The Religiosity and Spiritual Beliefs and Practices of Clinical Social Workers: A National Survey

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This article describes the religious and spiritual beliefs and practices among a national sample of 426 licensed clinical social workers (LCSWs). Given the significant role LCSWs' intrinsic religiosity plays in whether or not they consider clients' religion and spirituality (RS) as it relates to practice, it is critical that the profession best understands current LCSWs' religious and spiritual beliefs, and in what ways these mirror or contrast those of the clients whom they serve. Findings from this secondary analysis of a recent national survey suggest that compared with the general U.S. population, fewer LCSWs self-identify as Protestant or Catholic, fewer engage in frequent prayer, and fewer self-identify as religious. However, more LCSWs engage in meditation and consider themselves to be spiritual. Although it appears that RS is an important area in both LCSWs' and clients' lives, the beliefs, practices, and degree of importance with either differ. This article addresses implications for practice and education, as identifying such differing views calls on the profession to strengthen its training surrounding LCSWs' self-awareness of their RS beliefs and recognizing that their clients may not hold similar beliefs or engage in similar practices.

KEY WORDS: *beliefs and practices; clinical social work; religion; spirituality; therapists*

Licensed clinical social workers (LCSWs) are often aware that one aspect of their clients' culture that occasionally emerges in treatment is the way in which their religious or spiritual (RS) beliefs are interwoven into presenting clinical issues. Not always having been trained on how to assess or integrate clients' beliefs, LCSWs may consider the use of self, not to impose one's spiritual beliefs, but to be mindful of the role it has in their lives while honoring its role in clients' lives. Yet, as LCSWs inquire about clients' beliefs, they may realize that many are very different from theirs or their colleagues' RS beliefs.

Although definitions abound, *religion* is "a system of beliefs and practices observed by a community, supported by rituals that acknowledge, worship, communicate with, or approach the Sacred, the Divine, God (in Western cultures), or Ultimate Truth, Reality, or nirvana (in Eastern cultures)," relying on teachings and scriptures and offering a moral code of conduct (Koenig, 2008, p. 11). As for *spirituality*, it may be defined as "the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and formation of community" (Koenig, McCullough, & Larson, 2001, p. 18). Furthermore, Allport and Ross (1967) have described two poles of religiosity, intrinsic and extrinsic, where "the extrinsically motivated person *uses* his religion, whereas the intrinsically motivated *lives* his religion" (p. 434). For the extrinsically religious, their religion exists for the individual's needs (for example, social support, status, self-justification, or some form of security), whereas the intrinsically religious are motivated by their religion with a desire to fully internalize, embrace, and live out their beliefs (Allport & Ross, 1967).

Recently, Pew Research Center (2015) reported that 77 percent of Americans consider religion to be at least somewhat important in their lives, and a recent increase in spiritual well-being. Furthermore, most Americans consider themselves to be at least moderately religious (58.3 percent) and spiritual (66.4 percent), revealing an overlap between the two groups; however, many consider themselves more spiritual and less religious or more religious and less spiritual (Hodge, 2015).

RS IN SOCIAL WORK

Even though RS is considered important in many Americans' lives (Hodge, 2015; Pew Research Center, 2015) and may be interwoven in clinical issues either as a source of strength or angst (Pargament, 2007), social work has not always attended to RS in

doi: 10.1093/sw/swx055

education or practice (Canda & Furman, 2010; Oxhandler & Pargament, 2014; Oxhandler, Parrish, Torres, & Achenbaum, 2015; Sheridan, 2009; Sheridan, Bullis, Adcock, Berlin, & Miller, 1992). With a growing body of research showing that RS integration has the potential of improving health and mental health outcomes (Koenig, King, & Carson, 2012; Koenig et al., 2001), the evidence-based practice (EBP) process serves as one method to support the integration of clients' RS in treatment, if the client desires (Oxhandler & Pargament, 2014). It is interesting to note that not only are clients expressing a preference for their RS—a client value and important aspect within the EBP process (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000)—to be included in treatment (Lietz & Hodge, 2013; Stanley et al., 2011; Tepper, Rogers, Coleman, & Maloney, 2001), but clients also express preference regarding therapists' RS. Indeed, highly religious prospective clients have indicated a preference to see therapists affiliated with a major religion as compared with atheism (Gregory, Pomerantz, Pettibone, & Segrist, 2008).

