousness and spiritual development that will not be reviewed here. However, the significance of his contribution in the understanding of human consciousness and the psychopathology associated with the developmental spectrum has been gaining academic notice (Bidwell, 1999; Hunt, 2007; Marquis & Wilber, 2007; Mitroff, 2003; Rowan, 2007).

As regards developing a curriculum that would provide an overview of Wilber's theory, Holden (2004) has provided a concise summary of Integral Psychology (IT) based on Wilber's works. Identifying herself as a spiritually-based psychotherapist, Holden describes in detail from an IT perspective how the psyche develops and changes, and how IT is based in a spectrum of spiritual unfolding which is relevant for our times as it is both developmental and multicultural. Holden's presentation includes how the counseling process would proceed in an IT model and notes various exceptions she makes to the IT model such as the diversity generated by genetically based propensities as a factor in the development of the psyche. She concurs with Wilber that the psyche unfolds in an unpredictable manner and that other factors, including the powerful influences of the natural and social environment are complexities involved in pathology, health, and wellness.

Hunt (2007) states "any directly experiential search for spiritual realization should not be undertaken lightly" (p. 227). Indeed, the altered states and developmental stages of consciousness that can result from spiritual searching must be recognized and

acknowledged by mental health professionals. For many consciousness researchers, it is inconceivable that this area of study is not included in training of psychotherapists and that it remains on the periphery of modern psychology (Fontana, 2003; Grof, 2000; Myers, 2003; Shafranske, 1996; Wilber, 2000, 2006).

The Importance of Integrating Spiritual and Religious Diversity into the Mental Health Professional, Education, and Supervision Process

The importance of integrating religious and spiritual values into the mental health professional education process began to gain attention in the early 1980s (Cashwell, Bentley, & Yarborough, 2007; Cashwell & Young, 2004; Kelly, 1994; Miller & Thoresen, 2003; Pate & High, 1995). Bergin (1980) warned the alienation of these values within the instruction and practice of counseling psychology would hinder the effectiveness of the profession. Far earlier, Jung (1938) cautioned that overlooking spirituality and religion within the counseling experience neglects what closely touches the human soul.

A paradigm shift has been developing over the past 20 years that recognizes the importance of integrating spirituality and religion into the therapeutic process (Benner, 2002; Burke et al. 1999; Chandler & Holden, 1992; Cox, Cox-Ervin, & Hoffman, 2005; Fukuyama & Sevig, 1997; Griffith & Griffith, 2002; Hall, Dixon, & Mauzey, 2004; Hill & Pargament, 2003; Kelly, 1994, 1995; Koenig, McCollough, & Larson, 2001; Koenig, 2005; Larson, 2003; Miller, 1999; Miller & Thorensen, 2003; Richards & Bergin, 2000; 2004; West, 2007; Zinnbauer & Pargament, 2000; Zinnbauer et al., 1997). However, there has been limited research on the need for inclusion of spirituality and religion in the

educational process of clinical counselors (Briggs & Rayle, 2005; Burke et al. 1999; Cashwell & Young, 2004; Fukuyama & Sevig, 1997; Hage, 2006; Hage, Hopson, Siegel, 2006; Hall, Dixon, Mauzey, 2004; Kelly, 1994; Pate & High, 1995) and even fewer studies examining spirituality as an important factor in counseling supervision (Berkel, Constantine, & Olson, 2007; Bishop, Avila-Jaurbe, & Efrain, 2003; Polanski, 2003).

In 1996, the APA published its first book on spirituality and religion, *Religion and the Clinical Practice of Psychology*, edited by Edward P. Shafranske. The text covered topics including the historical perspectives of the relationship between religion and psychology and the impact religion has on a variety of coping issues including prosocial behaviors, depression, and addictions. Shafranske and his colleagues provide extensive evidence for the inclusion of spirituality and religion in the education, supervision, and clinical practice of psychotherapy throughout the text. There were a number of significant texts preceding the Shafranske volume (See Allport, 1957; London, 1964; Lovinger, 1984), and literally hundreds of texts addressing spiritual and religious issues in counseling thereafter. However, this is the first APA-approved text on spirituality and religion reflecting the changing attitudes within the field of psychology.

Marks (2006) provides an overview of how spirituality and religion has emerged as one of the most critical issues facing contemporary psychology. For instance, the Diagnostic Statistical Manual of Mental Disorders (DSM-III, 1980) contained several "malignant references to religiosity and religious belief" that were subsequently eliminated in the DSM-IV (1994), due to the emerging body of empirical data refuting the previous anti-religious positions (Marks, 2006, p.135). In his review, Marks identifies

three books subsequent to the Shafranske text that contributed to major changes in the field of psychology. The first is Pargament's (1997) *The Psychology of Religion and Coping,* which provided a balanced presentation of over 200 studies, identifying both the beneficial and the negative aspects of religious framing. Koenig's (1998) edited *Handbook of Religion and Mental Health,* was a thorough examination of the impact spirituality and religion had on a variety of mental health illnesses including depression and anxiety as well as personality and psychotic disorders. The third text, entitled *Handbook of Religion and Health,* was edited by Koenig, McCullough, and Larson (2001). This 700+ page volume is the most widely cited text in the psychology of spirituality and religion literature. It reviews over 1200 studies, of which some 80% link spirituality and religion to positive well-being.

In addition to the increasing number of volumes addressing spirituality, religion, and mental health over the past two decades, there has been an explosion of mainstream and peer-reviewed journal articles reporting on the association between spiritual and religious beliefs and improved physical and mental health (Weaver et al., 2006). This upward trend in empirical studies investigating the role spirituality and religion plays in contemporary psychology would suggest incontrovertible evidence for the need to integrating these issues into counselor education, supervision, and treatment.

Support for inclusion of spirituality and religion in the educational process of clinical counselors can be found in multiple studies. Beginning with the earliest and progressing through to the most current surveys, the following literature review tracks the progression of activity taken by the primary spirituality and religion researchers in their

efforts to investigate and demonstrate the need for including these topics into the training programs of the mental health professional.

Bergin and Jensen (1990) conducted a national survey of 425 mental health professionals including clinical psychologists, psychiatrists, clinical social workers, and marriage and family therapists to determine the religiosity of psychotherapists in America. The findings indicated a discrepancy between the participants reporting of their personal versus professional attitudes toward religion. While 46% of the participants agreed with the statement "My whole approach to life is based on religion," only 29% expressed the belief that religious issues were relevant in treatment. Bergin (1991) subsequently discussed the influence of counselor values in treatment and made recommendations for including education in values and religious issues to promote the adequate training of clinicians "so that the vast population of religious clientele may be better served" (p. 394). Bergin (1980) had argued in an earlier publication that the changing views among mental health professionals were evident in the developing zeitgeist:

> The emergence of studies of consciousness and cognition, which grew out of disillusionment with mechanistic behaviorism and the growth of humanistic psychology, has set the stage for a new examination of the possibility that presently unobservable realities – namely, spiritual forces – are at work in human behavior (p. 96).

The foundations of our present progress toward including spiritual and religious diversity in training programs can be located in the early essays of Bergin (1980) and Shafranske (1984). Much of these first discussions were focused on religious values and concerns associated with the tendency for clinicians to identify religious or spiritual issues, not as a

cultural and developmental process, but as some variation of pathology. Bergin's (1983) meta-analysis of 24 studies related to religion and psychotherapy throughout the 1960s and 1970s resulted in ambiguities due to poorly defined methods of measuring religiosity and inadequate specification of concepts of religious variables. The analysis demonstrated that improving clinical education, practice, and research would yield better evidence of the diverse factors associated with religiosity.

The research of Pate and Bondi (1992) was among the earliest to offer recommendations for counselor education programs based on the review of the available literature of the time. Religious and spiritual beliefs had been established in the literature as a valid aspect of counseling psychology during the 1980s. The avenue the movement began to take was the approach of multicultural awareness during the late 1980s and early 1990s. In 1988, both the ACA and CACREP included language in their ethical standards to include the importance of cultural diversity in the training and work of mental health professionals (ACA, 1988; CACREP, 1988). Pate and Bondi presented evidence for the importance of expanding the training programs to include the issues related to spiritual and religious cultural diversity of the client and the clinician. In addition, the authors suggested specific interventions that would reduce the potentially negative impact of unexamined religious beliefs and values of the clinician.

Kelly (1994) presents evidence for the role of religion and spirituality within counselor education programs, citing heavily the research of Bergin and Shafranske. Kelly's study surveyed the opinions of 525 counselor education program directors about spirituality and religion. Of the 343 overall responses, 287 indicated there were no

courses addressing spirituality and religion. Attention to clients' (*N* = 177) and supervisee's (*N* = 171) spiritual and/or religious issues were also rare. Fewer than 50% of the respondents reported spiritual and/or religious issues to be very important or important in the preparation of counselors. Kelly also demonstrated that most state-affiliated programs provided little or no attention to spiritual and/or religious issues, raising questions associated with the ethical, philosophical, and legal concerns in these programs.

Pate and High (1995) investigated CACREP programs regarding the importance of client religious beliefs and practices in the education of counselors. At the time, there were 72 counselor education programs holding accreditation and 60 programs responded to the survey. The Pate and High study was a near replication of Kelly's (1994) study. Of the responding programs, only 16% reported spiritual and/or religious issues were of more than some importance; 60% indicated these issues were addressed under the Social and Cultural Foundations component of their curriculum; and of the 45 respondents who indicated their training included formal assessment training, only 33% indicated part of the intake assessment addressed a client's spiritual and/or religious beliefs and practices. Overall, the Pate and High findings contributed to the growing concern that students graduating from accredited counseling programs lack the most basic skills in assessing their client's spiritual and/or religious needs.

Kelly (1997) provided a comment on and extension of the Pate and High (1995) study. Kelly compared four different accreditation programs: CACREP-accredited programs, APA-accredited programs, Council on Rehabilitation Education (CORE)

programs, and American Association for Marriage and Family Therapy Education (AAMFT) programs. The findings suggested that curricular consideration of spiritual and/or religious issues were lowest in CORE (*n* = 26) respondents and highest in AAMFT (*n* = 15) respondents. CACREP (*n* = 42) respondents were slightly higher than APA (*n* = 28) program respondents and overall, Kelly concluded the study demonstrated "a continuing need to achieve appropriate inclusion of this important aspect of life in counselor training" (Kelly, 1997, p. 9).

Burke et al. (1999) reviewed the survey data from the general population, clinicians, and accredited program counselor educators, concluding the inclusion of spiritual and religious topics in the core curriculum areas would be the "reasonable and sound approach to preparing counselors to work ethically and effectively with these issues in secular counseling settings" (p. 251). The Burke et al. review asserts a cautionary note that the evidence of previous studies demonstrating that fewer than half of the accredited programs were giving spirituality and religion adequate attention suggests a failed recognition on the part of accreditation organizations to recognize "worldview and experience" of clients (p.252). The authors include a discussion of the ethical implications of neglecting this dimension of human functioning and conclude the competent counselor is "self-aware of his or her own spiritual/religious values and sensitive to their operation in the counseling session" and failing to recognize these is more likely to create the proselytizing effect that so many fear (Burke et al., 1999, p. 256).

As regards the supervision of counseling students related to religious and

spiritual diversity, most of the current research focuses on the multicultural competence standards of CACREP. In a review by Berkel, Constantine, and Olson (2007), it is acknowledged that religion and spirituality are left out of most education programs and faculty members who function as clinical supervisors frequently have little or no formal training in the integration of spiritual and religious diversity (see also Young et al., 2002). Continuing education is recognized as necessary for supervisors and faculty members.

Bishop, Avila-Juarbe, and Thumme (2003) reviewed the counseling supervision literature for information on spirituality and noted one of the largest volumes on clinical supervision published to that point, a 354 page textbook by Bernard and Goodyear (1998), only devoted three paragraphs to the topic of spirituality. In addition, citing Souza (1999), there were fewer publications on spirituality in counselor education than there were in other disciplines such as psychology, social work, teacher education, and nursing.

Miller (1999) points out that both the American Medical Association and the APA have requirements regarding the preparation of students attending accredited training programs in psychology and psychiatry, to develop the ability to work in a knowledgeable and ethical manner with people whose spiritual and religious backgrounds vary widely. However, Miller laments the lack of faculty capable of role modeling such integration within clinical training programs and asserts the following:

> As a group, mental health professionals in general, and psychologists in particular, tend to report low levels of religious belief and involvement relative to the U.S. population. The historical reasons for this are unclear, but this underrepresentation serves to pass on a deficit in sensitivity from generation to generation of psychotherapists. This is one reason why religious laity and professionals have been sometimes wary of referring

to mental health professionals (pp.254).

According to Miller, this trend is being interrupted by the growing number of transpersonal, existential, and pastoral counseling psychology practitioners. However, what Miller refers to as the "mainstream scientist-practitioner," remains dominant, despite the ever growing scholarship and resources available (p. 254). Miller recommends the training and supervision of future therapists include competency preparation to address spiritual and religious issues with their clients.

Polanski (2003) identifies supervision as a significant teaching and learning opportunity for the integration of spiritual and religious diversity. As an important part of professional development, the process of examining personal values and the potential influence of those values cannot be understated. Polanski recommends the use of questions and reflections designed to encourage the exploration of spiritual and religious beliefs, the role spirituality plays in one's life, and to facilitate the reconstruction of emerging realities related to the meaning and purpose of religion/spirituality. The use of words and images that are consistent with the belief system of the client is also recommended. Polanski also discusses the various means of teaching skills associated with helping clients deepen their heart connection and exercise compassion and loving-kindness toward themselves and others. Finally, Polanski recommends supervisors teach Fowler's (1981, 1996) model of faith development to acknowledge the influences such as biological, emotional, and cognitive development, as well as psychosocial experiences and cultural influences. It is acknowledged supervisors play a vital role in the professional development of their supervisees and with proper preparation, the readiness

for addressing these important issues may lead to more positive client outcomes.

Falender and Shafranske (2007) emphasize that professional ethics require psychologists to be competent and responsible in the performance of their duties. They provide a model for competency-based supervision, outlining 12 recommendations establishing behavioral expectations and performance standards to promote skill acquisition, as well as supervisor self-assessment. The model concerns itself with the advancement of character factors, such as integrity, clinician perseverance, strength of conviction, and courage, all of which suggest becoming an ethical professional involves much more than "following a set of rules" (p. 236). In providing clinical training, it is critical for supervisors to model unbiased, adequate, and appropriate practices in all competency areas, including spiritual and religious diversity.

Aten and Hernandez (2004) argue that despite an increase in interest and acceptance regarding the recognition of clients' religious and spiritual systems and beliefs among psychologists and the APA, "it still appears that very few psychologists receive the proper training and supervision necessary to competently address religion in therapy" (p. 153). Presenting a model to encourage supervisor actions that would promote supervisee competencies in addressing the spiritual and religious needs of their clients, Aten and Hernandez identify eight domains as guidelines for improving supervision in this regard. They, too note the need for formal curriculum and continuing education to advance the field:

> By incorporating readings, lectures, and discussions on religion and supervision into course curricula, educators can have a direct impact on the next generation of supervisors. Professional organizations can also increase awareness and education in this

> area by sponsoring preconference workshops and conference presentations on religion and supervision (2004, p. 159).

More research is needed to better understand mental health professional's perspectives of spirituality. The effects of spirituality and religion on professional beliefs, values, and judgments can be addressed in clinical supervision, providing the training and preparation is adequate.

Review of Interventions for Counseling Educators

The counseling profession is moving toward spiritual and religious competency (Richards & Bergin, 2000), and recent national surveys are revealing the majority of responding counselors endorse the effort to achieve a spiritual and religious competency throughout the CACREP core areas (Young et al., 2002). The current accreditation standards (CACREP, 2001) provide the following eight common core curricular areas as the minimal criteria for the preparation of professional counselors:

a. Professional Identity
b. Social and Cultural Diversity
c. Human Growth and Development
d. Career Development
e. Helping Relationships
f. Group Work
g. Assessment
h. Research and Program Evaluation

The advancements reflected in the 2001 CACREP standards which required increased attention to an individual's spiritual and religious features under Section B, Social and Cultural Diversity area of study, is due in part to the research and persistence of Bergin (1980, 1983, 1991); Burke and Miranti, (1992); Kelly (1994, 1995, 1997) and others (Fukuyama & Sevig, 1997, 1999; Ingersoll, 1997, 1998; Pate & High, 1995; Richards &

Bergin (2000, 2004); Shafranske, 1996; Shafranske & Malony, 1990, 1996; Young, et al., 2002, 2007). To some extent, CACREP's acknowledgement of this need has encouraged the integration of graduate courses in spirituality and religion into counseling programs, not only in the United States (Burke et al., 1999; Cashwell & Young, 2005; Frame, 2003; Fukuyama & Sevig, 1997; Miller, 2003), but also in Canada (Leseho, 2007), Hong Kong (Coe, 2007) and the United Kingdom (Heelas & Woodhead, 2005).

Burke et al. (1999) present a comprehensive proposal for including topics addressing spirituality and religion in all eight CACREP common-core areas of study. Significant to the Burke et al. study are the five major assumptions which underlie their thesis:

(a) The distinction between spirituality and religion
(b) Spirituality and religion have diverse meanings and expressions
(c) Spirituality and religion have multiple negative as well as positive effects
(d) Effective inclusion of spirituality and religion builds counselor educators' self-awareness
(e) When approached ethically, spirituality and religion are legitimate topics (p. 252).

Accreditation standards, in the view of Burke et al., are insufficient at attending to these issues at present. The authors stress the importance of advancing counselor education to include a formal curriculum of spiritual and religious diversity.

Myers and Williard (2003) conducted a review of recent surveys identify the importance of spirituality among counseling professionals and the general public. The authors propose the integration of spirituality within a wellness paradigm would assist counselors and counselor educators value and address spirituality "as an integral component of optimum human functioning" (p. 142). The recommendations offered by

these authors to establish preparation programs for counselors in training include the following:

(a) a developmentally based wellness orientation
(b) defining spirituality in an inclusive manner
(c) opportunities for trainees to explore, understand, and articulate their own spirituality
(d) exposure to many diverse spiritual and religious beliefs, values, and phenomena as part of the preparation process
(e) exposure to assessment and intervention techniques compatible with the philosophy of spiritual and holistic wellness (p. 152).