Although it is imperative for social workers to be equipped to assess and understand the role clients' RS plays in health and mental health treatment, it is also important to consider the role social workers' RS has in their daily life, extending into their practice. Social workers' RS may be intrinsically interwoven into their work, informing their practice as their practice informs their RS beliefs (Singletary, 2005), and in many cases, their decision to become social workers may have been heavily influenced by their RS beliefs (Garland, 2016). However, social workers must cautiously consider the role their RS has in practice, ensuring that their beliefs are never imposed on a vulnerable client. Doing so would violate the National Association of Social Workers' (NASW) *Code of Ethics* (2015), especially under code 1.06 as it relates to not exploiting or taking advantage of clients to further any RS interests. RS is also woven into our ethical responsibilities to clients regarding cultural competency and social diversity (code 1.05), respecting colleagues' diversity (code 2.01), not discriminating (code 4.02), and the broader society regarding social and political action (code 6.04) (NASW, 2015). Just as social workers are trained to practice self-awareness by exploring how their values and biases can influence their practice, social workers' RS beliefs can also influence their practice behaviors and views.

In fact, a social worker's RS beliefs and practices are predictive of whether clients' RS is assessed and integrated in treatment (Canda & Furman, 2010; Kvarfordt & Sheridan, 2009; Larsen, 2011; Oxhandler et al., 2015). Not only does intrinsic religiosity predict LCSWs' views and behaviors toward integrating clients' RS, but also LCSWs' self-efficacy and perceived feasibility (Oxhandler et al., 2015). Recently, LCSWs' intrinsic religiosity was identified as the *top* predictor ($\beta = .44$) of their orientation toward integrating clients' RS—including attitudes, self-efficacy, perceived feasibility, and behaviors—followed by prior training in this area ($\beta = .32$) (Oxhandler et al., 2015). Among the same sample of LCSWs, 329 responded to two items on what helps or prevents the assessment and integration of clients' RS in practice. Of the 319 who responded to what helps them integrate RS, personal religiosity emerged as an overarching theme, with 44 percent mentioning their RS journey, RS belief system, RS practices, or RS curiosity (Oxhandler & Giardina, 2017). This critical role of the practitioners' RS—primarily, their intrinsic religiosity—in the process of considering clients' RS is not limited to social work, as *Namaste Theory* was developed based on similar quantitative findings across helping professions (Oxhandler, 2017). Therefore, LCSWs' RS beliefs cannot be ignored as part of the treatment process, particularly as they influence the consideration of clients' RS beliefs, which have the potential of affecting client outcomes.

PREVIOUS STUDIES OF SOCIAL WORKERS' RS BELIEFS

Given the significant role that social workers' RS plays in whether this area of clients' lives is considered, clients' expressed preferences regarding social workers' RS and the importance of assessing for and integrating clients' RS in practice, it is critical for the profession to understand current LCSWs' RS beliefs and practices and how they compare with those of the general U.S. population. Previous studies have gathered minimal information about practitioners' RS beliefs, and few used items from national surveys of Americans with the intention to compare results. In an effort to paint a broad picture of social workers' RS, we have included a few studies' findings.

In 2004, Sheridan surveyed 204 LCSWs in a mid-Atlantic state and found that a majority of respondents were Christian (57 percent), followed by Buddhist (18 percent), existentialist (14 percent), Jewish (12 percent), and agnostic (8 percent); 32 percent selected multiple affiliations. Among various ideological positions, 46 percent reported a "belief in a personal God

whose purposes ultimately will be worked out in human history" (Sheridan, 2004, p. 12), with 29 percent reporting a "belief in a transcendent or divine dimension found in all manifestations of nature" (p. 12). Regarding current RS practices, LCSWs reported regular service attendance (38 percent weekly, 21 percent monthly), over half reported some daily RS practice (such as praying, reading scriptural texts, or meditating), with an additional 28 percent using such practices several times a week. Finally, 25 percent reported active participation and high involvement in an organized religious or spiritual group, and another 26 percent engaged in regular participation and some involvement.

Much like Sheridan's (2004) findings, a majority of Murdock's (2005) national sample of gerontological social workers (N = 299) self-identified as Christian (65 percent), followed by Jewish (19 percent). Murdock's (2005) questions on religiosity were slightly different than Sheridan's, and fewer respondents (28 percent) reported weekly communal spiritual activity or daily private spiritual activity (39 percent). In these two studies, there is a similarity with affiliation activity level, with 21 percent reporting high or active, and 38 percent reporting regular or some activity.

Likewise, Larsen (2011) conducted a national survey of NASW members' (N = 225) personal spiritual beliefs, how those beliefs affect their attitudes regarding RS in social work practice, and the use of RS interventions in practice. Among the respondents, 58 percent were affiliated with a Christian denomination, 45 percent reported attending weekly religious services (a higher percentage than the previous studies), and 82 percent reported believing in God or a higher power. Unlike previous researchers, Larsen asked about the degree to which respondents perceived themselves as religious or spiritual, with 59 percent reportedly religious and 94 percent spiritual. She also asked about their intrinsic religiosity using the Intrinsic Spirituality Scale (Hodge, 2003) and found that her sample had a slightly higher degree of intrinsic religiosity as compared with the instrument's average score.

Finally, Canda and Furman (1999, 2010) conducted two national surveys of NASW members' use of spiritually derived interventions and their personal RS. The 2008 sample (N = 1,804) had 57 percent self-identify as Christian (58 percent in 1997), 20 percent self-identify as Jewish (6 percent in 1997), and 14 percent nonreligious. Canda and Furman compared these results with data from the Association of Religion Data Archives that suggested 82 percent of Americans are Christian—a large discrepancy from the social workers. As Canda and Furman (2010) noted, many studies echo these findings, with social work having "fewer Christians, more Jews, more other religious, and more nonreligious" people (p. 118) as compared with the general population.

Although these studies help us begin to understand social workers' RS, they are limited in generalizability. Furthermore, items used in these surveys of social workers are not used in surveys of U.S. adults, preventing the ability to make side-by-side comparisons. Only one study to date has attempted to compare social workers with U.S. adults using 10 items from the General Social Survey (GSS) and a demographic item to identify whether the respondent is a social worker (N = 145, of which 53 held graduate degrees) (Hodge, 2002). Although this study used a relatively small sample, Hodge (2002) noted it included BSW and MSW-level practitioners that closely matched NASW's demographics. His findings indicated a large shift in social workers' belief system from childhood to adulthood, with MSW-level practitioners less likely to believe in a life after death or that the Bible represents the actual word of God as compared with the beliefs of U.S. adults. Social workers were more likely to self-identify as Jewish or unaffiliated and as being part of a more liberal denomination as compared with the general U.S. adult population. It is interesting to note that there was little difference between social workers and U.S. adults with regard to frequency of religious service attendance or strength of religious affiliation. Hodge (2002) concluded that although similarities exist between social workers and U.S. adults regarding religious service attendance, the two groups' beliefs are different. He posited that this difference might result in secular social workers not valuing or recognizing RS strengths or struggles, which could affect the delivery of services. However, this study is 14 years old, had a small sample pooled over 26 years (1972–1998), and did not explore other facets of RS that may be important to understanding the similarities and differences among social workers' and clients' RS.

CURRENT STUDY

To date, no study has simultaneously examined a national sample of LCSWs' intrinsic religiosity and frequency of religious activities, extent to which they are religious or spiritual, or their RS affiliation

and practice behaviors and do a side-by-side comparison with U.S. adults. Our research questions were: (a) What are LCSWs' degrees of intrinsic religiosity and frequency of religious activities? (b) How religious and spiritual do LCSWs consider themselves, and how does this compare with the U.S. population? (c) What RS practices do LCSWs most frequently engage in, and how do they compare with those of the U.S. population? and (d) What religious affiliations do LCSWs identify with, and how do their affiliations compare with those of the U.S. population?

METHOD

To address our questions, we analyzed data gathered from a 2013 national survey of LCSWs. The original study consisted of 984 social workers randomly selected from the National Social Work Finder on HelpPro who were contacted by e-mail and mail to participate in an online survey; 482 (49 percent) responded (Oxhandler et al., 2015). For this study, the analysis was restricted to the 426 LCSWs who responded to RS items.