Similar to the Burke et al. (1999) study, this literature outlines a curriculum designed not only to promote the competency of clinicians as they treat spiritual and/or religious clients, but also is invested in the process of providing clinicians with the opportunity to examine their own spiritual and religious constructions. Being aware of personal religious values is critical for unbiased therapy (Bergin, 1980, 1991; Bishop, 1992; Miller, G., 1999, 2003; Miller, W., 1998, 1999; Pate & Bondi, 1992; Pargament, 1999; Pargament & Saunders, 2007; Shafranske & Malony, 1985; Shafranske, 2000; Steen, Engles, & Thweatt, 2006). Awareness of personal spiritual and religious values and knowledge of religious diversity has become an ethical requirement (Henriksen & Trusty, 2005; McCarthy & Peteet, 2003; Openshaw & Harr, 2005; Plante, 2007; Richards & Bergin, 2005).

In an effort to guide mental health professionals and students toward a more holistic approach to client care, Griffith and Griffith (2002) provide a review of case studies to illustrate their approach to psychotherapy. Encouraging clinicians to listen to their clients' stories with an ear for their spiritual lives, Griffith and Griffith recommend learning about clients' religious beliefs, spiritual and/or religious practices, and to

recognize and respond when spiritual or religious practices or beliefs are destructive. In remaining open to spiritual stories, clinicians can encourage conversations about spiritual experiences.

Sperry and Shafranske (2005) edited *Spiritually Oriented Psychotherapy* and included chapters with a psychoanalytic consideration, Jungian approach, and cognitive-behavioral orientation for addressing the spiritual needs of clients. The contributors to the text include many of the leading researchers in the field of spirituality, including David Benner, David Lukoff, and Sian-Yang Tan. The text is divided into three parts designating separate sections to address theoretical foundations and one for contemporary approaches. The third part is a discussion related to commentary and critical analysis. This text includes many of the elements an instructor would look for in developing effective curriculum for a mental health professional preparation program.

Briggs and Rayle (2005) provide a rationale for the integration of spiritual diversity into counselor education programs and suggest activities for the incorporation of knowledge and skills in CACREP core courses. The authors point to the lack of regard for spirituality research in the 2001 CACREP Standards which "simply mention spirituality as a consideration in counseling programs, and no additional guidelines are given" (p. 64). Briggs and Rayle build on the work of Burke et al. (1999), outlining the relevance of spirituality coursework in counselor preparation programs. They provide a good overview of the various definitions related to spirituality and religion, provide examples for infusing spirituality research into the core areas of CACREP courses, and recommend the text by Cashwell and Young (2004), *Spiritual and Religious Values in*

Counseling: A Guide to Competent Practice, for teaching future counseling professionals.

This review of the available mental health professional education curricula for incorporating spiritual and religious competencies into instructional methods reflects what has been made available in the past several years. Undoubtedly there are emerging texts and research articles that will continue to contribute to the body of evidence demonstrating the need for integrating spirituality and religiosity into counselor education programs.

Concerns About the Prominence of Spirituality and Religion in Mental Health Counseling

The growing prominence of religious and spiritual beliefs and practices in counseling psychology has given rise to a number of concerns. Primary among these concerns are those related to the historical conflicts between the objective perspectives of psychology as science versus the transcendent nature of spirituality (Young et al., 2002). The term *spirituality* has been assigned a broad range of definitions and much debate has occurred regarding this “fuzzy” concept which lacks empirical grounding (Spilka, 1993, p.1). Miller and Thorensen (2003) view spirituality as “that which transcends ordinary physical limits of time and space, matter and energy” (p. 27), while Zinnbauer et al. (2001) point out that historically, spirituality was not distinguished from religiousness. Since the 1950s, there has been increasing interest in spirituality as a result of increased disillusionment with organized religion (Wuthnow, 1998).

Religion, spirituality, and science continue to remain at odds with one another; while science is able to define the external world, providing a sense of predictability and

control (Paulson, 2005), spiritual and religious beliefs are less likely to sustain the rigorous standards of science and, at their worst, can be irrational and disabling (Ellis, 1980; Griffith & Griffith, 2002; Helminiak, 2001; Meissner, 1996). Freudian (1927) theory promoted the belief that religion is a development of mankind due to "man's [sic] helplessness and need for protection" (p.29). Freud tenaciously worked to establish psychology as an empirical science and rejected views of any who differed from his own and, in particular, would not tolerate the notion that mythology, philosophy, and religious seeking was an integral part of the psychological experience (Lesser, 1999).

Later, Skinner's (1938) behaviorism theory and the rational emotive behavioral theory of Ellis (1962), contributed to the minimization of spirituality and religion with their theories which attempted to confront irrational thoughts and influences, such as religion, in their view, and asserted that behaviors and mental states are a result of certain stimuli in the environment and nothing more. Such views of religious and spiritual experience, beliefs and practices as pathological, went unchallenged until the so-called "third force" in psychology began to emerge with the theories of Rogers, May, and Maslow in the late 1940s.

Another concern associated with a scientific emphasis is related to patterns of religious coping among the mentally ill (Hartog & Gow, 2005; Kohls & Walach, 2007; Marks, 2006). Larson and Larson (2001) discuss negative religious coping which interfere with, rather than promote, treatment and recovery. These include seeing illness as a punishment from God or as a result of weak faith in God. The outright rejection of medical intervention has been linked with certain religious beliefs leading to earlier

death. Larson and Larson report some religious views result in rigidity, enmeshment, and emotional harshness (p.6). While these concerns are legitimate, psychological distress and disturbance is frequently associated with a spiritual experience and care must be taken to differentiate between these experiences (Kohls & Walach, 2007). Within the past two decades, the psychology of religion has become more inclusive and less likely to conclude pathology when clients report affinity to the divine that may or may not be associated with a specific religious tradition (Russinova & Cash, 2007). Indeed, research related to religious coping among the severely mentally ill suggests that quality of life is positively affected by spiritual and religious practices (Baetz et al., 2006; Bussema & Bussema, 2007; Fallot, 2007; Hill & Pargament, 2003; Larson & Larson, 2001, 2003; Miller & Thorensen, 2003; Pargament, 1997; Rogers, Poey, Reger, & Tepper, 2002; Russinova & Cash, 2007). Bellany et al. (2007) found that among individuals diagnosed with a serious mental illness, between 60% and 90% perceive themselves as religious and/or spiritual. These and other studies suggest among the severely mentally ill, spirituality is recognized as an effective means of coping with difficult emotions. The significance of spiritual and religious diversity and knowledge of appropriate assessment methods are understated in current training programs (Hathaway, Scott, & Garver, 2004). These are skills mental health professionals have acknowledged are lacking (Kelly, 1994, 1997; Openshaw & Harr, 2005; Pate & High, 1995; Plante, 2007; Prest, Russel, & D’Souza, 1999; Russell & Yarhouse, 2006; Young, Wiggins-Frame, & Cashwell, 2007; Young et al., 2002).

How therapists respond to a client's spiritual and/or religious issues is dependent upon several factors. Preparation through coursework and adequate supervision in spirituality and religion are essential if we are to avoid the concerns identified by Bergin (1991) regarding the healthy and unhealthy ways of being religious and the role of counselor values, Grof (2000) regarding the recognition and appropriate response to spiritual crisis, and Wuthnow (1998) in terms of sensitivity to the various aspects of religious and spiritual diversity encountered in today's culture.

Specific concerns of therapy emerge when clients present with aspects of spiritual/religious beliefs that are antithetical to wholesome growth. Helminiak (2001) outlines situations that require the clinician to reject such beliefs outright including the following:

> *Satanic control and hexes.* This belief avoids taking personal responsibility for behaviors, reduces the possibility of personal integrity, and supports vulnerabilities that are unlikely without the individual's compliance.
>
> *Prohibition against being angry with God*. This belief restricts emotion, rationalizes self-blame, reinforces learned understanding of what is permissible communication, and prevents healthy integration and healing.
>
> *Prohibition against questioning.*This belief stems from a reliance on an external authority and discourages the open-mindedness required for human growth and progress.
>
> *Equating inner peace with the will of God.* This belief promotes an isolating, one sided criterion of what is right and represents an overly simplistic spiritual understanding (p. 177-180).

Among Helminiak's recommendations for competent treatment of spiritual and religious clients, are approaches he terms as validation, reinterpretation, and rejection. Helminiak prefers the straightforward and direct approach and believes the substance of spiritual

growth must be the ongoing integration of the spirit and psyche. With a coherent and comprehensive psychology of spirituality, and a secure commitment to wholesome values, Helminiak asserts, the effective psychotherapist is one who is deeply authentic and spiritually integrated.

Miller and Thoresen (2003) provide a warning to health care providers who face multiple potential abuses when addressing the spiritual and/or religious aspects of functioning with their clients including religious discrimination and proselytizing, invasion of privacy, and the imposition of their own religious orientations on the client. It is noted, however, that there is no evidence suggesting a disproportionate occurrence of discrimination related to religious and spiritual matters as compared to gender, age, ethnicity, sexual orientation, and economic or political factors leading to grounds for discrimination. Miller and Thoresen emphasize the need for sensitivity and attention to ethical conduct.

Russell and Yarhouse (2006) identify constraints to religious and spiritual training in counseling education programs. Among the barriers reported were (a) a belief that religious and spiritual topics are irrelevant in clinical work, (b) low incidence of formal training in issues of faith, (c) limited access to religious or spiritual training materials, and (d) fear of offending a client or engaging in practice leading to ethical violations (p. 434). These findings reveal a pattern of avoidance leading Russell and Yarhouse to conclude insufficient training related to religion and spiritual diversity among the study's participants. The recommend enriched supervision and coursework in this area to reduce fear and avoidance of these topics.

The literature related to concerns associated with the integration of spirituality and religion into counselor education and supervision demonstrates a common theme throughout: Many studies indicate a perception that religious and spiritual topics are not relevant to mental health treatment, or that addressing these topics may lead to escalating pathology, or ethical violations. One of the commonalities noted is the lack of formal training in addressing these topics with clients. Another is the lack of faculty capable of role modeling spiritual and religious diversity in training and supervision.

Psychological Interventions That Disrupt Spiritual or Religious Functioning

As evidenced by past and current studies, an individual's spiritual and/or religious beliefs and practices contribute to positive psychological functioning. While it has been acknowledged that in some cases, religion can disrupt healthy psychological functioning, the negative aspects of religiosity are outweighed by the feelings of connection and comfort gained by attending to the spiritual. It should be noted however, there are interventions that can disrupt one's spiritual or religious functioning.

The misinterpretations of psychological symptoms are, according to transpersonal psychology, the result of an absence of the spiritual dimension (Cortright, 1997; Grof, 2000). Spiritual emergencies are profound psychological experiences that are potentially transformative. These spiritual events involve non-ordinary experiences that are frequently perceived as pathological but, according to Grof (2000) "if they are correctly understood and supported, these psycho-spiritual crises can result in emotional and psychosomatic healing, remarkable psychological changes, and consciousness evolution" (p.137). Mental health professionals who lack even the most basic understanding of

nonordinary states of consciousness, or spiritual emergencies, are likely to misinterpret and misdiagnose these experiences as pathological. If Maslow (1971) was correct, we are all born with a longing for transcendent experiences, and this deserves clinical care.

Religious and Spiritual Experiences of Mental Health Professionals

In 1985, when Bergin and Jensen (1990) surveyed four groups of psychotherapists including clinical psychologists, marriage and family therapists, social workers, and psychiatrists ($N = 414$), on their religious values, the findings confirmed earlier research that mental health professionals reported low rates of conventional religious affiliation and participation. The study captured 59% of a national sampling of the four groups of psychotherapists, half of which had 16 or more years of clinical practice. Using the *Religious Orientation Scale* (ROS), developed by Allport and Ross (1967), scores reflected 54% of the respondents could be classified in religious terms. A Gallup poll of the general public (*Religion in America*, 1985) published that same year reflected 80% of the American public respondents could be classified in religious terms. Bergin and Jensen acknowledged findings they did not expect in that 41% of the therapists reported attending religious services on a regular basis (compared with 40% of the general public) and 77% of therapists responding indicated they try to live according to their religious beliefs (compared with 84% of the general public). This discrepancy was attributed to the fact that earlier studies had been conducted primarily with clinical psychologists, who Bergin and Jensen reported were the least religious of the four subgroups studied.

Ragan, Malony, and Beit-Hallahmi (1980) had contributed to the research with their study which surveyed the APA ($N = 555$) to determine, in general, if religiosity

among psychologists was lower than that of the general population, and specifically, if different specializations reported higher levels of religiosity. Working from the perspective of earlier studies (Lehman, 1974; Lehman & Shriver, 1968), examining the differences among faculty religiosity, Ragan et al determined that religiosity levels among psychologists "was much lower than that of the overall general population and academicians in general" (p. 208). The finding that psychologists who study religion would be more religious was expected. However, the hypothesis that psychologists in subspecialties which do not study religion would be more religious was not found. In fact, the study found no differences in subspecialties among psychologists.

In a very early study, Lehman and Witty (1931) compared the attitudes of physicists and psychologists (natural sciences versus social sciences). These researchers found physicists were more likely to attribute the mysteries encountered in the phenomena they studied in terms of religious explanations, whereas psychologists demonstrated attitudes that their science "eventually could explain most phenomena and that physical science could explain the remainder" (Ragan et al, 1980, p.209). Clearly, even in the 1930s, there were indications of "increasing bewilderment" in the fields of physiology, biology, and physics and these scientists (particularly the youngest surveyed) were more willing to acknowledge the mysterious workings of humans and our universe to powers greater than science (Lehman & Witty, 1931, p. 664).

Shafranske and Malony's (1990) study revealed APA members ($N = 409$) reported a low degree of formal religious (institutional) involvement; less than 20% reported that organized religion provided spiritual support. Nearly 25% of the

respondents reported negative feelings associated with past religious experiences. Using the Ideology Orientation Scale, adapted from Lehman (1974), which measures degrees of belief in a personal God, Shafranske and Malony found 40% of the respondents endorsed a personal, transcendent God orientation. Overall, 53% of the respondents indicated having religious beliefs is desirable; 14% rated having religious beliefs is undesirable. Other findings of this study included the growing recognition of the need to implement curriculum to address spirituality and religion into preparation programs. Approximately 33% reported feeling competent in addressing their clients' religious and/or spiritual concerns. More than half of the respondents (54%) indicated the psychology of religion as "desirable" in clinical psychologists' educational training; nearly one-third (29%) rated this as "undesirable" and 17% were undecided or neutral.

Bilgrave and Deluty (1998) investigated the relationship between religious beliefs and psychotherapeutic orientations among 237 clinical and counseling psychologists. The findings indicated spirituality and religion were increasing among clinical and counseling psychologists as 72% of the respondents indicated their religious beliefs influenced their treatment practices and 66% indicated their practice was influenced by their religious beliefs. The study revealed clear associations between affirmed Christian affiliation and a cognitive–behavioral approach to treatment; respondents who affirmed Eastern and mystical orientations were more likely to report a practice based on an existential and/or humanistic approach. Bilgrave and Deluty concluded that most psychologists engage in a thoughtful, deliberate synthesizing process based upon their personal experiences of religious and spiritual knowledge and their education in the

social sciences. Indeed, this research began to identify the emerging pattern of dissonance among psychologists:

> Psychologists are exposed to two quite different social contexts: one (usually family and church) that encourages a religious understanding of the human condition, and the other (usually undergraduate and graduate education) that promulgates a scientific and humanistic understanding of the human condition. Given this dual exposure, psychologists are then faced with the challenge of reconciling these two very different ways of making sense of the world (p.346).

Bilgrave and Deluty concurred with the earlier studies conducted by Bergin and Jensen (1990) and Shafranske and Malony (1990), in that psychologists report lower levels of religiosity than the general public. However, these researchers also found a significant number of psychologists do report having religious beliefs and that those beliefs are personally relevant and they influence their psychological practice.

In a more recent study, Smith and Orlinsky (2004) examined the religious and spiritual experience among mental health professionals from New Zealand, Canada, and the United States (*N* = 975). The findings contribute to the growing awareness that the religious and spiritual character of counseling professionals is changing. Fifty-one percent of the respondents exhibited a definable personal spirituality and 27% a pattern of religious spirituality. Only 21% of the participants exhibited a pattern of secular morality (a focus on personal moral or ethical standards versus spiritual or religious). In all, 78% of the therapists indicated they value some form of spirituality. Smith and Orlinsky note the following:

> Our study shows that the nature of religiosity among psychotherapists is multifaceted, and our results challenge the dominant image of the psychotherapist as someone who is adamantly secular and critical of religion" (p. 151).

Current research is changing the perception that psychologists oppose and neglect religious and spiritual issues in their clinical practice. How are these professional factors and evolving personal beliefs contributing to the changes in counselor education?

Dissonance Among Mental Health Professionals

Cognitive dissonance theory (Festinger, 1957) suggests that people dislike feeling inconsistent. Festinger proposed that when individuals experience as state of psychic tension created by an inconsistency between attitudes (worldview) and behaviors the result is a strong desire to eliminate the tension (dissonance) by altering the attitude or behavior. Previous research investigating the cognitive dissonance that may exists among psychologists has suggested that while a majority of psychologists self-report high levels of spiritual and/or religious commitment, many indicate conflict associated with these internal beliefs and their clinical practice (Eckhardt, Kassinove, & Edwards, 1992; Gerson, Allen, Gold, & Kose, 2000; Russell & Yarhouse, 2006; Shafranske, 2000). Smith and Orlinsky (2004) found a pattern of personal spirituality (independent of institutional religion) among 51% of the 975 international psychotherapists surveyed. Patterns defining secular morality (all aspects of religiosity were unimportant – except personal moral and ethical standards) were identified by just 21% of the therapists. Delaney, Miller, and Bisono (2007) survey of 489 APA members found 82% regarded religion as beneficial, while only 7% regarded religion as harmful to mental health. These findings suggest mental health professionals are responding to spirituality research surveys more positively and that advances are being made in the reconciliation of science and religion (Rioux & Barresi, 1997).

The complexities of religious/spiritual experience among mental health professionals and the general population is evident. Early studies which focused on how these multifaceted belief systems influenced clinical judgment suggested the internal conflict between professional and religious beliefs had been significant (Eckhardt et al., 1992; Kassinove & Uecke, 1991). More recent investigations suggest there is minimal impact, however, religious beliefs were found to be related to clinical judgment by Gerson, Allen, Gold, and Kose (2000) when surveying 87 psychotherapists. Investigating therapists' professional and religious beliefs to determine if possible dissonance existed to influence clinical judgment, participants responded to religiosity surveys and were asked to assess two clinical vignettes. Religious beliefs were found to be related to clinical judgments, particularly when therapists indicated strong beliefs both religiously and professionally. These researchers suggest their findings call into question whether or not therapists can maintain an isolated position regarding their clinical judgments about religious versus nonreligious clients.