The online survey contained the Religious/Spiritually Integrated Practice Assessment Scale (Oxhandler & Parrish, 2016) and a variety of demographic items. RS-specific items included one item to assess religious preference, two from the GSS measuring the extent one is religious or spiritual (Smith, Marsden, Hout, & Kim, 2014), one item developed for this survey assessing frequently practiced RS behaviors, and the Duke University Religion Index (DUREL) (Koenig & Büssing, 2010). The DUREL includes two items to measure religious activities (organized and nonorganized religious activity) and three items to measure intrinsic religiosity. The intrinsic religiosity subscale was based on items from Hoge's (1972) Intrinsic Religiosity Motivation Scale, built on Allport and Ross's (1967) work.

To compare LCSWs' RS beliefs and practices with those of the general U.S. population, we assessed items drawn from the GSS and the Baylor Religion Survey (BRS). The GSS is a nationally representative survey of noninstitutionalized adults conducted every two years by the National Opinion Research Center (NORC) at the University of Chicago (Smith et al., 2014). The BRS is a repeated, cross-sectional national survey of U.S. adults conducted by researchers at Baylor University and the Gallup Organization (Dougherty et al., 2011). For our analyses, we used data from the 2010 and 2014 waves of the BRS and the 2014 wave of GSS. The GSS data were weighted using WTSSALL, as advised by NORC (Smith et al., 2014). SPSS 23 was used to run descriptive analyses on all variables. In addition to describing LCSWs' religiosity and making descriptive comparisons with similar items in the GSS or BRS, chi-square analyses compared the LCSWs' and GSS participants' categorical responses regarding the extent to which they consider themselves religious or spiritual (Smith et al., 2014), as well as their religious affiliations across the United States and within each region (Northeast, South, Midwest, and West).

RESULTS

Not surprisingly, all LCSWs reportedly hold a master's degree, with 9.3 percent also holding a doctoral degree. Respondents' average age was 56 years, and they were mostly female (78.7 percent). A majority identified as white or Caucasian (86.9 percent), with fewer identifying as Hispanic or Latino (4.2 percent), African American or black (3.8 percent), Asian or Pacific Islander (2.0 percent), or as some other racial or ethnic group (3.1 percent). Our sample includes LCSWs systematically drawn from all U.S. regions, with 39.6 percent living in the Northeast, 24.2 percent in the South, 20.4 percent in the West, and 15.9 percent in the Midwest.

LCSWs' Intrinsic Religiosity and Religious Activities

Responses to the DUREL items are presented in Table 1. Among the first three items, measuring intrinsic religiosity, over two-thirds (67.1 percent) reportedly experience the presence of the divine in their lives, and more than half (54 percent) indicated their religious beliefs lie behind their whole approach to life. Just under half of LCSWs (48.2 percent) reportedly try to carry religion over into all other dealings in their life.

Many LCSWs also regularly participate in religious activities such as community and private religious activities, and at a slightly lower frequency than the general population. Specifically, one-third of LCSWs reported attending religious services at least a few times a month (31.9 percent) compared with 38 percent of 2014 GSS respondents. When asked how often they spend time in private religious activities such as meditation or prayer, more than half of LCSWs (57.3 percent) reported engaging in such activities at least weekly. Although other national surveys do not ask this specific DUREL item, of 2014 GSS respondents, 74.3 percent reported praying at least weekly (57.5 percent of which pray daily). Although not a direct comparison, like

Table 1: Intrinsic Religiosity and Religious Activities among LCSWs (DUREL Measures)

DUREL Item	%	*n*
Intrinsic religiosity		
"In my life, I experience the presence of the Divine (i.e., God)." ($n = 423$)		
Definitely true of me	38.3	162
Tends to be true	28.8	122
Unsure	13.0	55
Tends not to be true	8.0	34
Definitely not true for me	11.8	50
"My religious beliefs are what really lie behind my whole approach to life." ($n = 424$)		
Definitely true of me	24.8	105
Tends to be true	29.2	124
Unsure	12.0	51
Tends not to be true	12.5	53
Definitely not true for me	21.5	91
"I try hard to carry my religion over into all other dealings in life." ($n = 421$)		
Definitely true of me	15.9	67
Tends to be true	32.3	136
Unsure	14.0	59
Tends not to be true	12.4	52
Definitely not true for me	25.4	107
Religious activities		
"How often do you attend religious services?" ($n = 423$)		
More than once a week	3.3	14
Once a week	16.5	70
A few times a month	12.1	51
A few times a year	29.1	123
Once a year or less	17.3	73
Never	21.7	92
"How often do you spend time in private religious activities, such as prayer, meditation, or Bible Study (or other religious text)?" ($n = 426$)		
More than once a day	8.9	38
Daily	26.1	111
Two or more times a week	17.8	76
Once a week	4.5	19
A few times a month	15.7	67
Rarely or never	27.0	115

Notes: LCSW = licensed clinical social worker; DUREL = Duke University Religion Index; data from 426 LCSWs who responded to RS items in Oxhandler et al. (2015).

religious service attendance, engagement in private religious activities occurs less frequently among LCSWs than in the general population.