Subjective religion and prejudice was a topic of concern during the 1950s and 1960s. Allport and Ross (1967) investigated the connection between religiosity and prejudice concluding one's personality structure and cognitive style is "often deeply embedded" and that "both states of mind are enmeshed with the individual's religious orientation" (p. 442). Allport (1950) asserted mature religion was comprised of three dimensions or characteristics: the ability to face complex issues such as ethical responsibility and evil without reducing the complexity a readiness to doubt and to be self-critical, and an emphasis on tentativeness and continual searching. The Allport-Ross

Religious Orientation Scale (ROS, 1967) has been used to investigate and distinguish the intrinsically religious individual from the more self-serving extrinsically religious individual. Other questionnaires with demonstrated validity and reliability have been developed for the study of religion, religious attitudes, motivations, and behavior and continue to be employed in an effort to investigate the role of religion and spirituality among mental health professionals (Bilgrave & Deluty, 1998, 2002; Hathaway, Scott, & Garver, 2004; Hodge & McGrew, 2006; Rioux & Barresi, 1997).

Research specifically related to internal conflicts and subsequent cognitive dissonance among psychologists, regarding their spiritual/religious beliefs and their scientific orientation, is minimal. Kassinove and Uecke (1991) studied doctoral psychology students to assess their perceived conflict levels associated with their endorsement of scientific and religious orientations. Eckhardt, Kassinove, and Edwards (1992) surveyed members of the APA to assess their endorsement of religion and science as sources of knowledge. Both studies resulted in similar findings: There were higher levels of self-reported perception of conflict stemming from endorsements of religious orientation of knowledge or modes of thought versus a scientific orientation. Eckhardt et al. suggest individuals with religious viewpoints who undergo scientific training may subsequently develop “conflicting styles which may lead to personal conflict” (p. 133). Rioux and Barresi (1997) modified the Eckhardt et al. composite scale to survey undergraduate psychology students ($N = 40$) to examine perspective of life experiences with various levels of scientific and religious orientations. Their findings suggested differences exist both in interpersonal and intrapersonal science-religion conflicts, as well

as differences in how individuals view their conflicting experiences.

Festinger (1957, 1964) hypothesized that human beings have a tendency to make cognitions and behaviors consonant, to avoid the unpleasant experience of dissonance, such as anxiety, shame, anger, etc. Several theorists have added to the 1957 version of Festinger's work, including Mills (1999), who suggests "selective exposure to information" was a key aspect that required revision (p. 30). Mills and Ross (1964) proposed people who are committed to a certain position will avoid information that does not support that position and will prefer information supporting their belief system.

Aronson (1969, 1999) reinterpreted Festinger's work and extended the theory by linking it with self-concept. Asserting that at the core of cognitive dissonance is the person's self-concept and subsequent discomfort about specific behaviors that are inconsistent with his or her sense of self (Aronson, 1999). The cognitive dissonance of hypocrisy (when dishonesty or duplicity is confronted) featured significantly in the expanded version. Aronson conducted various studies in which he developed the "induction-of-hypocrisy paradigm," to demonstrate that the high-dissonance condition of hypocrisy compels people to behave in a manner more consistent with their internal attitudes and beliefs (Aronson, 1999, p. 116). This self-consistency interpretation of cognitive dissonance "indicates that the production of aversive consequences is not essential for the creation of dissonance," as Festinger had maintained (Harmon-Jones & Mills, 1999, p. 17).

Among the primary issues related to the integration of spirituality into counseling psychology involve the self-consistency of the clinician. Helminiak (2001)

asserts "attention to spirituality challenges psychology to abandon its self-image as value-free" (p. 170). Indeed, for psychologists to acknowledge the scientific evidence for the positive correlation between spirituality, religion, and well-being is a significant challenge. However, to continue to discount the empirically-grounded studies linking these dimensions of human experience is akin to the prejudicial attitudes toward religion and spirituality demonstrated by Freud's developmental-immaturity perspective, and Ellis's (1980) attitude "... the less religious [people] are, the more emotionally healthy they will tend to be" (p. 637).

Psychologists are increasingly reporting an interest in, and value for, spirituality and/or religion in their clinical practice, and to some extent, in their personal attitudes (Bilgrave & Deluty, 1998; Delaney, Miller, & Bisono, 2007; Rioux & Barresi, 1997; Smith & Orlinsky, 2004). Nearly 15 years ago, Jones (1994) offered his proposal for the "boldest model yet," regarding a constructive relationship between religion and science in the profession of psychology. Jones argues:

> Because there is no impassable chasm between science and
> religion, it is inevitable that religion and religious belief
> will and do relate to the scientific discipline of psychology (p. 115).

Jones notes an erosion of the traditional or positivistic view of science, beginning in the late 1950s, and a growing consensus among some scholars that "psychology is not a unitary scientific discipline, but is rather a complex blend of natural and human sciences" (p.118). Current scientific investigations related to psychology and religion includes neuroscience (Seybold, 2005) and cognitive science (Sorensen, 2005) in the explanation of religious and spiritual experiences. Yet even though there is a growing body of

literature and a profusion of sound evidence for the efficacy of spirituality and religion in counseling psychology, as Bartoli (2007) argues, implementing curriculum to build competency in these area is not enough. In the view of Bartoli and others, mental health professionals must become conscious of their own views, biases, and perspectives on religion and spirituality, by pursuing self-awareness and confronting their own discomfort or disinterest toward these areas (Richards & Bergin, 2000).

Conclusion

From this brief review of the factors associated with the integration of spirituality and religion into the counseling psychology educational curriculum the following conclusions can be drawn. First, the science of psychology has come full circle regarding the study of the religious experience. James' (1902) view of the importance of emotion in religious experience can be found in some of the most current cognitive psychology research (Seybold, 2005; Sorensen, 2005). While the science of psychology rejected the study of spirituality and religion throughout most of the 20th century, there were 8,000 records of scientific studies addressing spirituality and religion between 2000 and 2006 alone (Bartoli, 2007).

Secondly, there is clear and convincing evidence for the efficacy of spirituality and religion as legitimate dimensions of positive human functioning. Koenig, McCullough, and Larson (2001), and the other researchers reviewed in this chapter demonstrate the importance of these dimensions and urge the counseling profession to integrate their findings into counselor education programs.

Third, the theoretical basis for spirituality as a component of the human

experience was established through the works of William James, Carl Jung, Rollo May, and others in an effort to present the sentiments of some of the most prominent figures associated with the study of psychology.

The focus then turned toward the importance of several factors associated with the integration of spirituality and religion into counseling psychology: process of spiritual identity and development, the importance of integrating these areas into the educational and supervisory experience of counselors in training, a review of possible interventions and potential concerns of integration, and research regarding the religious and spiritual experiences of mental health professionals. Each of these factors represents a separate area of study within the psychology of religion with an abundance of available research to draw from. Each is valid considerations for counselor educators.

Finally, a brief review of the cognitive dissonance theory was provided to illustrate the coexisting systems of beliefs reported by mental health professionals in recent surveys related to spirituality and religion in counseling psychology. Findings from multiple studies were reviewed demonstrating a growing interest and acceptance of these dimensions on the part of psychologists. Many therapists are reporting spirituality is relevant in their lives but report a reluctance to discuss religious or spiritual issues in therapy. Despite the substantial scholarship there remains an important gap regarding the integration of religious and spiritual issues in academic programs and clinical supervision. The gap is associated with the barriers mentioned above and the reluctance on the part of credentialing boards to mandate curriculum changes in counselor education programs. Therefore, the research conducted for this dissertation focused on the extent to

which religious beliefs and scientific ideologies coexist among a sample of APA and ACA members to examine the level of dissonance they may experience regarding these beliefs. Chapter 3 describes the methodology used in the research.

CHAPTER 3:

RESEARCH METHOD

Introduction

The purpose of this quantitative study was to examine the value of integrating spiritual and religious diversity into mental health professional training programs. This chapter includes a description of the research design, the proposed sample selection and size, and a description of the instrumentation that was used in the study. The data collection process and analysis is also discussed. Finally, reviews of the methodological assumptions and limitations as well as the ethical procedures that ensure compliance with standards for conducting research are provided.

Research Design

This study utilized a survey design to determine if there are relationships between religious ideologies and/or scientific orientations among American Psychological Association (APA) members and American Counseling Association (ACA) members regarding the practice of counseling psychology and their self-rating of the importance of integrating of spiritual and religious diversity curriculum into mental health professional training programs. Data was gathered using the Religious Ideology, Scientific Orientation, and Conflict Questionnaire (Eckhardt et al., 1992). This was evaluated using an independent *t* test. In addition, a multiple linear regression analysis was used to define the relationships between the two predictor variables, religious ideology and/or scientific orientation worldviews, and the level of approval to examine the effects for the integration spiritual and religious diversity in current training programs.

With a 148,000 APA-member population, a confidence interval of +/- 5% and confidence level of 95%, the sample size for the APA was calculated to be 383 (Mitchell & Jolley, 2004). The ACA has a 40,600 member population. Using the same confidence interval (+/- 5%) and a confidence level of 95%, the sample size for the ACA was calculated to be 381 (Mitchell and Jolley, 2004). Based on previous research for similar studies, the return rates have ranged from 50% (Young et al., 2007) to 69% (Young et al., 2002). Delaney, Miller, and Bisono's (2007) survey of APA regarding member religiosity experienced a 53% response rate. On average 40% of psychotherapists respond to mailed questionnaires or surveys of this nature (Wogan & Norcross, 1985). Dillman (1991) suggests response rates can be improved by reducing nonresponse error, or "a discrepancy between the frequency of a population characteristic and that estimated by the survey that occurs because some people did not respond" (p.229). The National Statistical Service (NSS, 2007) suggests increasing the sample size to allow for low response rates due to undeliverable addresses and/or refusals. The sample size for this study was increased by 15% as an allowance for expected nonresponse. This would indicate approximately 440 surveys will be sent to randomly selected APA members and 438 surveys will be sent to randomly selected ACA members.

A representative sample will be provided by the APA's Center for Workforce Studies, and by the ACA's Research Division, including a profile of how the sample will be drawn. The surveys will yield data that will be entered into SPSS to conduct an independent group *t* test, regression analysis, and correlations will be used to determine how and in what way the responses relate with one another. By means of a multiple

regression, the two predictor variables (religious ideology and scientific orientation) was used simultaneously to examine respondents' level of approval of the core competencies. The survey questions were formatted in Likert-type items on the questionnaires. Data was be gathered using two questionnaires with a total of 47 items requiring approximately 10 min to complete.

The justification for using the proposed design and approach is articulated by Mitchell and Jolley (2004), who describe the benefits of formatting research questions in a Likert-type scale as follows:

> One way to give yourself power (the ability to find relationships among variables) is to use Likert-type items. Traditionally, most psychologists have assumed that a participant who strongly agrees (a "5") and a participant who merely agrees (a "4") differ by as much, in terms of how they feel, as a participant who is undecided (a "3") differs from someone who disagrees (a "2"). Both participants differed by the same distance on the scale (1 point), and so both supposedly differed by the same amount psychologically. In other words, Likert-type scales are assumed to yield interval data. With interval data, differences between ratings correspond perfectly to differences in feelings (pp. 193-194).

Well designed questionnaires are able to gathering reliable subjective measures. In addition, self-administered questionnaires have the advantage of being easily distributed to a large number of people in a cost-effective manner (Mitchell & Jolley, 2004). This design also protects the privacy of the participants and because of the high levels of anonymity; this approach (in contrast to open-ended interviews, for example) was favorable to elicit honest responses to the very personal information related to one's spirituality. One of the goals of this research was to investigate the feelings and attitudes of practicing mental health professionals in the way they approach the spiritual and religious diversity of their clients, students, and/or supervisees. Among the benefits of the

present questionnaire design is its usefulness for gathering information regarding spiritual and religious attitudes and beliefs experienced by practitioners who are trained in the social sciences. In particular, the design and approach hoped to gather and evaluate information related to the dichotomy that has been developing among mental health professionals who would identify themselves as having a scientific ideology but who are beginning to acknowledge the advances in science and technology which provide evidence for the spiritual paradigm shift that is occurring within the field of psychology. It was important to conduct the data analysis of this study with the recognition that while many psychologists and other mental health professionals have self-reported low levels of spirituality in the past (Delaney, Miller, & Bisono, 2007), that appears to be changing.

Setting and Sample

The APA is the largest association of psychologists worldwide (APA, 2008). The organization is based in Washington, D.C. and promotes the advancement of psychology as a science and a profession. This includes promoting health, education, and human welfare within the 54 professional divisions of the APA and the 21 specialty professional journals published under its purview.

In accordance with the APA general policy, all proposals to conduct research among its members are subject to review and approval (APA, 2008). Evidence of approval by the Walden University Institutional Review Board (IRB) was required prior to APA approval to begin research (IRB approval number 05-01-09-0288115). A process was undertaken to gain approval from the APA to conduct this study in order to be granted permission and to be provided with a randomized mailing list to survey members.

The Center for Workforce Studies (CWS) is a division of the APA which oversees the collection, analysis, and dissemination of information relevant to psychology's workforce and educational system. The CWS informed this researcher of the materials required for submission which included copies of all instruments, cover letters, reminder postcards and a copy of the actual research proposal including a description of the target population, number of participants, and selection criteria.

The ACA is headquartered in Alexandria, Virginia, near Washington D.C. With a comprehensive network of 19 professional divisions and 56 branches, the ACA promotes public confidence and trust in the counseling profession (ACA, 2009). In accordance with the ACA general policy, a process was undertaken to gain approval from the ACA to conduct this study in order to be granted permission and to be provided with a randomized mailing list to survey ACA members, similar to the APA process.

Instrumentation and Materials

Participants received a packet including the Informed Consent form (Appendix B), the Survey General Directions form (Appendix C), the survey instrument consisting of two questionnaires, and a numbered, stamped, return envelope. A postcard announcing the study and requesting participants' response was mailed one week before the survey packet mailing which occurred in late May, 2009. Respondents were asked to return the surveys by June 13, 2009, giving them 3 weeks to reply.

The first questionnaire, the *Core Competencies Questionnaire* (CCQ, Appendix D), named for the purposes of this study, is described below and is divided into a demographic form and the nine core competency items, each of which was assigned

mean scores when the data was collected and processed. Construct validity has been established previously for items contained in the CCQ (See Shafranske & Malony, 1990) through clear operational definitions. Cronbach's alpha was used to analyze the reliability of the CCQ.

Section I contains nine items pertaining to demographic data collection. The data from this section was compiled and reviewed to describe the characteristics of the sample. Section II contains nine items designed to rate the importance of the core competencies for addressing spiritual and religious diversity in counselor education (e.g., "Explain the difference between religion and spirituality, including similarities and differences"). Respondents rated the competencies in this subscale using a 4-point Likert-type scale with the anchors of 1 (*disapprove*), 2 (*approve*), 3 (*recommend*), or 4 (*performed*). The scores range from 9 – 36 (9 being the highest level of disapproval possible and 36 being the highest level of approval) on this section. This section qualifies the term "religious" as being used generically to describe both religiosity, that is, participation in an organized religion, and personal spirituality. Higher scores indicate high levels of approval for implementing the core competencies to address spiritual and religious diversity into the mental health profession including counseling, teaching, and/or supervision process.

The CCQ was constructed by adapting a section of the Shafranske and Malony's (1990) questionnaire combined with the ASERVIC's Summit on Spirituality's nine core competencies developed in 1995. Although the instrument's reliability and validity have not been established (or otherwise not included) in the 1990 study, the Shafranske and

Malony framing of approval levels of the nine core competencies was chosen for this study because they are highly applicable to the goals of this research. Reliability (internal consistency) for this adaptation will be calculated during the data processing stage of the research and presented in chapter 4.

The second survey, Religious Ideology, Scientific Orientation, and Conflict Questionnaire (RISOCQ, Appendix F) is a 29-item questionnaire designed by Eckhardt et al. (1992) to assess the participant's level of endorsement of a scientific orientation in one's personal and professional life, and to measure the degree to which scientific attitudes can benefit humanity. The Religious Ideology portion has evidence of internal consistency reliability as measured by Cronbach's alpha with a coefficient of .93. This indicates excellent inter-item consistency; reliability for the Scientific Ideology Scale as measured by Cronbach's alpha is .70, indicating moderate and acceptable inter-item consistency (Eckhardt et al., 1992). The Conflict Scale has evidence of internal consistency reliability as measured by Cronbach's alpha of .70 indicating a moderate inter-item consistency (Eckhardt et al., 1992). The instrument's reliability (internal consistency) for this study will be calculated during the data processing stage of the research and presented in Chapter 4.

In assessing attitudes of scientific ideology (acceptance of objective evidence as opposed to systems of faith), the RISOCQ was used to examine the relationships between APA and ACA members self-rating on religious ideology, religious affiliation, and their level of agreement for integrating spiritual and religious diversity issues into counselor education programs. Respondents rated themselves on this scale using a 5-

point Likert-type scale ranging from 1 (*strongly agree*) to 5 (*strongly disagree*) (i.e., "It is only through empirical research and hypothesis testing that the world can advance"). The scores range from 20 – 100 (20 being the highest level of agreement possible on each scale and 100 being the highest level of disagreement on each scale. The process of answering the two surveys was estimated to require 10 min to complete.

The necessary forms for this research are located in the appendix section of this dissertation.

Data Collection and Analysis

Data was collected through the use of the CCQ and the RISOCQ questionnaires. The research questions were framed in such a way that the respondents who score high on criterion variables related to personal spirituality and religious ideology, beliefs that mental health professional training programs warrant education that includes spiritual and religious diversity, and high on predictor variables associated with a scientific orientation of the mental health practitioner, will be quantified to the research hypotheses and the strength of the relationships was computed. Data was gathered and by means of an independent group *t* test and multiple regressions, the two predictor variables (religious ideology and scientific orientation) were used simultaneously to examine respondents' level of approval of the core competencies. Preliminary analyses included means, standard deviation, frequencies, and a zero order correlation which were used to test for potential confounding effects of the demographic variables. Inferential analyses included assessment of the following research questions and hypotheses:

Research Questions and Hypotheses

The following research questions and hypotheses have been derived from a review of existing literature in the area of spiritual and religious diversity issues in mental health professional training programs:

RQ1: Will cognitive dissonance (conflict score) increase with participants who hold both religious ideology and a scientific orientation for explanations of knowledge?

*H*o1: There will be no significant difference between those who score higher versus those who score lower on both the religious ideology scale and the scientific orientation scale on levels of cognitive dissonance (conflict scale).

Ha 1: There will be a significant difference between those who score higher versus those who score lower on both the religious ideology scale and the scientific orientation scale on levels of cognitive dissonance (conflict scale).

RQ2: Does either religious ideology or scientific orientation predict respondent approval of integrating the core competency standards into current mental health professional training programs?

Ho 2: Either religious ideology or scientific orientation predicts respondent approval of integrating the core competencies standards into current mental health professional training programs.

Ha 2: Either religious ideology or scientific orientation do not predict respondent approval of integrating the core competencies standards into current mental health professional training programs. However, there is not enough evidence to suggest which would be the stronger predictor.

Protection of Participants' Rights and Ethical Assurances

Ethical assurances established by the Council for the Advancement of Standards (CAS, 2006) were the guiding principles for this research including autonomy, non-malfeasance, beneficence, justice, fidelity, veracity, and affiliation. Approval from the Walden University IRB, the APA and ACA, was obtained prior to proceeding with the research study. Participants acknowledged consent to participate in the study by completing and returning the survey. Participation was voluntary and could be discontinued at any time, without penalty. As a potential conflict of interest issue, the consent acknowledged that the researcher is currently an active member of both the ACA and the APA. The results of the data collection were analyzed in an aggregate format as an additional form of confidentiality. The raw data will be electronically stored for a minimum of 5 years and will be password protected. The raw data from this study will be made available by the researcher upon request. In an effort to ensure protection of the participants there are no identifiers as to names of the participants recorded with the data.

CHAPTER 4: RESULTS

Introduction

The purpose of this study is two-fold, first, to assess cognitive dissonance, as measured by the conflict scale (the dependent variable), by comparing those who score higher versus lower on both religious ideology and scientific orientation (the independent variable). Data was gathered using the Religious Ideology, Scientific Orientation, and Conflict Questionnaire (Eckhardt et al., 1992). This was evaluated using an independent groups *t* test. Second, this study quantitatively examined the relative influence of religious ideology and/or scientific orientation on APA and ACA members' approval of integrating the ASERVIC core competencies into mental health professional training programs. By means of a multiple regression, the two predictor variables (religious ideology and scientific orientation) were used simultaneously to examine respondents' level of approval of the core competencies. This chapter includes a comprehensive analysis of how the data support or fail to support the hypotheses, presents tables demonstrating the results, and provides a discussion of the findings of the data.

Research Tools

Two research tools were used in the study. The Core Competency Questionnaire (CCQ), the Association for Spiritual, Ethical, and Religious Values in Counseling's (ASERVIC) Summit on Spirituality's nine core competencies described in chapter 3, was used to measure participants' approval of integrating the spiritual core competencies into training programs. The second questionnaire, the Religious Ideology, Scientific Orientation, and Conflict Questionnaire (RISOCQ) designed by Eckhardt et al. (1992),

was used to measure the relative influence of religious ideology and scientific orientation on participants' approval of integrating spiritual core competencies into training programs, and to assess cognitive dissonance among mental health professionals related to this issue. These measures have been normed with mental health professional in the past (see Cashwell & Young, 2004; Eckhardt et al. 1992; Young, Wiggins-Frame & Cashwell, 2007).

Data Analysis

In late May 2009, a total of 878 surveys were mailed to members of the APA (N = 440) and to the ACA (N = 438). Of the 878 mailed surveys, 141 APA members responded and 142 ACA members responded for a total return rate of 32.2%. After cleansing the data matrix for missing values that would have biased the results of the analyses (Field, 2005; George & Mallery, 2005), the final number of the study participants was 258. An independent groups *t* test and multiple regression analyses were used to test the following hypotheses and compare the scores gathered.

RQ1: Will cognitive dissonance (conflict score) increase with respondents who hold both religious ideology and a scientific orientation for explanations of knowledge?

Null 1: There will be no significant difference between those who score higher versus those who score lower on both the religious ideology scale and the scientific orientation scale on levels of cognitive dissonance (conflict scale).

Alternative 1: There will be a significant difference between those who score higher versus those who score lower on both the religious ideology scale and the scientific orientation scale on levels of cognitive dissonance (conflict scale).

RQ2: Does either religious ideology or scientific orientation predict respondent approval of integrating the core competency standards into current mental health professional training programs?

Null 2: Either religious ideology or scientific orientation predicts respondent approval of integrating the core competencies standards into current mental health professional training programs.

Alternative 2: Either religious ideology or scientific orientation do not predict respondent approval of integrating the core competencies standards into current mental health professional training programs. However, there is not enough evidence to suggest which would be the stronger predictor.

Using the Statistical Package for the Social Sciences (SPSS version 17.0) to analyze a data matrix consisting of response variables structured into cases (one row for each respondent) and columns, containing the numerically coded responses of the respondents, concerning different aspect of their demography, spiritual core competencies, religious ideology, scientific orientation, and cognitive dissonance (conflict). The research design was as follows: First, the response variables were summarized using frequency distributions and descriptive statistics. Secondly, Cronbach's alpha analysis was conducted to evaluate and verify the internal reliability of the ASERVIC core competencies. As indicated in chapter 3, the instrument's reliability had not been established (or otherwise not included) in previous studies whereas the Religious Ideology, Scientific Orientation, and Conflict Questionnaire had established interitem consistency. Thirdly, an independent samples t test was used to determine if

there was a significant difference between the respondents who scored higher versus those who scored lower on both the religious ideology scale and the scientific orientation scale with respect to their levels of cognitive dissonance (conflict). The forth step was to conduct a multiple linear regression analysis to determine which was a stronger predictor of approval of the ASERVIC core competencies, religious ideology or scientific orientation.

Descriptive Statistics

The frequency distributions of the response variables, and their means, medians, and standard deviations, are presented in Appendix F. Of the final data set of 258, 86 (33.3%) were male and 172 (66.7%) were female. All possible age groups were represented, from 21 to 100 years (Table 1). The most frequently reported age groups were 41 to 50 years (23.3%) and 51to 60 years (37.6%).

Table 1

Distribution of the Ages of the Respondents

Age	Frequency	Percent	Valid percent	Cumulative percent
21-30	17	6.6	6.6	6.6
31-40	38	14.7	14.7	21.3
41-50	60	23.3	23.3	44.6
51-60	92	35.7	35.7	80.2
61-70	40	15.5	15.5	95.7
71-80	4	1.6	1.6	97.3
81-90	1	.4	.4	97.7
91-100	1	.4	.4	98.1
Unknown	5	1.9	1.9	100.0
Total	258	100.0	100.0	

The majority of the sample identified themselves as White (non-Hispanic) ethnicity, representing 86.4% of the total (Table 2) while the remainder belonged to minority ethnic groups. The proportions of the respondents were approximately equally distributed in geographic location between the five main regions of the United States, East, the Mid-West, the West, and the South (Table 3).

Table 2

Ethnic Groups of the Respondents

Item/ Measure	Frequency	Percent	Valid percent	Cumulative percent
Asian	4	1.6	1.6	1.6
Hawaiian native/Pacific Islander	3	1.2	1.2	2.7
Black/African American	10	3.9	3.9	6.6
White (non-Hispanic)	223	86.4	86.4	93.0
Hispanic	11	4.3	4.3	97.3
Native American/ Alaskan native	1	.4	.4	97.7
Other	6	2.3	2.3	100.0
Total	258	100.0	100.0	

Table 3

Geographic Locations of the Respondents

Item/ measure	Frequency	Percent	Valid percent	Cumulative percent
East	61	23.6	23.6	23.6
Southeast	49	19.0	19.0	42.6
Southwest	21	8.1	8.1	50.8
West	64	24.8	24.8	75.6
Mid West	63	24.4	24.4	100.0
Total	258	100.0	100.0	

The majority (61.6%) held doctoral degrees, while the remainder had master's degrees (Table 4). Most (63.2%) had been in practice from 6 to 30 years (Table 5).

Table 4

Degree Held by Respondents

Item/ measure	Frequency	Percent	Valid percent	Cumulative percent
Master's degree	99	38.4	38.4	38.4
Ph.D	127	49.2	49.2	87.6
Psy.D	17	6.6	6.6	94.2
Ed.D	15	5.8	5.8	100.0
Total	258	100.0	100.0	

Table 5

Years of Clinical Practice of the Respondents

Item/ measure	Percent	Frequency	Valid percent	Cumulative percent
Unknown	17	6.6	6.6	6.6
Less than one Year (student)	18	7.0	7.0	13.6
2-5	34	13.2	13.2	26.7
6-10	43	16.7	16.7	43.4
11-15	32	12.4	12.4	55.8
16-20	32	12.4	12.4	68.2
21-30	56	21.7	21.7	89.9
31-50	25	9.7	9.7	99.6
Over 50	1	.4	.4	100.0
Total	258	100.0	100.0	

Fully 43.0% of the respondents worked in private practice, while 23.6% worked in a university or college setting. The others indicated employment in other work settings (Table 6).

Table 6

Work Setting of the Respondents

Item/ measure	Frequency	Percent	Valid Percent	Cumulative Percent
Unknown	1	.4	.4	.4
Private Practice	111	43.0	43.0	43.0
Community Counseling setting	23	8.9	8.9	52.3
University/ College	61	23.6	23.6	76.0
Corrections	3	1.2	1.2	77.1
Hospital or other medical setting	22	8.5	8.5	85.7
Elementary, middle, or high school	9	3.5	3.5	89.1
Government	9	3.5	3.5	92.6
Industry/organizational	1	.4	.4	93.0
Other	18	7.0	7.0	100.0
Total	258	100.0	100.0	

The theoretical orientation of the majority (53.1%) was eclectic/integrative while 24.5% adopted a cognitive behavioral orientation. Those with psychoanalytic, cognitive, behavioral, humanistic, existential, Jungian, or other orientations represented the minority groups (Table 7).

The religious affiliation of the respondents were predominantly Christian, belonging to the Protestent (35.7%) or Catholic (19.4%) denominations. Seven non-Christian religious affiliations were represented by 24.4% of the respondents. 12.0% of the respondents affirmed that they were agnostic or atheists (Table 8).

Table 7

Theoretical Orientation of the Respondents

Item/ measure	Frequency	Percent	Valid Percent	Cumulative Percent
Eclectic/Integrative	137	53.1	53.1	53.1
Cognitive Behavioral	63	24.4	24.4	77.5
Psychoanalytic	14	5.4	5.4	82.9
Cognitive	10	3.9	3.9	86.8
Behavioral	10	3.9	3.9	90.7
Humanist	9	3.5	3.5	94.2
Existential	2	.8	.8	95.0
Jungian	3	1.2	1.2	96.1
Other	10	3.9	3.9	100.0
Total	258	100.0	100.0	

Table 8

Religious Affiliation of the Respondents

Item/ measure	Frequency	Percent	Valid Percent	Cumulative Percent
Unknown	4	1.6	1.6	1.6
Agnostic	18	7.0	7.0	8.5
Atheist	13	5.0	5.0	13.6
Buddhist	15	5.8	5.8	19.4
Catholic	50	19.4	19.4	38.8
Greek Orthodox	1	.4	.4	39.1
Hindu	1	.4	.4	39.5
Jewish	22	8.5	8.5	50.8
Mormon	1	.4	.4	51.2
Protestant	92	35.7	35.7	86.8
Utilitarian	12	4.7	4.7	91.5
Personal Spirituality	9	3.5	3.5	95.0
Pantheist	2	.8	.8	95.7
New Age	7	2.7	2.7	98.4
Uncertain	4	1.6	1.6	100.0
Total	258	100.0	100.0	

The value of Cronbach's *a* for the group of nine, variables addressing core competencies exceeded 0.86, indicating good internal consistency reliability. Cronbach's *a* was justified in this study because it is the most frequently used statistic applied routinely by sociologists, psychologists, and clinicians to evaluate the internal consistency reliability of response variables in questionnaires and instruments used for behavioral, psychological, clinical diagnostics, and other assessments (Cronbach & Shavelson, 2004; Hogan et al., 2000).

An independent samples *t* tests was used to determine if there was a significant difference between the respondents who scored higher versus those who scored lower on both the religious ideology scale and the scientific orientation scale with respect to their levels of cognitive dissonance (conflict scale). The mean responses to the items addressing religious ideology and scientific orientation were computed. Two groups of respondents were classified with respect to the level of these responses. The first group (mainly reflecting agreement with the items) consisted of the respondents (n = 73) with low scores, below the mean on both scales. The second group (mainly reflecting disagreement with the items) consisted of respondents (n = 62) with high scores above the mean on both scales.

Nearly 57% of the respondents scored a mean of between 2.75 and 3.25 on both the religious ideology and scientific orientation scales (Figure 1). This implies the majority of respondents did not display strong agreement or strong disagreement for or against religious ideology or scientific orientation, thereby creating a bell-shaped distribution with a central tendency. The mean score was 3.16, the median (center of the

distribution) was 3.15, and the mode (the highest frequency) was 3.15. The standard deviation was 0.27. The distribution ranged from a minimum of 2.45 (2.6 standard deviations below the mean) to a maximum of 4.05 (3.3 standard deviations above the mean). The distribution included outliers (more than 2 standard deviations either side of the mean).

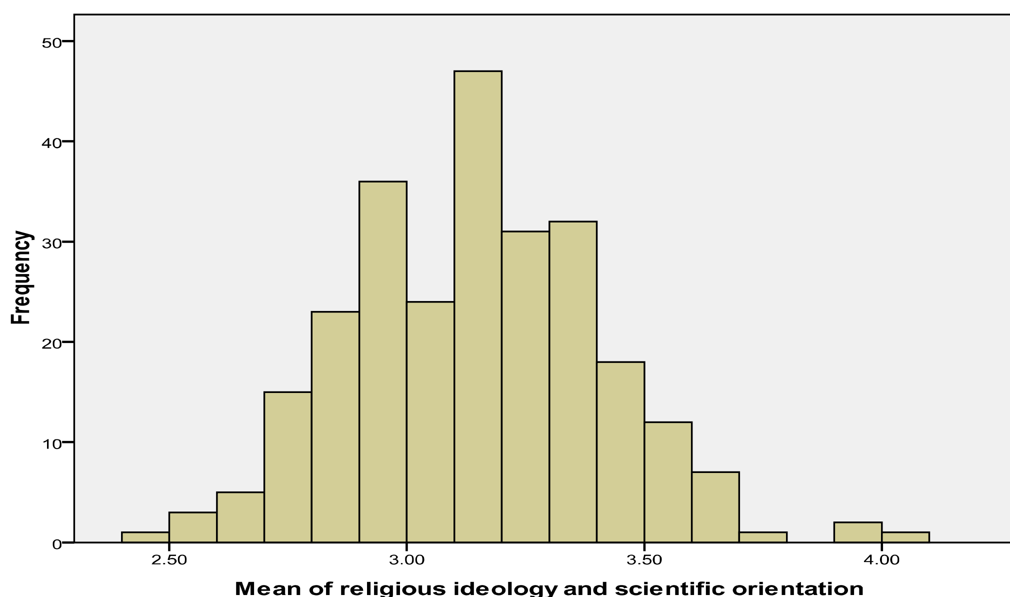

Figure 1. Mean responses to the religious ideology and scientific orientation scales

The results of the independent samples *t* tests provided evidence to indicate a trend. The mean response to three out of the nine variables, specifically Conflict 2Conflict 3, and Conflict 6 varied significantly at the 0.05 level between the two groups of respondents (Table 10). The sources of the variation between the mean responses are visualized in Figures 2, 3, and 4. The significant differences between the means of the variables Conflict 2, Conflict 3, and Conflict 6 at the 0.05 level reflected differences between the shapes and the skewed frequency distributions. The η^2 values varied from .000 to .038,

reflecting very low effect sizes, and indicating that results of the *t* test exhibited a high level of substantive importance. When the Bonferroni correction was applied, and the prescribed significance level was reduced to *a* = 0.005, the medians of only one of the variables, Conflict 3, which addressed disagreement with the concept that “For me, science and religion do not conflict with each other because they exist in different realms” varied significantly with respect to the two groups of respondents (Table 9). The power of each *t* test to reject a false null hypothesis at $\alpha = 0.005$ was less than the conventionally recommended threshold of 0.8, but greater than 0.8 at $\alpha = .05$ for Conflict 3 (Table 9a).

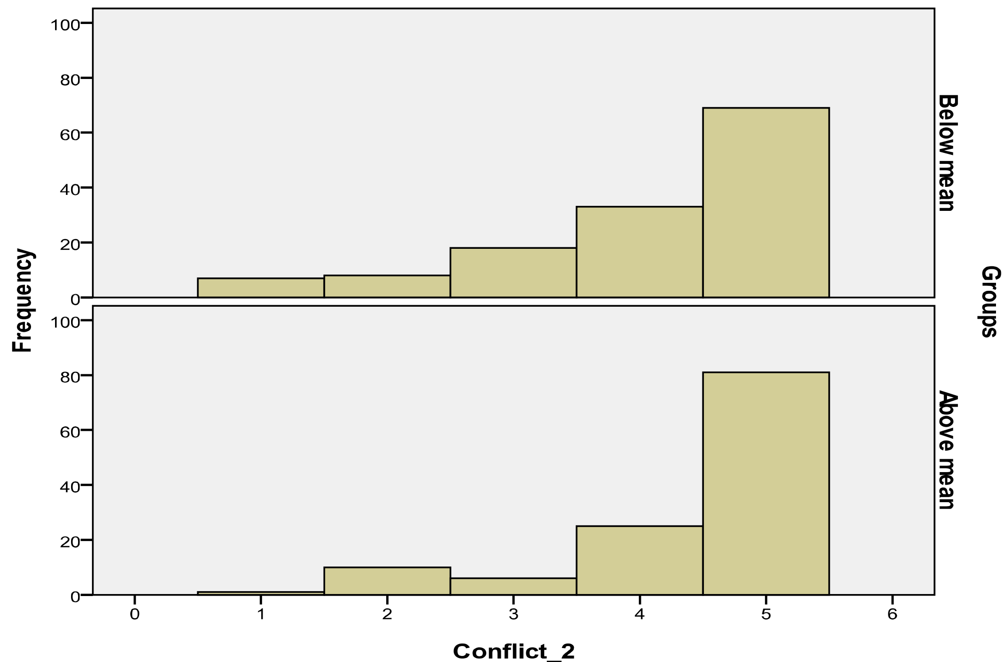

Figure 2. Relative frequency distributions of the response variable Conflict 2.