LCSWs' Degree of Being Religious or Spiritual

A significant majority of LCSWs (81.9 percent) reported being at least moderately spiritual, whereas only 35.1 percent are at least moderately religious, and a pronounced contrast exists between those who are very spiritual (44 percent) and very religious (8.8 percent). Furthermore, 38.4 percent of LCSWs reported not being religious, versus only 6.1 percent who are not spiritual.

This pattern differs substantially from that of the U.S. population. Drawing on both our survey and the 2014 GSS data, Table 2 shows that U.S. adults are more religious [$\chi^2(3, N = 2{,}943) = 78.07$, $p < .001$] and less spiritual [$\chi^2(3, N = 2{,}939) = 61.41$, $p < .001$] compared with LCSWs, with small effect sizes for each. Over half of GSS respondents (54.2 percent) consider themselves at least moderately religious (versus 35.1 percent of LCSWs), and 65.1 percent are at least moderately spiritual (versus 81.9 percent of LCSWs). Additional analyses reveal that the correlation between measures of RS is higher for U.S. adults in the GSS sample (0.56, $p < .001$) than for LCSWs (0.33, $p < .001$), further suggesting that RS may be more intertwined for the general population than for LCSWs (see Hodge, 2015).

LCSWs' RS Practices

LCSWs were provided a list of RS activities to select any they practice frequently. Meditation (56.7 percent), prayer (45.7 percent), and yoga or other physical practice (37.7 percent) were the most frequently selected. Fewer reported regularly attending religious services (31.6 percent), reading religious texts (25.1 percent), listening to RS music or radio (20.1 percent), or attending small social gatherings devoted to RS matters (19.0 percent). The least reported practices were watching RS television (8.7 percent), worshiping outside of religious services (8.2 percent), and other RS practices (16.4 percent).

Whereas few surveys have asked about the U.S. population's use of such RS activities, data from the 2014 GSS and 2010 and 2014 BRS allow limited comparisons. In 2010, 24.8 percent of BRS respondents reported meditating, which is much lower than the rate reported by LCSWs in our survey. In 2014, 36.6 percent of BRS respondents read religious texts at least monthly and 27.7 percent participated in religious education in the previous month. Finally, 74.3 percent of GSS respondents pray at least weekly. These results suggest that LCSWs rely on many RS activities less frequently than do U.S. adults, with the exception of meditation.

Table 2: Level of Spirituality and Religiosity among LCSWs and the General Population

Item	LCSW Survey %	LCSW Survey *n*	GSS %	GSS *n*	χ^2	*p*
"To what extent do you consider yourself a religious person?"						
Very religious	8.8	37	16.8	423	78.07[a]	<.001
Moderately religious	26.3	111	37.4	942		
Slightly religious	26.5	112	25.4	641		
Not religious	38.4	162	20.4	515		
"To what extent do you consider yourself a spiritual person?"						
Very spiritual	44.0	187	28.2	709	61.41[a]	<.001
Moderately spiritual	37.9	161	36.9	928		
Slightly spiritual	12	51	23.7	597		
Not spiritual	6.1	26	11.1	280		

Notes: LCSW = licensed clinical social worker; GSS = General Social Survey. Data from 2013 LCSW survey and 2014 GSS.
[a]The effect sizes for both chi-square analyses were calculated using Cramér's V and were considered small (extent religious, V = .16; extent spiritual, V = .14).

LCSWs' RS Affiliations

Table 3 reveals that LCSWs' religious affiliation differs from that of the general population [$\chi^2(4, N = 2{,}393) = 593.41$, $p < .001$] in two important ways and reports large effect sizes across regions. First, LCSWs are about half as likely as GSS respondents to identify with either of the two largest religious traditions in the United States—Protestantism and Catholicism. Second, affiliation with non-Christian groups is much higher for LCSWs (42.9 percent) than for GSS respondents (5.5 percent), with 21.6 percent of LCSWs self-identifying as Jewish. It is interesting to note that the percentage of LCSWs indicating no religious preference (20 percent) corresponds well with GSS respondents (20.7 percent).

Because patterns of RS affiliation vary across the United States (Grammich et al., 2012), we examined affiliation patterns across U.S. Census divisions. Table 3 indicates that regional patterns generally reflect the national pattern, with LCSWs' affiliations significantly different from those of the U.S. population in each of the regions: Northeast [$\chi^2(4, N = 571) = 118.07$, $p < .001$], South [$\chi^2(4, N = 1{,}014) = 192.3$, $p < .001$], Midwest [$\chi^2(4, N = 628) = 85.4$, $p < .001$], and West [$\chi^2(4, N = 719) = 155.61$, $p < .001$]. In the Northeast and West, Catholics seem to be particularly underrepresented among LCSWs, whereas in the South Protestants are less represented. Alternatively, there are more LCSWs who self-identify as Jewish, Buddhist, or other across all four regions and the nation overall.

DISCUSSION

Many noteworthy findings emerged from this study. First, although LCSWs' RS differs from that of the general population in several ways, our findings reveal that many LCSWs are far from secular, view RS as important in their lives, experience the transcendent or the divine, and view RS as intertwined with other areas of their lives, extending into their social work practice. In addition to these intrinsic expressions of RS, many LCSWs engage in RS activities, such as attending religious services and prayer.

However, our findings indicate ways in which LCSWs' RS differs from that of the U.S. population. First, LCSWs appear to distinguish between the two aspects of RS more clearly than do U.S. adults, with more LCSWs at least moderately spiritual (82 percent versus 54 percent of Americans) and fewer religious (35 percent versus 65 percent of Americans), whereas many U.S. adults are both spiritual and religious or view RS as intertwined. Although LCSWs report participating in RS activities, they engage in more private or individual religious activities (for example, meditation, prayer, yoga), and fewer participate in activities such as worship outside of a religious service, attending small social gatherings on an RS matter (for example, Bible studies), or reading religious texts. This finding is not surprising, given the large presence of non-Christian LCSWs in our sample; however, it suggests that LCSWs should be aware of and seek training on clients' RS practices that differ from their own. Finally, we found that LCSWs' RS affiliation in the United States, and across U.S. regions, differs from that of the U.S. population, with LCSWs more likely to identify with non-Christian traditions. The percentage of LCSWs who identify as Jewish is noteworthy and consistent with previous studies (Canda & Furman, 2010; Hodge, 2002; Murdock, 2005). While we recognize that some LCSWs may identify as

Table 3: Religious Affiliation among LCSWs and the General Population

	United States		Northeast		South		Midwest		West	
	LCSW (%)	GSS (%)	LCSW (%)	GSS (%)	LCSW (%)	GSS (%)	LCSW (%)	GSS (%)	LCSW (%)	GSS (%)
Religious affiliation										
Protestant	24.3	48.5	18.1	29.6	29.0	62.4	32.8	51.5	21.8	39.6
Catholic	12.8	25.4	11.9	37.1	17.0	19.3	19.4	25.1	5.7	26.8
Jewish	21.6	1.5	28.8	3.2	22.0	1.4	9.0	0.4	19.5	1.6
Hindu	0.2	0.6	0.0	1.7	1.0	0.5	0.0	0.0	0.0	0.3
Buddhist	6.4	1.1	8.8	2.7	4.0	0.0	6.0	0.9	5.7	1.9
Muslim	0.2	0.4	0.0	0.7	0.0	0.2	0.0	0.5	1.1	0.2
Other	14.5	1.9	10.0	2.4	12.0	0.9	14.9	1.2	24.1	2.2
None	20.0	20.7	22.5	22.6	15.0	15.1	17.9	20.5	21.8	27.6