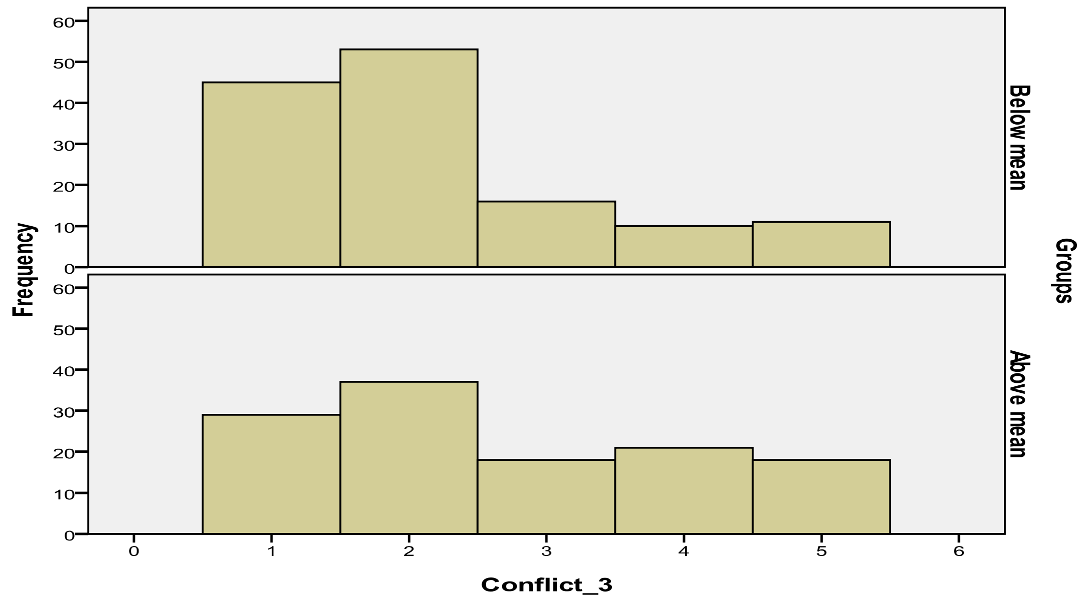

Figure 3. Relative frequency distributions of the response variable Conflict 3.

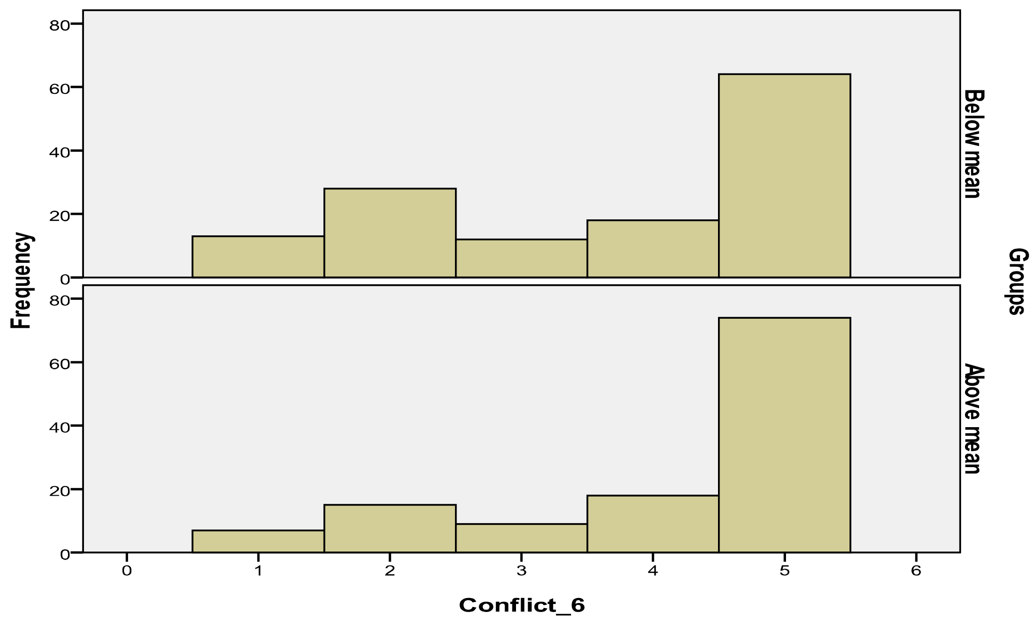

Figure 4. Relative frequency distributions of the response variable Conflict 6.

Table 9

Comparison of Cognitive Dissonance (Conflict Scale) for Two Groups of Respondents

Dependent variable	Item	Independent samples *t* test for equality of means		Effect size	Power to reject a false null hypothesis	
		t (133)	*p*	η^2	$\alpha = 0.05$	$\alpha = 0.005$
Conflict 1	In my personal life…	-1.500[a]	.135[ns]	.009	.32	.09
Conflict 2	With emerging...	-2.386[a]	.018*	.022	.66	.33
Conflict 3	For me, science…	-3.177[b]	.002*	.038	.87	.64
Conflict 4	I have sometimes had to…	.271[a]	.787[ns]	.000	.06	.01
Conflict 5	I have had arguments …	-.807 [a]	.421[ns]	.003	.13	.02
Conflict 6	I've recognized that if…	-2.508[b]	.013*	.003	.13	.37
Conflict 7	In my day-to-day…	-1.396[a]	.164[ns]	.008	.28	.08
Conflict 8	My profession al training..	-1.773[a]	.077[ns]	.012	.42	.15
Conflict 9	I have had to …	-1.432[b]	.153[ns]	.008	.29	.08

* significant at $\alpha = 0.05$ [ns] not significant at $\alpha = 0.05$ [a] equal variances assumed [b] equal variances not assumed

The minimum sample sizes to achieve a target power of 0.8 at $\alpha = .05$ using the observed mean differences and standard deviations for four of the dependent variables were ≤ 62 (i.e., less than the actual samples sizes of the respondents); however, due to the large standard

deviations, and the small differences between the means, the minimum sample sizes to achieve a target power of 0.8 were greater than the actual samples sizes for five of the dependent variables (Table 10).

Table 10

Power Analysis To Compute the Minimum Sample Sizes for Independent Samples t *Tests*

Dependent variable	Difference between two means	Standard deviation	Minimum sample size in each group for target power = 0.8 at $\alpha = .05$
Conflict 1	0.690	1.291	56
Conflict 2	0.538	0.964	52
Conflict 3	0.634	1.244	62
Conflict 4	0.307	1.295	281
Conflict 5	0.290	1.417	376
Conflict 6	0.734	1.170	41
Conflict 7	0.337	1.119	175
Conflict 8	0.250	1.014	260
Conflict 9	0.276	1.004	209

Inferential Statistics

At the 0.05 level of significance, no significant regression model to predict the approval of core competency using scientific orientation and religious ideology as predictor variables could be constructed (Table 10). The model was not confounded by partial correlations or biased due to co-linearity between the independent variables. The VIF statistics were close to 1, and the partial correlation coefficients did not decline significantly when compared with the zero-order correlation coefficients. The residuals were not distributed evenly and randomly either side of their mean (zero) value with respect to the predicted values (Figure 5) reflecting non-homogeneity of variance. In addition, the skewed frequency

distribution of the residuals (Figure 6) and the results of the Kolmogorov-Smirnov test (Table 10) provided evidence at the 0.05 level to indicate that the residuals deviated from normality. The standard error of the estimated values of the dependent variable was high indicating that the precision of the estimate was poor (Table 10). The *R* Square value (adjusted for the number of variables in the models) indicated that only 1.2% of the variability in the dependent variable was explained. The ANOVA results (F (2,255) = 2.546, p = .080) provided evidence to indicate that the MLR model did not explain a significant proportion of the variability in the dependent variables at α = 0.05. The *t* tests on the partial regression coefficients provided evidence to indicate that one of the regression coefficients (p = .048 for religious ideology) was marginally significantly different from zero at α = .05. The regression coefficient for scientific orientation (p = .349) was not significantly different from zero.

Table 11

Results of MLR To Predict Approval of Core Competency Using Scientific Orientation and Religious Ideology as Predictor Variables

(a) *R* Square

R	R^2	Adjusted R^2	*SE* of the estimate
.140	.020	.012	5.931

(b) ANOVA

Source of variance	*SS*	*df*	*MS*	*F*	*p*
Regression	179.085	2	89.542	2.546	$.080^{ns}$
Residual	8968.656	255	35.171		
Total	9137.740	257			

table continues

(c) Regression coefficients and residual normality statistics

Variable	Un-standardized coefficients	Standardized coefficients	t	p	Kolmogorov Smirnov Z	p
	β	Beta weights				
Intercept	18.674		4.152	.000*	1.704	.006*
Scientific orientation	.087	.058	.938	.349ns		
Religious ideology	.225	.124	1.988	.048*		

* significant at α = 0.05 [ns] not significant at α = 0.05

(d) Correlations

Variable	Zero-order	Partial
Scientific orientation	.066	.059
Religious ideology	.154	.124

(e) Colinearity statistics

Variable	Tolerance	VIF
Scientific orientation	.996	1.004
Religious ideology	.996	1.004

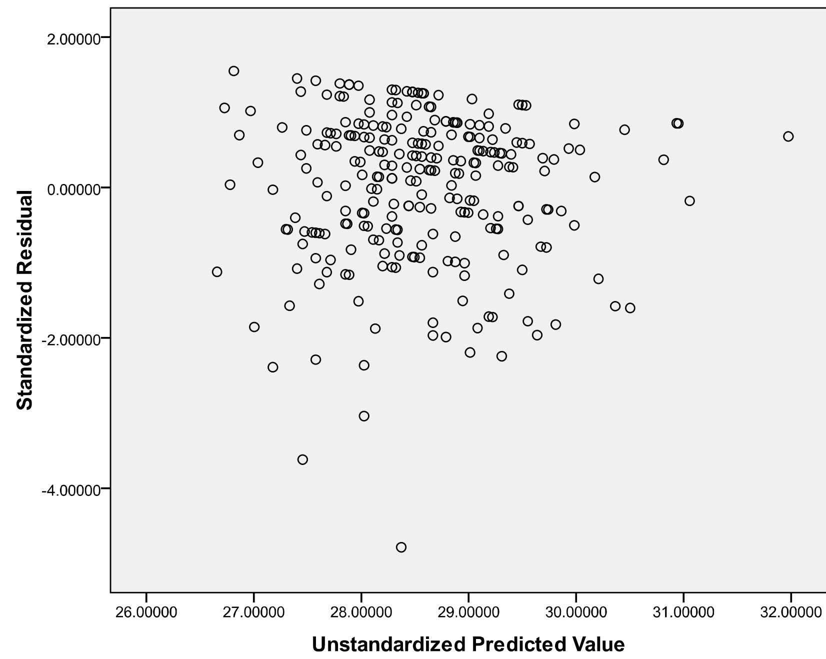

Figure 5. Distribution of residuals.

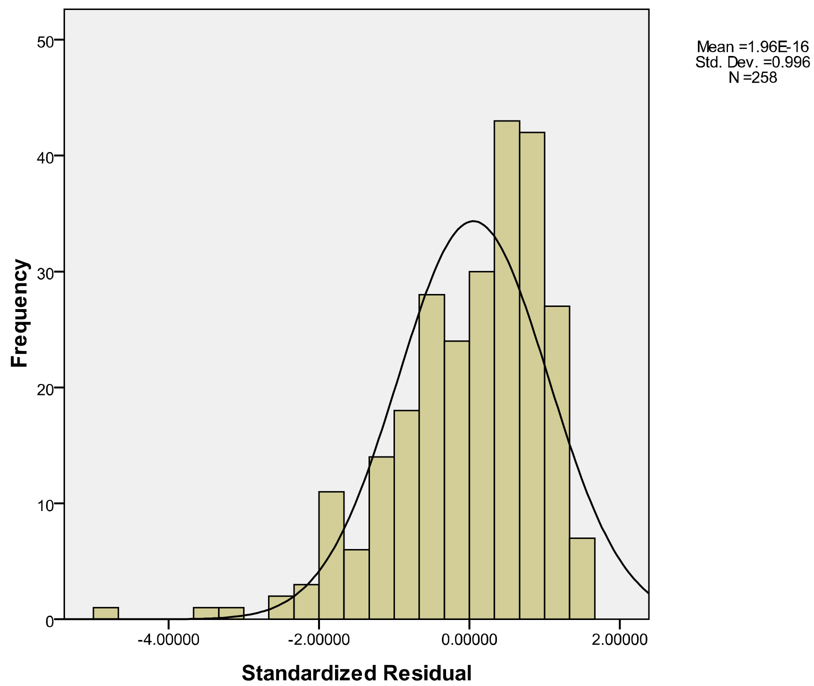

Figure 6. Frequency distribution of residuals.

Summary of Results

The results are considered with respect to the research questions and hypotheses. There was insufficient evidence to provide an unequivocal answer to RO 1: Will cognitive dissonance (conflict score) increase with respondents who hold both religious ideology and a scientific orientation for explanations of knowledge? The answer is not clear because it depends on the interpretation of the statistics.

Overall, the *t* test provided results that were consistent with null hypothesis 1 (i.e., there is no significant difference between those who score higher versus those who score lower on both the religious ideology scale and the scientific orientations scale on levels of cognitive dissonance). However, there was a significant difference on Conflict item 3: "For me, science and religion do not conflict with each other because they exist in different realms".

In contrast, there was evidence to provide an unequivocal answer to RO 2: Is religious ideology and/or scientific orientation among APA and ACA members a stronger predictor for approval of integrating the core competencies standards into current mental health professional training programs? This was because of the non-significant amount of variance explained by the predictors. There was very little dissonance in this group. However, the values of the regression coefficients may be biased, and must be interpreted with caution. The effect sizes were low, since less than 11% of the variability in the dependent variable could be explained, and the standard errors were high, so the models lacked precision.

Although the multiple regression failed to identify significant predictors of approval of the core competency variables, as an exploratory aspect of this study, the bivariate correlations were explored. Caution must therefore be used when interpreting these results. Multivariate predictors of the approval of core competency standards were identified at the 0.05 level. Three of the core competency variables (1, 2, and 6) were not significantly correlated with the variables concerned with religious ideology or scientific orientation. The religious ideology variables were, however, significant predictors of four of the core competency variables (4, 5, 7, and 9). The scientific orientation variables were significant predictors of three of the core competency variables (3, 5, and 8). The religious ideology and scientific orientation scales were predictors of both the core competency responses associated with the personal spirituality of the respondent and also the core competency responses associated with the client's spirituality.

The results of the multiple regression analysis are tentatively consistent with Alternative Hypothesis 2: There will be a positive relationship between religious ideology and/or scientific orientation on respondents' approval of integrating the core competency standards into current mental health professional training programs. However, there is not enough evidence to suggest which would be the stronger predictor.

This chapter has described the findings of the research surveying APA and ACA members regarding their level of approval of the ASERVIC (1995) core competencies for integrating spiritual and religious diversity into mental health counseling. It also measured the level of cognitive dissonance members may experience considering the integration of these issues into mental health counseling and counselor education

programs. The results of the data analyses indicate that of the members responding to the study, the majority did not report experiencing cognitive dissonance regarding spiritual and religious diversity issues.

CHAPTER 5:

DISCUSSION

The purpose of this quantitative dissertation was two-fold.. First, to assess cognitive dissonance, as measured by the conflict scale (the dependent variable), by comparing those who score higher versus lower on both religious ideology and scientific orientation (the independent variable). Data were gathered using the Religious Ideology, Scientific Orientation, and Conflict Questionnaire (Eckhardt et al., 1992). This was evaluated using an independent groups *t* test. Second, this study quantitatively examined the relative influence of religious ideology and/or scientific orientation on APA and ACA members' approval of integrating the ASERVIC core competencies into mental health professional training programs. By means of a multiple regression, the two predictor variables (religious ideology and scientific orientation) were used simultaneously to examine respondents' level of approval of the core competencies. No previous research has focused on assessing how one's religious ideology and scientific orientation relate to the acceptance of the core competencies.

Two hypotheses were tested. The first hypothesis examined whether cognitive dissonance would increase with participants who hold both religious ideology and/or a scientific orientation for explanations of knowledge. A *t* test revealed very little dissonance in this group. The results supported the null hypothesis. This analysis examining cognitive dissonance among mental health professionals regarding explanations of knowledge was contrary to previous research that suggested some mental health professionals have experienced discomfort when considering the balance between

religious ideology and scientific orientation (Bergin and Jensen, 1990; Eckhardt et al. 1992; Richards & Bergin, 2000). The post hoc power analysis indicated the relatively small sample size may have contributed to the support of the null hypothesis. Obtaining a larger sample size is recommended for future research.

The second hypothesis explored whether religious ideology and/or scientific orientation among ACA and APA members would be a stronger predictor for approval of integrating the core competencies standards into current mental health professional training programs. It was hypothesized that there would be a relative influence of religious ideology and/or scientific orientation on members' approval of integrating spiritual core competencies into training programs. In practical terms, the outcomes would provide data for what is hindering the integration of these topics into counselor education programs. Multiple regression analysis was preformed to test this specific hypothesis. The results failed to support the null hypothesis. Therefore, it can be stated that either religious ideology or scientific orientation will be a stronger predictor for approval of integrating the core competencies standards into current mental health professional training programs; however, there is not enough evidence to suggest which would be the stronger predictor. As noted above, no previous research exists on this topic. Related research on the core competencies among ACA found members strongly support the importance of the competencies regardless of their personal attitudes related to religion and spirituality (Young, Wiggins-Frame, & Cashwell, 2007).

Implications

Overall, cognitive dissonance among mental health professionals in the current population is minimal regarding religious ideology and/or scientific orientations of knowledge. In addition, the participants of this study approve of the integration of spiritual and religious diversity into the counseling education process. Previous research has suggested psychologists avoided issues related to spirituality and religion when working with clients (Bergin, 1980, 1983; Frame, 2003; Young, Wiggins-Frame, & Cashwell, 2007; Zinnbauer & Pargament, 2000) Moreover, in the past, psychologists have reported low rates of conventional religious affiliation and participation (Bergin & Jensen, 1990; Eckhardt, et al. 1992; Richards & Bergin, 2000). This study is significant because it included an exploration of cognitive dissonance and the integration of spiritual and religious diversity in counseling education programs. It is important to acknowledge that there has been a shift among mental health professionals over the past few decades in that the interest in spirituality and religion within the behavioral sciences has exploded (Weaver, et al. 2006). Yet, formal training in these areas continues to be neglected in programs that prepare today's mental health professionals (Briggs & Rayle, 2005; Curtis & Glass, 2002; Kelly, 1994, 1997; Pate & High, 1995; Russell & Yarhouse, 2006; Young, Cashwell, Wiggins-Frame, & Belaire, 2002).

The responses from the present study suggest among the mental health professionals participating, attitudes toward spiritual and religious ideologies are more accepting than they have been in the past. Nearly 74% of respondents agreed or somewhat agreed with the statement "I have a religious identity that is a central part of

me". The current study demonstrates today's psychologists are less influenced by secular limitations than have been seen in the past and suggests psychologists appreciate religious and spiritual concerns and view them as relevant to clinical practice.

The findings of the current study support Smith and Orlinsky (2004) who conducted an international survey of psychotherapists (*N* = 975) and concluded 51% exhibited a pattern of definable personal spirituality, suggesting religiosity among psychotherapists is complex, and consistent with Shafranske and Malony's (1990) findings that spirituality plays an important role in the lives of psychotherapists.

Regarding approval for the ASERVIC core competencies, responses indicate nearly 90% of the participants either approve, recommend or have performed core competency 1: "Explain the difference between religion and spirituality, including similarities and differences." Only 8% disapproved of that core competency. Over 98% of the respondents either approve, recommend, or perform core competency 5: "Demonstrate sensitivity and acceptance of a variety of religious and/or spiritual expressions in client communications." Fully 90% of the respondents either recommend or have performed core competency 8: "Be sensitive to and receptive of religious and/or spiritual themes in the counseling process as befits the expressed preference of each client." These data suggest among the APA and ACA members responding, the majority approve, recommend or have performed all of the nine core competency standards for integrating spiritual and religious diversity issues into mental health counseling as defined by ASERVIC (1995). These findings refute the research available over 15 years ago when Kelly (1994), as well as Pate and Bondi (1992), demonstrated low approval

ratings by mental health professionals regarding the integration of spiritual and religious course curricula into counselor education programs. More recently, Russell and Yarhouse (2006) found only 27% of the APA-accredited programs they surveyed would implement such curriculum if it were developed and available.

While secular issues of separation of church and state within the American political and cultural structure accounts for some of this neglect (Young, Wiggins-Frame, & Cashwell, 2007), most researchers assert the exclusion of spiritual and religious diversity stems from the historical tensions between science and religion (Blanch, 2007; Hill & Pargament, 2003; Young, Wiggins-Frame, & Cashwell, 2007). Both medical and mental health services are experiencing the considerable impact of this “new frontier” of the relationship between current scientific inquiry, religion, spirituality and health (Russinova & Cash, 2007, p. 271).

As the counseling profession is increasingly identified with healthcare ideology (Hansen, 2007) and empirical studies are demonstrating the role of faith regarding physical and emotional well being (Weaver et al. 2006), the need for integration of spirituality and religious diversity into mental health care is evident. Findings from this study will contribute to the research to identify what may be hindering the integration of spiritual and religious topics into counselor education programs. Moreover, multicultural awareness includes the recognition that spiritual and/or religious diversity is an inherent dimension in human functioning and development. Finally, mental health professional would benefit from exploring spiritual and/or religious diversity topics to develop a foundation for resilient and ethical practice.

Limitations and Future Considerations

There are several limitations to this study. First, a larger sample size is recommended across the multiple divisions of the APA and ACA to increase validity and generalizability of the study. The present study was based on a 32% response rate from a national sample. In addition, it must be noted that survey research produces data based on self-report. This particular sample may have elected to participate in the study due to bias toward integrating spiritual and religious diversity training into counselor education programs.

Secondly, more research is needed related to the religious ideology and scientific orientation scales. The internal validity of this instrument did not prove to be good predictors of approval of the core competencies. It is further recommended the study be repeated using the revised competencies for addressing spirituality and religious issues in counseling.

Third, to obtain more detailed information regarding the responses of the participants, it is recommended that an exploratory factor analyses be conducted. The implications of age, education, and geographic location on respondents' approval of the competencies, for example, could reveal significant determinants regarding these issues among psychologists.

The development of curriculum addressing spirituality and religion for counselor training programs is needed. The studies reviewed in this dissertation suggest this area of development is growing with many innovative approaches (Cashwell & Young, 2004; Plante, 2007, 2008; Zinnbauer & Pargament, 2000). However, the 2009 CACREP

Standards remain ossified with regard to spiritual and religious diversity, with the exception of the new requirements addressing addiction issues.

The need for integrating spiritual and religious diversity topics into counselor education programs is evident. The current standards that include a reference to "religious preference" in the common-core area of Social and Cultural Foundations is inadequate (CACREP, 2009), and recent research indicates more is needed to prepare mental health professionals for the diverse client populations of today (Plante, 2007; Russell & Yarhouse, 2006). The APA (2002) *Ethics Code* requires clinicians to be mindful of the diversity domain of spirituality and religion. Therefore, some have concluded that spiritual and religious diversity becomes a standard core competency area in training programs (Hathaway, 2008). Schregardus (2007) argued that spirituality affects every aspect of an individual's life and neglecting this dimension of human functioning may delay healing or even result in attrition. Furthermore, mental health professionals who seek out opportunities to enhance their knowledge of spiritual and religious diversity experience improved personal and professional well-being (Baker, 2003; Blanch, 2007).

Implications for Social Change

Findings suggest an important social-change implication: Counselors may not perceive a conflict between religious ideology and scientific orientation and therefore may be willing to accept the integration of the ASERVC competencies into their training. Implications also include changes in curricular requirements within academic programs that train counselors, social workers, and psychologists to integrate these competencies;

considerations for ethical guidelines addressing religious and spiritual diversity, and the development of continuing education coursework pertaining to spiritual and religious diversity competencies. The findings from this research can potentially contribute to the integration of spiritual and religious diversity training in counseling education programs. Clearly, the influence of religious and spiritual beliefs upon an individual's physical and mental health is indisputable. The promise and potential of a fully integrated field of psychology which prepares its professionals to be aware of and sensitive to the diversity of spiritual beliefs and practices is immeasurable. The benefits to clients and clinicians alike include enhanced abilities to cope with life's uncertainties and crises (Baker, 2003; Pargament, 1997; Plante & Sherman, 2001; Seligman, 2002) improved overall health and wellness (Cox, Ervin-Cox & Hoffman, 2005; Koenig, McCullough & Larson, 2001; Richards & Bergin, 2004; Shafranske, 1996), and an approach to religious and spiritual experiences that will broaden our ability to understand the personal and social implications of faith (Fontana, 2003; Mruk & Hartzell, 2003; Yalom, 2008).

The implications of social change associated with the integration of spiritual and religious diversity into professional counseling education programs extend far beyond the counseling profession. The current social realities marking the cultural diversities among Eastern and Western systems of belief as important social institutions must be acknowledged. Moreover, cultural migration and subsequent religious diversity in the United States is demonstrating the percentage of the population affiliated with Christian and Jewish beliefs are static or declining while there are reported substantial increases associated with New Age, Hindu, Buddhist, and Muslim beliefs (World Christian

Encyclopedia, 2001). Therefore, the recognition of need for religious and spiritual diversity competency within the counseling profession is evident. The larger social implications of this cultural momentum are associated with the spiritual revolution (Heelas & Woodhead, 2005) that predicts religion and spirituality in the modern world will result in the "cultivation of unique, personal subjectivities" (p. 131). Psychologists unprepared for this revolution risk marginalizing the profession.

As the data for this study was being collected, the Association for Spiritual, Ethical and Religious Values in Counseling (ASERVIC) met and approved the revised Competencies for Addressing Spiritual and Religious Issues in Counseling. The Summit II on Spirituality, lead by Craig Cashwell, a leading spirituality researcher, along with 15 other leaders in the field of counseling and spirituality met at the ACA Conference in Charlotte, North Carolina, in May 2009. The original nine spirituality competencies used in this research were revised into the new 14 competencies (Appendix F). The revised competencies are ideally suited for integration into counseling education programs as they address all aspects of the counseling process. Further recommendations would include investigating the curricular experiences of students and practicing mental health professionals learning these revised competencies.

The 2009 Council for Accreditation of Counseling and Related Educational Programs (CACREP) Standards will be requiring counseling programs to provide increased attention to addiction-related issues within their criteria (Morgen & Cashwell, 2009). This decision is viewed as a break through for increasing awareness of the importance of preparing professional counselors to address the spiritual and religious

issues of their clients. More research in this area is needed to demonstrate empirical evidence for the revised ASERVIC competencies.

Conclusions

In conclusion, the aim of this study was to explore current levels of dissonance among mental health professionals regarding spiritual and religious diversity issues and the level of approval for integrating the ASERVIC's (1995) core competency standards into counselor education programs. The findings indicate respondents approve of the integration of spiritual and religious issues into professional training programs regardless of ethnicity, qualifications, and which organization they were affiliated with (APA or ACA). Moreover, there was little cognitive dissonance associated with this approval.

More research is needed with the revised ASERVIC core competencies to provide additional data and to continue to build consensus for these changes among mental health professionals. The literature associated with competencies preparation regarding spiritual and religious diversity indicates overwhelming evidence of the need for these changes. The Association for Spiritual, Ethical and Religious Values in Counseling (ASERVIC) has been leading the way with collaborative efforts to develop methods and interventions for working with spiritually and religiously diverse clients.

The primary aim of counseling is to give meaning to life. Attempting to assist clients in navigating the journey of life without considering the spiritual and/or religious aspects of their experiences ignores the majority of preeminent scholars within psychology, and increasingly, among other disciplines. This research has attempted to identify what may be hindering the integration of spiritual and religious diversity into

counselor education programs. The results of this study suggest that many mental health professionals recognize the need for these integrations and there appears to be little evidence of the conflict seen in the past regarding spirituality, religion, and the practice of counseling psychology.

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APPENDIX A:

HISTORICAL CONTEXT FOR THE INTEGRATION OF SPIRITUAL AND RELIGIOUS DIVERSITY INTO COUNSELING EDUCATION PROGRAMS

At the beginning of the twentieth century, the religious practices of nearly all Americans were within a Christian or Jewish belief system (Butler, 1992). By the end of the twentieth century, there were at least five major religious groups to which Americans reported adhering (see Table 1). The resulting diversity of this cultural development in our society has multiple implications for the mental health professional including education, supervision, and practice.

Table A1

Religious Adherence by Americans and Worldwide

Religion	Number of Adherents
United States	
Christian	151,225,000
Jewish	3,137,000
Muslim	527,000
Buddhist	401,000
Hindu	227,000
World	
Christian	1,927,953,000
Jewish	14,117,000
Muslim	1,099,634,000
Buddhist	323,894,000
Hindu	780,547,000

Source: United States: Bedell, 1997, pp. 252-258
World: *World Almanac*, 1997, p.646

Religious affiliation and attendance remains strong in the United States; only 6% of the general population report they have no religious preference (Gallup, 2000). The religious diversity that exists in American culture is evidenced by the growing interest in integrating various religious traditions into new forms of spirituality. Indeed, research into the domains of religion, spirituality, and health has been increasing throughout this century. For example, between 1900 and 1959, a literature search in PsycINFO yielded a total of 3,803 articles related to religion or spirituality; whereas between 1960 and 2006 the same search words yielded 21,500 articles (Bartoli, 2007). The analysis of empirical studies over the past 35 years indicate the term "spirituality" as a construct in studies examining the association with health is increasing while studies using the term "religion" is decreasing (Weaver et al., 2006). Furthermore, in the early part of the 20th century these investigations were, in general, focused on various pathological processes associated with religious beliefs (Freud, 1927) and the latter part of the century has been focused on a "religiously affiliated spirituality as wholesome growth" (Helminiak, 2001, p. 163). Whether this is indicative of the general shift of meaning from one term to the other is not known. As Hoge (1996) pointed out, the topics of religion, belief and affiliation are "laden with definitional problems" (p. 21). The evolution of the term "spirituality" has included the humanistic perspective (Maslow, 1968; May, 1953; Rogers, 1960), images of the mystical soul (James, 1902; Jung, 1938), elements of transpersonal thought (Cortright, 1997; Wilber, 1980, 2006), and has been deeply rooted in existential theory (Frankl, 1962; May, 1950; 1957; Yalom, 1995). Current views of spirituality seem to be inclusive of broad definitions, reflecting changing attitudes and

values pertaining to how to understand and cope with modern life. As Americans increasingly report spiritual beliefs and behaviors that are not limited to any one particular religious tradition, their level of religiosity does not seem to be waning (Hoge, 1996). However, Sorenson (2004) suggests the dichotomy present in today's culture, the sense of "being spiritual but not religious" makes it more difficult to investigate these constructs. Indeed, there are multiple constructs within the current research literature. Schregardus (2007) asserts the term "spiritual" is synonymous with the search for the sacred. Rituals as spiritual practices to engage the sacred dimension now include religious activities but are no longer limited to traditional religious rituals (Wilber, 2006). Griffith and Griffith (2002) identify the spiritual dimension of life, that which is sacred, as the richest sources of healing and transformation available in therapeutic work. Zinnbauer and Pargament (2000) suggest the term "sacred" improves the clarity of the construct as the term involves a searching for meaning regardless if the object of that searching is an absolute (as in religion) or a personally constructed reality (as in spirituality) for both are valid in the search for meaning. Some of the most recent research attributes this diversity of definitions to the spiritual paradigm shift that has been taking place in American culture and identified within the field of psychology (West, 2007).

Powers (2005) provides an overview of spirituality and counseling literature published in the past century. Powers asserts the field of psychology began with the works of William James (1902) who determined through his studies that spiritual experiences were legitimate psychological phenomenon. Psychology then moved through

the behaviorists who maintained only observable phenomenon was worthy of psychological science, and then returned to the forces involved in spirituality within the humanistic approach. Powers notes the movement toward multicultural awareness and sensitivity has also influenced the current trend, even though it was initially concerned with ethnic and racial differences, it soon expanded to include gender, sexual orientation, physical disabilities, age, socioeconomic level, and finally, religion. Powers notes in her conclusions counseling psychology has "finally come back to where William James started more than 100 years ago" with the "understanding that spiritual experiences are a legitimate psychological phenomena worthy of counselors' attention" (p.224).

The past four decades seem to reflect the most activity within the social sciences databases related to psychology and religiosity (Bartoli, 2007; Powers, 2005; Weaver et al., 2006). Sociologist Robert Wuthnow (1998) contends religion and spirituality in American culture began to take on a rebellious tone during the 1950s as the understanding of the sacred began to change. The authority of science as the dominating source of truth had given way to disillusionment, a result of the social and political changes of the times (Bergin, 1980; Wuthnow, 1998). Some of the social factors contributing to this transformation in religion and spirituality included increasing violence, the murder of public figures, escalating drug addiction and the threat of nuclear power in a cold-war era (Kurtz, 1999). Wuthnow suggests the broad uncertainties of world war, terrorism, environmental pollution, and the powerlessness most feel in the face of these developments, contributed to the reshaping of religious seeking and behavior. All of these factors continue to be of escalating global concern and studies are

documenting that clients desire an exploration of their spiritual values with their counseling professional in an effort to cope with these growing uncertainties (Larson & Larson, 2003; Martinez, 2007; Rose, Westefeld, & Ansley, 2001; Schregardus, 2007).

Spirituality and Religion in the Context of Specific Religious Belief Systems

The relationship between Christian religious faith and individuals well-being was investigated by Perry (1998) who found that participants ($N = 26$) identified several tools to combat circumstances that could lead to distress and disease. Among these were the religious community which leads to a reduction of risk taking behaviors, a sense of coherence and meaning derived from Scriptures, prayer, and the special nature of the personal relationship with Christ.

Khalid (2006) discusses the significance of spirituality in counseling Muslim clients. She asserts the Islamic perspective holds spirituality as a central construct and views mental unrest as a manifestation of an “incongruent heart or unstable soul that is lost and has become distant from itself and the creator” (p. 7). As an integrative counselor, Khalid supports a model that incorporates cognitive theory to challenge maladaptive thoughts, behavioral theory to challenge maladaptive learning habits, person- centered and psychodynamic theory to identify unresolved conflicts and feelings, and the use of Islamic/spiritual techniques to acknowledge the spiritual self in keeping with Muslim tradition (locating distress in the soul and heart).

In an effort to promote understanding of mental health issues among Muslims Kobeisy (2006) discusses the challenges facing faith-based practices. Noting that there are over one billion Muslims in the global community and recognizing the vast diversity

that exists among the subcultures of Muslims, the various degrees of faith, practice, and identification with Islam must be taken into account. Kobeisy reminds the reader that seeking mental health treatment is a stigma within the Muslim community as it is in any community. In fact, according to Islamic tradition Kobeisy states "actual knowledge of the self and its sources of happiness or illnesses can be trusted only to the revelation that comes from God, the Creator" (p. 61). Faith and Islamic religious practices and beliefs provide support to individuals and communities and impact positive mental health within Muslim cultures in much the same manner as in other cultures.

Levitt and Balkin (2003) discuss the importance of religious beliefs and practices from a Jewish perspective and assert many counselors are unprepared to address the spiritual and religious issues of individuals who practice Judaism. Among the factors that influence positive mental health within this cultural community, according to Levitt and Balkin, are the importance of family and family rituals, identity and values exploration, and the history or the experience of being Jewish throughout the generations. The authors note that many Jews present with higher levels of generalized anxiety and even paranoia than clients from other religious backgrounds. In order to provide diversity-sensitive counseling, the mental health professional needs to acquire a good understanding of the central role of both ritual and tradition in Judaism and an awareness of historical oppression, ethnocentrism and anti-Semitism.

Spirituality and Religion as Applied to Specific Populations

Helmeke and Bischof (2007) examined the role of spirituality and religion as it relates to couples therapy. Spirituality and religion have been rooted in the field of

marriage and family therapy (MFT) since the earliest days of the movement in the 1930s. It follows that the MFT educational requirements for accredited programs include religion and spirituality along with other multicultural and diversity training. Helmeke and Bischof review the advantages of including spirituality in couples counseling including prayer as a conflict resolution tactic, concepts related to forgiveness, and the use of Christian meditations. Also noted is the need for increased attention in the training and supervision of counselors regarding spirituality.

Hodge, Cardenas, and Montoya (2001) investigated spiritual and religious participation in rural youth as a protective factor against substance abuse and found increased spirituality led to lower rates of alcohol, marijuana, and hard drugs. The respondents ($N = 475$) answered surveys measuring participants spirituality levels, religious participation rates, and substance use. The researchers suggest spirituality plays a significant role in inhibiting substance abuse during adolescence. It was noted that the findings of the study had significant implications for adolescent substance abuse prevention programs. It was also noted that while there is an increase in academic interest in spirituality and religion, there remains a lack of training in these topics among social workers. Recommendations included developing competencies in these areas to increase comfort levels and sensitivities as well as reducing potential imposition of values, respects the adolescents' autonomy, parental rights, and other ethical and legal considerations.

Hodges (2002) provides a thorough discussion of the dimensions of spirituality and religion and human growth and development especially as it pertains to emotional

well-being during adulthood. Hodges argues that emotionally healthy adults engage in an active spiritual life to find meaning and purpose in life, and is mindful of an intrinsic value system that informs and guides their work and decisions. She contrasts this with the adult who suffers chronic depression, finds no meaning in life and frequently reports feeling hopeless, empty, and alienated. Hodges maintains the evidence for healthy emotional development is clear: "… healthy human growth and transition must include an examination of the various factors of the human experience: social, educational, family, vocational, and religious/spiritual" (p. 114). Overall, Hodges notes, religious beliefs and practices have been shown to be among the best predictors of positive coping, life satisfaction, and the "appreciation of the mystery and sacredness of life" (p.114). The author concludes that more training is needed if therapists are to assist clients in the integration of their spirituality in a supportive and reaffirming manner.

APPENDIX B

CONSENT FORM

You are invited to participate in a research study investigating the value of integrating spiritual and religious diversity training into counselor education programs. You were selected as a potential participant in this study as a part of a national random sample of practicing mental health professionals. We ask that you read this form and ask any questions you may have before agreeing to be in the study. This study is being conducted by Sharon R. Gough, a doctoral candidate at Walden University.

Background Information: The purpose of this study is to examine the value of integrating spiritual and religious diversity curriculum into mental health professional training programs. Data will be gathered and analyzed by using the attached survey to investigate the extent to which religious ideology and/or scientific orientation exists among mental health professionals.

Procedures: If you agree to participate in this study please complete the attached survey and return it in the self-addressed envelope provided. There are two questionnaires enclosed. The first questionnaire, *Core Competency Questionnaire* (CCQ) consist of 9 questions regarding your demographics, work setting and religious affiliation followed by 9 questions related to the core competencies for addressing spiritual and religious diversity within mental health professional training programs. The second questionnaire is the *Religious Ideology, Scientific Orientation, and Conflict Questionnaire (*RISOCQ),

(Eckhardt et al., 1992). This 29-item questionnaire was designed to gather information regarding religious ideology and/or scientific orientation and the extent to which these two orientations are related to conflict. Please complete the survey and mail them back to this researcher in the self-addressed stamped envelope included in your packet.

Confidentiality: The records of this study will be kept private. In any sort of report that might be published, I will not include any information that will make it possible to identify a participant. Research records will be kept in a locked file; only the researcher will have access to the records.

Voluntary Nature of the Study: Your participation in the study is voluntary and you are free to withdraw at any time during the process of completing the surveys.

Risks and Benefits of being in the Study: There are no physical risks and potential emotional risks are minimal. You may find some of the items very personal and emotionally upsetting. Please answer them honestly as there will be no identifiers available to the researcher or others. Potential benefits may include better knowledge and increased awareness of the spiritual and religious diversity issue in counseling psychology.

Potential Conflict of Interest Issues: The researcher is currently an active member of both the American Counseling Association and the American Psychological Association.

Contacts and Questions: The researcher conducting this study is Sharon R. Gough. She can be reached by email at Sharon.Gough @waldenu.edu. The researcher's advisor is Dr. Alethea Baker who can be reached by email at Alethea.Baker@waldenu.edu. The Research Participant Contact is Dr. Leilani Endicott and if you would like to talk privately about your rights you may contact Dr. Endicott at 800-925-3368, ext. 1210. Please retain this consent for your records and contact the researcher if you would be interested in receiving a copy of the results of this study.

Statement of Consent: **"**I have read the above information. I have asked any necessary questions and received answers. To protect my privacy signatures are not required. By completing and returning the attached survey I indicate my consent to participate."

APPENDIX C:

GENERAL SURVEY DIRECTIONS

For the purpose of this research, spirituality is defined as provided by the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC, 1998): "Spirituality includes one's capacity for creativity, growth and the development of a value system. Spirituality encompasses a variety of phenomena, including experiences, beliefs, and practices. Spirituality is approached from a variety of perspectives, including psycho-spiritual, religious, and transpersonal. While spirituality is usually expressed through culture, it both precedes and transcends culture" (par. 3-4).

The definition of religious is used generically to describe both religiosity, i.e., participation in an organized religion, and personal spirituality.

The survey consists of two questionnaires with 47 items total. The first questionnaire, *Core Competency Questionnaire,* is divided into two sections. Section I pertains to demographic data collection. Section II relates to the importance of the core competencies for addressing spiritual and religious diversity in mental health professional training programs. Section II questions are rated on a Likert-type scale.

The second questionnaire, *Religious Ideology, Scientific Orientation, and Conflict Questionnaire* was designed by Eckhardt et al. (1992) to (a) assess the extent to which religious beliefs and scientific ideologies exist among a national random, cross-division sample of mental health professionals and (b) the extent to which these two orientations are related to conflict within individuals who hold both explanations of knowledge. These items are rated on a 5-point Likert-type scale.

The survey will take approximately 10 minutes to complete.

Please read the instructions and questions carefully and answer by selecting the answer that best represents your opinion.

Thank you very much for your cooperation and support of this research.

APPENDIX D:

CORE COMPETENCIES QUESTIONNAIRE

Section I: **Demographics**

1. Sex:
    1. Male
    2. Female
2. Age: ______
3. Ethnicity:
    1. Asian American
    2. Hawaiian native/Pacific Islander
    3. Black/African American
    4. White (non-Hispanic)
    5. Hispanic
    6. Native American/Alaskan Native
    7. Other: ___________________________________
4. Please enter your U.S. zip code in which you practice:

    ____

5. Degree held:
    1. Masters degree
    2. Ph.D.
    3. Psy.D.
    4. Ed.D.
6. Years in practice: ______
7. What work setting best describes your primary employment? (check one)
    1. Private Practice
    2. Community Counseling Agency
    3. University/college
    4. Corrections
    5. Hospital or other medical setting
    6. Elementary, Middle or High School
    7. Government
    8. Industry/Organizational
    9. Other ______________________________________

8. Please rate to what extent your clinical practice is guided by each of the following theoretical orientations from 1 to 5 on the following scale:

1 (not at all) 2 (rarely) 3 (occasionally) 4 (frequently) 5 (most frequently)

____ 1. Eclectic/integrative
____ 2. Cognitive-Behavioral
____ 3. Psychoanalytic
____ 4. Cognitive
____ 5. Behavioral
____ 6. Humanistic
____ 7. Existential
____ 8. Jungian
9. Other ________________________________

9. Please indicate which one most closely describes your religious affiliation or affirmation.

1. Agnostic
2. Atheist
3. Buddhist
4. Catholic
5. Greek Orthodox
6. Hindu
7. Humanist
8. Islam
9. Jewish
10. Mormon
11. Protestant (denomination) ______________________
12. Other _____________________________________

Section II: Core Competencies for Addressing Spiritual and Religious Diversity. **Please indicate whether you disapprove, approve, recommend, or have performed the following standards for infusing spiritual and religious dimensions of client's belief and practices into your counseling, teaching, and/or supervision process.** **(Note: In this section "religious" is used generically to describe both religiosity, i.e., participation in an organized religion, and personal spirituality).**	**DISAPPROVE**	**APPROVE**	**RECOMMEND**	**PERFORMED**
10. Explain the difference between religion and spirituality, including similarities and differences.	1	2	3	4
11. Describe religious and spiritual beliefs and practices in a cultural context.	1	2	3	4
12. Engage in self-exploration of religious and spiritual beliefs in order to increase sensitivity, understanding and acceptance of diverse belief systems.	1	2	3	4
13. Describe your religious and/or spiritual belief system and explain various models of religious or spiritual development across the lifespan.	1	2	3	4
14. Demonstrate sensitivity and acceptance of a variety of religious and/or spiritual expressions in client communications.	1	2	3	4
15. Identify limits of your understanding of a client's religious or spiritual expression, and demonstrate appropriate referral skills and generate possible referral sources.	1	2	3	4
16. Assess the relevance of the religious and/or spiritual domains in the client's therapeutic process.	1	2	3	4
17. Be sensitive to and receptive of religious and/or spiritual themes in the counseling process as befits the expressed preference of each client.	1	2	3	4
18. Use a client's religious and/or spiritual beliefs in the pursuit of the client's therapeutic goals as befits the client's expressed preference.	1	2	3	4

APPENDIX E:

RELIGIOUS IDEOLOGY, SCIENTIFIC ORIENTATION, AND CONFLICT QUESTIONNAIRE

Religious Ideology, Scientific Orientation, and Conflict Questionnaire (Eckhardt et al., 1992). Please select the answer that most closely reflects your level of agreement.	**Agree**	**Somewhat agree**	**Neutral**	**Somewhat disagree**	**Disagree**
1. I have a religious identity that is a central part of me.	1	2	3	4	5
2. There is a god whose teachings are true.	1	2	3	4	5
3. Heaven, purgatory, hell, and the afterlife do not exist.	1	2	3	4	5
4. Because they cannot be verified, I have come to recognize that biblical stories are fictions, of only some historical significance.	1	2	3	4	5
5. I do not need proof to believe that religious miracles actually occurred (i.e., I accept them on faith).	1	2	3	4	5
6. The origin of the universe and all that exists is better explained by evolution and science than by religion.	1	2	3	4	5
7. Extraordinary biblical stories (i.e., god speaking through a burning bush or the parting of the Red Sea) are true indications of the power of god.	1	2	3	4	5
8. The bible is an accurate account of the creation of the world.	1	2	3	4	5
9. Since god probably does not exist, prayer is of little or no service to me.	1	2	3	4	5

Religious Ideology, Scientific Orientation, and Conflict Questionnaire (Eckhardt et al., 1992). (cont.)	**Agree**	**Somewhat agree**	**Neutral**	**Somewhat disagree**	**Disagree**
10. Because they offer no scientific evidence to support them, religious teachings are often wrong.	1	2	3	4	5
11. Science yields the only real truths about the world.	1	2	3	4	5
12. Scientific findings are often limited and incorrect because they do not consider deeper spiritual issues.	1	2	3	4	5
13. I look for evidence and accept almost nothing by faith.	1	2	3	4	5
14. Some things are simply outside the realm of scientific investigation.	1	2	3	4	5
15. I use scientific findings to guide my personal and professional life whenever possible.	1	2	3	4	5
16. Science creates more problems than it solves.	1	2	3	4	5
17. I base my professional decisions on my own intuition rather than information obtained through hypothesis testing.	1	2	3	4	5
18. It is only through empirical research and hypothesis testing that the world can advance.	1	2	3	4	5
19. I live my life as a scientist.	1	2	3	4	5
20. Scientific analyses will never be able to fully explain the complexities of life.	1	2	3	4	5
21. In my personal life, I occasionally experience conflict between my religious beliefs and scientific findings.	1	2	3	4	5

Religious Ideology, Scientific Orientation, and Conflict Questionnaire (Eckhardt et al., 1992). (cont.)	Agree	Somewhat agree	Neutral	Somewhat disagree	Disagree
22. With emerging scientific evidence, I often have to question my religious beliefs.	1	2	3	4	5
23. For me, science and religion do not conflict with each other because they exist in different realms.	1	2	3	4	5
24. I have sometimes had to act in ways that don't correspond to my personal beliefs in order to go along with the religious ideology of my family.	1	2	3	4	5
25. I have had arguments with my family members regarding the necessity of religious practices.	1	2	3	4	5
26. I've recognized that if I did not participate in religious rituals, my family would be upset with me.	1	2	3	4	5
27. In my day-to-day professional life, I have experienced some conflicts in regards to scientific findings and my personal religious beliefs.	1	2	3	4	5
28. My professional training has led to some conflicts since I have had to learn to use materials or procedures that were incongruent with my religious beliefs.	1	2	3	4	5
29. I have had to compromise some of my religious beliefs in the performance of my job.	1	2	3	4	5

APPENDIX F:

FREQUENCY DISTRIBUTIONS OF RESPONSE VARIABLES

Section II: Core Competencies for Addressing Spiritual and Religious Diversity. **Please indicate whether you disapprove, approve, recommend, or have performed the following standards for infusing spiritual and religious dimensions of client's belief and practices into your counseling, teaching, and/or supervision process.**	**UNKNOWN**	**DISAPPROVE**	**APPROVE**	**RECOMMEND**	**PERFORMED**
10. Explain the difference between religion and spirituality, including similarities and differences.	5 1.9%	21 8.1%	97 37.6%	31 12.0%	104 40.3%
11. Describe religious and spiritual beliefs and practices in a cultural context	3 1.2%	18 7.0%	80 31.0%	54 20.9%	103 39.9%
12. Engage in self-exploration of religious and spiritual beliefs in order to increase sensitivity, understanding and acceptance of diverse belief systems.	3 1.2%	13 5.0%	48 18.6%	44 17.1%	150 58.1%
13. Describe your religious and/or spiritual belief system and explain various models of religious or spiritual development across the lifespan.	5 1.9%	83 32.2%	73 28.3%	38 14.7%	59 22.9%
14. Demonstrate sensitivity and acceptance of a variety of religious and/or spiritual expressions in client communications.	2 .8%	1 .4%	30 11.6%	31 12.0%	194 75.2%
15. Identify limits of your understanding of a client's religious or spiritual expression, and demonstrate appropriate referral skills and generate possible referral sources.	3 1.2%	5 1.9%	42 16.3%	83 32.2%	125 48.4%
16. Assess the relevance of the religious and/or spiritual domains in the client's therapeutic process.	4 1.6%	8 3.1%	37 14.3%	38 14.7%	171 66.3%
17. Be sensitive to and receptive of religious and/or spiritual themes in the counseling process as befits the expressed preference of each client.	1 .4%	4 1.6%	20 7.8%	42 16.3%	191 74.0%
18. Use a client's religious and/or spiritual beliefs in the pursuit of the client's therapeutic goals as befits the client's expressed preference.	2 .8%	8 3.1%	38 14.7%	35 13.6%	175 67.8%

Religious Ideology, Scientific Orientation, and Conflict Questionnaire (Eckhardt et al., 1992). Please select the answer that most closely reflects your level of agreement.	**No Response**	**Agree**	**Somewhat agree**	**Neutral**	**Somewhat disagree**	**Disagree**
1. I have a religious identity that is a central part of me.	2 .8%	147 57.0%	43 16.7%	23 8.9%	13 5.0%	30 11.6%
2. There is a god whose teachings are true.	1 .4%	100 38.8%	31 12.0%	51 19.8%	16 6.2%	59 22.9%
3. Heaven, purgatory, hell, and the afterlife do not exist.	1 .4%	59 22.9%	26 10.1%	55 21.3%	34 13.2%	83 32.2%
4. Because they cannot be verified, I have come to recognize that biblical stories are fictions, of only some historical significance.	0	52 20.2%	47 18.2%	42 16.3%	38 14.7%	79 30.6%
5. I do not need proof to believe that religious miracles actually occurred (i.e., I accept them on faith).	0	83 32.2%	62 24.0%	27 10.5%	29 11.2%	57 22.1%
6. The origin of the universe and all that exists is better explained by evolution and science than by religion.	1 .4%	95 36.8%	39 15.1%	49 19.0%	29 11.2%	45 17.4%
7. Extraordinary biblical stories (i.e., god speaking through a burning bush or the parting of the Red Sea) are true indications of the power of god.	0 .4%	54 20.9%	30 11.6%	49 19.0%	32 12.4%	93 36.0%
8. The bible is an accurate account of the creation of the world.	0	31 12.0%	22 8.5%	35 13.6%	29 11.2%	141 54.7%
9. Since god probably does not exist, prayer is of little or no service to me.	0	19 7.4%	14 5.4%	24 9.3%	25 9.7%	176 68.2%

Religious Ideology, Scientific Orientation, and Conflict Questionnaire (Eckhardt et al., 1992). (cont.)	**No Response**	**Agree**	**Somewhat agree**	**Neutral**	**Somewhat disagree**	**Disagree**
10. Because they offer no scientific evidence to support them, religious teachings are often wrong.	0	12 4.7%	21 8.1%	41 15.9%	56 21.7%	128 49.6%
11. Science yields the only real truths about the world.	0	10 3.9%	25 9.7%	34 13.2%	56 21.7%	133 51.6%
12. Scientific findings are often limited and incorrect because they do not consider deeper spiritual issues.	0	25 9.7%	74 28.7%	47 18.2%	57 22.1%	55 21.3%
13. I look for evidence and accept almost nothing by faith.	0	25 9.7%	40 15.5%	43 16.7%	79 30.6%	71 27.5%
14. Some things are simply outside the realm of scientific investigation.	1 .4%	140 54.3%	72 27.9%	13 5.0%	16 6.2%	16 6.2%
15. I use scientific findings to guide my personal and professional life whenever possible	0	65 25.2%	92 35.7%	46 17.8%	33 12.8%	22 8.5%

Religious Ideology, Scientific Orientation, and Conflict Questionnaire (Eckhardt et al., 1992). (cont.)	No Response	Agree	Somewhat agree	Neutral	Somewhat disagree	Disagree
16. Science creates more problems than it solves.	1 .4%	1 .4%	10 3.9%	40 15.5%	62 24.0%	144 55.8%
17. I base my professional decisions on my own intuition rather than information obtained through hypothesis testing.	0	13 5.0%	44 17.1%	43 16.7%	96 37.2%	62 24.0%
18. It is only through empirical research and hypothesis testing that the world can advance.	0	15 15.8%	57 22.1%	32 12.4%	97 37.6%	57 22.1%
19. I live my life as a scientist.	0	13 5.0%	68 26.4%	65 25.2%	50 19.4%	62 24.0%
20. Scientific analyses will never be able to fully explain the complexities of life.	0	113 43.8%	87 33.7%	24 9.3%	20 7.8%	14 5.4%
21. In my personal life, I occasionally experience conflict between my religious beliefs and scientific findings.	0	25 9.7%	58 22.5%	27 10.5%	46 17.8%	102 39.5%
22. With emerging scientific evidence, I often have to question my religious beliefs.	1 .4%	8 3.1%	18 7.0%	24 9.3%	57 22.1%	150 58.1%
23. For me, science and religion do not conflict with each other because they exist in different realms.	0	74 28.7%	90 34.9%	34 13.2%	31 12.0%	29 11.2%

Religious Ideology, Scientific Orientation, and Conflict Questionnaire (Eckhardt et al., 1992). (cont.)	**No Response**	**Agree**	**Somewhat agree**	**Neutral**	**Somewhat disagree**	**Disagree**
24. I have sometimes had to act in ways that don't correspond to my personal beliefs in order to go along with the religious ideology of my family.	0	16 6.2%	44 17.1%	16 6.2%	30 11.6%	152 58.9%
25. I have had arguments with my family members regarding the necessity of religious practices.	0	32 12.4%	37 14.3%	18 7.0%	41 15.9%	130 50.4%
26. I've recognized that if I did not participate in religious rituals, my family would be upset with me.	0	20 7.8%	43 16.7%	21 8.1%	36 14.0%	138 53.5%
27. In my day-to-day professional life, I have experienced some conflicts in regards to scientific findings and my personal religious beliefs.	0	4 1.6%	46 17.8%	27 10.5%	41 15.9%	140 54.3%
28. My professional training has led to some conflicts since I have had to learn to use materials or procedures that were incongruent with my religious beliefs.	0	9 3.5%	25 9.7%	21 8.1%	41 15.9%	162 62.8%
29. I have had to compromise some of my religious beliefs in the performance of my job.	1 .4%	8 3.1%	26 10.1%	14 5.4%	25 9.7%	257 99.6%

APPENDIX G:

TABLES PREDICTING ASERVIC CORE COMPETENCIES APPROVAL

Table GI

Results of Stepwise MLR to predict Core Competency Variable 1: "Explain the difference between religion and spirituality, including similarities and differences"

(a) *R* Square

R	*R* Square	Adjusted *R* square	Standard error of the estimate
.137	.019	.011	1.110

(b) ANOVA

Source of variance	Sum of Squares	Degrees of Freedom	Mean Square	F	p
Regression	5.969	1	2.984	2.421	.091^{ns}
Residual	314.341	255	1.233		
Total	320.310	257			

(c) Regression coefficients and residual normality statistics

Variable	Un-standardized coefficients	Standardized coefficients	t	p	Kolmogorov Smirnov Z	p
	β	Beta weights				
Intercept	2.348		8.069	.000*	3.204	.000*
Pro-scientific orientation	.096	.073	1.176	.241^{ns}		
Eclectic/Integrative orientation	.257	.115	1.857	.064^{ns}		

* significant at $\alpha = 0.05$ ^{ns} not significant at $\alpha = 0.05$

(d) Correlations

Variable	Zero-order	Partial

Pro-scientific orientation	.073	.073
Eclectic/Integrative orientation	.115	.116

(e) Co-linearity statistics

Variable	Tolerance	VIF
Pro-scientific orientation	1.000	1.000
Eclectic/Integrative orientation	1.000	1.000

Table G2

Results of Stepwise MLR to predict Core Competency Variable 2: "Describe religious and spiritual beliefs and practices in a cultural context"

(a) R Square

R	*R* Square	Adjusted *R* square	Standard error of the estimate
.245	.060	.053	1.016

(b) ANOVA

Source of variance	Sum of Squares	Degrees of Freedom	Mean Square	F	p
Regression	16.823	3	8.411	8.146	.000*
Residual	263.301	255	1.033		
Total	280.124	257			

(c) Regression coefficients and residual normality statistics

Variable	Un-standardized coefficients	Standardized coefficients	t	p	Kolmogorov Smirnov Z	p
	β	Beta weights				
Intercept	3.337		15.864	.000*	2.224	.000*
Age	-.165	-.191	-3.138	.002*		
Eclectic/Integrative orientation	.286	.137	2.249	.025*		

* significant at α = 0.05 ns not significant at α = 0.05

(d) Correlations

Variable	Zero-order	Partial
Age	-.203	-.193
Eclectic/Integrative orientation	.154	.139

(e) Co-linearity statistics

Variable	Tolerance	VIF
Age	.992	1.008
Eclectic/Integrative orientation	.992	1.008

Table G3

Results of Stepwise MLR to predict Core Competency Variable 3: "Engage in self-exploration of religious and spiritual beliefs in order to increase sensitivity, understanding and acceptance of diverse belief systems"

(a) R Square

R	*R* Square	Adjusted *R*	Standard error of

		square	the estimate
.345	.119	.109	.949

(b) ANOVA

Source of variance	Sum of Squares	Degrees of Freedom	Mean Square	F	p
Regression	30.898	3	10.299	11.439	.000*
Residual	228.702	254	.900		
Total	259.601	257			

(c) Regression coefficients and residual normality statistics

Variable	Un-standardized coefficients	Standardized coefficients	t	p	Kolmogorov Smirnov Z	p
	β	Beta weights				
Intercept	2.898		9.479	.000*	2.704	.000*
Pro-scientific orientation	.262	.222	3.702	.000*		
Region	-.332	-.164	-2.760	.006*		
Years in practice	-.090	-.159	-2.640	.009*		

* significant at α = 0.05 [ns] not significant at α = 0.05

(d) Correlations

Variable	Zero-order	Partial
Pro-scientific orientation	.249	.226
Region	-.176	-.171
Years of experience	-.219	-.163

(e) Co-linearity statistics

Variable	Tolerance	VIF

Pro-scientific orientation	.963	1.039
Region	.986	1.014
Years of experience	.952	1.051

Table G4

Results of Stepwise MLR to predict Core Competency Variable 4: "Describe your religious and/or spiritual belief system and explain various models of religious or spiritual development across the lifespan"

(a) R Square

R	*R* Square	Adjusted *R* square	Standard error of the estimate
.285	.081	.074	1.142

(b) ANOVA

Source of variance	Sum of Squares	Degrees of Freedom	Mean Square	F	p
Regression	29.332	2	14.666	11.255	.000*
Residual	332.285	255	1.303		
Total	361.616	257			

(c) Regression coefficients

Variable	Un-standardized coefficients	Standardized coefficients	t	p	Kolmogorov Smirnov Z	p
	β	Beta weights				
Intercept	1.208		5.081	.000*	1.668	.008*
Anti-religious ideology	.277	.256	4.270	.000*		
University setting	.336	.121	2.009	.046*		

* significant at α = 0.05 ^{ns} not significant at α = 0.05

(d) Correlations

Variable	Zero-order	Partial
Anti-religious ideology	.258	.258
University setting	.125	.121

(e) Co-linearity statistics

Variable	Tolerance	VIF
Anti-religious ideology	1.000	1.000
University setting	1.000	1.000

Table G5

Results of Stepwise MLR to predict Core Competency Variable 5: "Demonstrate sensitivity and acceptance of a variety of religious and/or spiritual expressions in client communications"

(a) R Square

R	*R* Square	Adjusted *R* square	Standard error of the estimate
.252	.064	.056	.746

(b) ANOVA

Source of variance	Sum of Squares	Degrees of Freedom	Mean Square	F	p
Regression	9.652	2	4.826	8.665	.000*
Residual	142.022	255	.457		
Total	151.674	257			

(c) Regression coefficients and residual normality statistics

Variable	Un-standardized coefficients	Standardized coefficients	t	p	Kolmogorov Smirnov Z	p
	β	Beta weights				
Intercept	1.627		3.328	.000*	3.993	.000*
Mean religious ideology	.487	.208	3.426	.001*		
Pro-scientific orientation	.129	.143	2.358	.019*		

* significant at α = 0.05 ns not significant at α = 0.05

(d) Correlations

Variable	Zero-order	Partial
Mean religious orientation	.208	.210
Pro-scientific orientation	.143	.146

(e) Co-linearity statistics

Variable	Tolerance	VIF
Mean religious orientation	1.000	1.000
Pro-scientific orientation	1.000	1.000

Table G6

Results of Stepwise MLR to predict Core Competency Variable 6: "Identify limits of your understanding of a client's religious or spiritual expression, and demonstrate appropriate referral skills and generate possible referral sources"

(a) R Square

R	*R* Square	Adjusted *R*	Standard error of

		square	the estimate
.163	.026	.023	.868

(b) ANOVA

Source of variance	Sum of Squares	Degrees of Freedom	Mean Square	F	p
Regression	5.240	1	5.240	6.955	0.009*
Residual	192.884	256	.753		
Total	198.124	257			

(c) Regression coefficients and residual normality statistics

Variable	Un-standardized coefficients	Standardized coefficients	t	p	Kolmogorov Smirnov Z	p
	β	Beta weights				
Intercept	3.047		32.548	.000*	4.150	.000*
Gender	.302	.115	2.637	.009*		

* significant at α = 0.05 ns not significant at α = 0.05

(d) Correlations

Variable	Zero-order	Partial
Gender	.163	.163

(e) Co-linearity statistics

Variable	Tolerance	VIF
Gender	1.000	1.000

Table G7

Results of Stepwise MLR to predict Core Competency Variable 7: "Assess the relevance of the religious and/or spiritual domains in the client's therapeutic process"

(a) R Square

R	*R* Square	Adjusted *R* square	Standard error of the estimate
.124	.015	.011	.946

(b) ANOVA

Source of variance	Sum of Squares	Degrees of Freedom	Mean Square	F	p
Regression	3.546	2	3.546	3.966	.047*
Residual	228.903	255	.894		
Total	232.450	257			

(c) Regression coefficients and residual normality statistics

Variable	Un-standardized coefficients	Standardized coefficients	t	p	Kolmogorov Smirnov Z	p
	β	Beta weights			4.659	.000*
Intercept	2.273		3.956	.000*		
Mean religious ideology	.359	.124	1.992	.047*		

* significant at α = 0.05   [ns] not significant at α = 0.05

(d) Correlations

Variable	Zero-order	Partial

Mean religious ideology	.124	.124

(e) Co-linearity statistics

Variable	Tolerance	VIF
Mean religious orientation	1.000	1.000

Table G8

Results of Stepwise MLR to predict Core Competency Variable 8: "Be sensitive to and receptive of religious and/or spiritual themes in the counseling process as befits the expressed preference of each client"

(a) R Square

R	*R* Square	Adjusted *R* square	Standard error of the estimate
.196	.038	.031	.718

(b) ANOVA

Source of variance	Sum of Squares	Degrees of Freedom	Mean Square	F	p
Regression	5.249	2	2.265	5.088	.007*
Residual	113.526	255	.516		
Total	136.775	257			

(c) Regression coefficients and residual normality statistics

Variable	Un-standardized coefficients	Standardized coefficients	t	p	Kolmogorov Smirnov Z	p
	β	Beta weights				
Intercept	3.091		15.700	.000 *	4.403	.000 *
Pro-scientific orientation	.143	.168	2.601	.010 *		
Agnostic/Atheist	.349	.164	2.545	.012 *		

* significant at $\alpha = 0.05$ ^{ns} not significant at $\alpha = 0.05$

(d) Correlations

Variable	Zero-order	Partial
Pro-scientific orientation	.118	.161
Agnostic/Atheist	.113	.157

(e) Co-linearity statistics

Variable	Tolerance	VIF
Pro-scientific orientation	.909	1.100
Agnostic/Atheist	.909	1.100

Table G9

Results of Stepwise MLR to predict Core Competency Variable 9: "Use a client's religious and/or spiritual beliefs in the pursuit of the client's therapeutic goals as befits the client's expressed preference"

(a) R Square

R	*R* Square	Adjusted *R* square	Standard error of the estimate
.230	.053	.042	.838

(b) ANOVA

Source of variance	Sum of Squares	Degrees of Freedom	Mean Square	F	p
Regression	9.957	3	3.319	4.728	.003*
Residual	178.295	254	.702		
Total	188.252	257			

(c) Regression coefficients and residual normality statistics

Variable	Un-standardized coefficients	Standardized coefficients	t	p	Kolmogorov Smirnov Z	p
	β	Beta weights				
Intercept	2.688		12.058	.000*	4.011	.000*
Anti-religious ideology	.180	.230	3.247	.001*		
Agnostic/Atheist	.406	.163	2.318	.021*		

* significant at α = 0.05 [ns] not significant at α = 0.05

(d) Correlations

Variable	Zero-order	Partial
Anti-religious orientation	.131	.200
Agnostic/Atheist	.048	.144

(e) Co-linearity statistics

Variable	Tolerance	VIF
Anti-religious orientation	.742	1.348
Agnostic/Atheist	.757	1.322
Private setting	.968	1.033

APPENDIX H

COMPETENCIES FOR ADDRESSING SPIRITUAL AND RELIGIOUS ISSUES IN COUNSELING

(Revised and Approved, 5/5/2009. Copyright 5/5/09)

Culture and Worldview

1. The professional counselor can describe the similarities and differences between spirituality and religion, including the basic beliefs of various spiritual systems, major world religions, agnosticism, and atheism.

2.The professional counselor recognizes that the client's beliefs (or absence of beliefs) about spirituality and/or religion are central to his or her worldview and can influence psychosocial functioning.

Counselor Self-Awareness

3. The professional counselor actively explores his or her own attitudes, beliefs, and values about spirituality and/or religion.

4. The professional counselor continuously evaluates the influence of his or her own spiritual and/or religious beliefs and values on the client and the counseling process.

5. The professional counselor can identify the limits of his or her understanding of the client's spiritual and/or religious perspective and is acquainted with religious and spiritual resources, including leaders, who can be avenues for consultation and to whom the counselor can refer.

Human and Spiritual Development

6. The professional counselor can describe and apply various models of spiritual and/or religious development and their relationship to human development.

Communication

7. The professional counselor responds to client communications about spirituality and/or religion with acceptance and sensitivity.

8. The professional counselor uses spiritual and/or religious concepts that are consistent with the client's spiritual and/or religious perspectives and that are acceptable to the client.

APPENDIX H (cont)

9. The professional counselor can recognize spiritual and/or religious themes in client communication and is able to address these with the client when they are therapeutically relevant.

Assessment

10. During the intake and assessment processes, the professional counselor strives to understand a client's spiritual and/or religious perspective by gathering information from the client and/or other sources.

Diagnosis and Treatment

11. When making a diagnosis, the professional counselor recognizes that the client's spiritual and/or religious perspectives can a) enhance well-being; b) contribute to client problems; and/or c) exacerbate symptoms.

12. The professional counselor sets goals with the client that are consistent with the client's spiritual and/or religious perspectives.

13. The professional counselor is able to a) modify therapeutic techniques to include a client's spiritual and/or religious perspectives, and b) utilize spiritual and/or religious practices as techniques when appropriate and acceptable to a client's viewpoint.

14. The professional counselor can therapeutically apply theory and current research supporting the inclusion of a client's spiritual and/or religious perspectives and practices.

APPENDIX I

PERMISSION EMAIL FROM DR. EDWARD SHAFRANSKE

Email from Dr. Edward Shafranske dated August 19, 2008

Sharon,

I have attached the surveys used in the 1990 article and in the 1996 "Religion and the Clinical Practice of Psychology" book chapter. Yes, you may use the items, many were drawn from Gallup polling and as I recall Maloney had secured approval from Yinger for the adaptations; the Batson items were from his scales. Look at the Batson and Ventis book. I have also attached the Psychiatric Annals article.

FYI – I am conducting a replication study (with Dr Ken Pargement) with a national sample of clinical counseling psychologists/APA dataset, so you may wish to consider a slightly different sample, to avoid what might be a direct overlap in the two studies.

I'd be interested in your findings,

Edward Shafranske, Ph.D., ABPP
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APPENDIX J
CURRICULUM VITAE

Sharon R. Gough
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Educational Background

Ph.D. Academic Psychology, Walden University, Minneapolis, Minnesota – anticipated graduation December 2009.

M.A. Community Counseling; M. A. School Counseling, Rollins College, Winter Park, Florida

B.A. Public Justice, State University of New York (SUNY), Oswego, New York

Professional Experiences:

1. Adjunct Instructor of Psychology: Western New Mexico University, Silver City, New Mexico, Spring 2005 – present (part time, both online and face-to-face instruction) teaching undergraduate and master-level psychology courses.

2. Psychotherapist – Border Area Mental Health Services, Inc. As a Licensed Professional Clinical Counselor (LPCC) and Licensed Alcohol and Drug Abuse Counselor (LADAC) providing assessment, diagnosis, and treatment planning at intake for new clients. March 3, 2008 – present.

3. Psychotherapist - Adult Unit – Padre Behavioral Hospital, Corpus Christi, TX. Responsible for individual and group psychotherapy, treatment planning, psychosocial assessments and consultations with multiple staff psychiatrists. This was a temporary research-based position toward doctoral dissertation. May 14, 2007 – February 2, 2008.

4. Psychotherapist - Gila Regional Medical Center, Silver City, N. M. Acute Inpatient Psychiatric Unit. Responsible for individual therapy, treatment planning, intake assessments, initial diagnosis, psychosocial, treatment panning, and consultations with staff psychiatrists. In this position I supervised interns from Western New Mexico University from the Chemical Addiction Program and the Master's in Counseling Program. April 5, 2004 –April 15, 2007.

5. Psychotherapist - Border Area Mental Health Services, Inc. Silver City N.M.

Outpatient therapist providing individual therapy to clients including substance abuse counseling and dual diagnosed clients. Supervised WNMU interns. November 5, 2001 – March 31, 2004.

6. Therapist/Therapist Intern, Devereux Outpatient, Rockledge, Fl. Providing diagnosis and therapy to children and their families in the home and in the school setting while completing master's degree. February 8, 1999 – October 25, 2001.

7. Child Protective Investigator, State of Florida Rockledge, Fl. Social work position investigated reports of abuse, neglect and exploitation. January 1994 – February 1999.

8. Youth Program Coordinator, Domestic Violence Program – Salvation Army – Cocoa, Fl. Provided assessment and counseling services to women and children who had been victims of domestic violence in a shelter setting. June 1992 - January 1994.

9. Domestic Violence Program Coordinator – Family Counseling Services of the Finger Lakes, Inc. – Geneva, New York. Coordinated and provided services to victims of family violence in a four county area of upstate New York. May 1989 – July 1991.

Licensure:

National Board for Certified Counselors, Inc. (NBCC) # 69150

LPCC – Licensed Professional Clinical Counselor (New Mexico #0076991)
LADAC – Licensed Alcohol and Drug Abuse Counselor (New Mexico #0081671)
LPC – Licensed Professional Counselor (Texas # 63100)
LCDC-Licensed Chemical Dependence Counselor (Texas # 827)

Professional Memberships:

National Alliance for the Mentally Ill (NAMI)
American Psychology Association (APA)

Presentations/Consultations:

1. I have developed presentations on health and stress management for medical staff and law enforcement officers in New Mexico, Texas, and New York.

2. I have developed and presented information related to family violence to civic groups and law enforcement in New York.