Notes: LCSW = licensed clinical social worker; GSS = General Social Survey. Data from 2013 LCSW survey ($n = 421$) and 2014 GSS ($n = 2,518$); Northeast: LCSW survey ($n = 160$), GSS ($n = 411$); South: LCSW survey ($n = 100$), GSS ($n = 914$); Midwest: LCSW survey ($n = 67$), GSS ($n = 561$); West: LCSW survey ($n = 87$), GSS ($n = 632$). Chi square analyses were conducted to compare the frequencies of LCSWs and GSS respondents' religious affiliations across each of the regions. To meet the assumption of at least 80 percent of expected frequency cells with a minimum of five and no cells equal to zero, those who selected Hindu, Buddhist, Muslim, or other were collapsed into one category ("other") for the analysis. Bonferroni post hoc tests were used to reduce the risk of a type I error using an alpha level of .05. All chi-square values (United States = 593.41; Northeast = 118.07; South = 192.30; Midwest = 85.40; West = 155.61) had a $df = 4$ and $p < .001$. The effect sizes for each chi-square analysis were assessed using Cramér's V and were all considered large with $df = 4$ (United States = .45; Northeast = .45; South = .44; Midwest = .37; West = .47).

Jewish in a more secular manner as their ethnicity (Rebhun, 2004), our question specifically asked, "What is your religious preference?"; in fact, only one LCSW within our sample reported Jewish identity both under race or ethnicity and religious preference. In addition, the proportion of LCSWs who identify with Eastern traditions (for example, Hinduism or Buddhism) and less common belief systems is also consistent with these previous studies. These trends tend to hold across U.S. regions, with some traditions underrepresented among LCSWs in several regions. With 82 percent of LCSWs self-identifying as at least moderately spiritual and an overwhelming majority being affiliated with an RS tradition, these results are encouraging for clients who prefer their therapist to be affiliated with an RS tradition, even if it differs from their own (Gregory et al., 2008).

Given the discrepancies in RS beliefs and practices between LCSWs and U.S. adults, implications for practice and education are profound. First, in practice, LCSWs may fail to recognize or misunderstand important RS-related social and cultural factors affecting clients' lives or may struggle to start where the client is. The social dimension of religion, distinct from a more individualistic spirituality, suggests that both potential resources and complicating factors, including the role in which beliefs, values, and expectations of other individuals and groups (for example, pastor, family, congregation), can influence the client. Just as with any cross-cultural difference, competent practice requires that social workers take steps to assess and understand the religious cultures and contexts of their clients. As LCSWs navigate the complexities of clients' presenting issues, not fully understanding or valuing the role of clients' RS could potentially lead either to inappropriately discounting a significant cultural component or potential resource in clients' lives, or conversely, to missing the role of the clients' religion as an interconnected source of struggle for the client (for example, scrupulosity).

In a separate study of this same sample (Oxhandler & Giardina, 2017), when asked "What (if anything) has helped or supported you to assess and/or integrate your clients' religious/spiritual beliefs in your clinical practice?", 44 percent of LCSWs indicated their personal religiosity. This use of self is of some concern in light of the vast RS differences between LCSWs and the general population in the current study. For example, even if the LCSW and client both identify with the same religious tradition, there may be significant differences in their beliefs or practices, and it should never be assumed that clients view the world with the same RS lens as the LCSW, even if they share the same religious affiliation. On the other hand, there may certainly be situations when a client who is affiliated with a very different religion has similar beliefs or practices with the LCSW, such as a nondenominational Christian client and a Buddhist LCSW both practicing mindfulness or meditation within their tradition.

In addition to developing and disseminating tools to help LCSWs identify clients' RS beliefs and practice, researchers and educators should strive to develop effective models and best practices for integrating clients' RS into practice. Furthermore, social work is called to pay attention to the ways in which RS is

considered and taught in education, including the various RS traditions, intrinsic religiosity, RS activities, and how RS might be interwoven into treatment. It is crucial that students also become deeply aware of their own RS beliefs and practices, how they might differ from clients' RS (even when the client may have the same religious affiliation), and how their RS carries out into their daily lives, including practice. With so many LCSWs self-identifying as spiritual, but so few as religious, LCSWs must also be comfortable with religiosity, especially with it being an important area of many U.S. adults' lives. Furthermore, given that components of RS are often considered interconnected, particularly with "feelings, thoughts, experiences, and behaviors that arise from the search for the sacred" (Hill et al., 2000, p. 66), these findings suggest that these terms do need to be conceptualized as different concepts as much as possible in future studies—especially when comparing LCSWs with the general population. Future studies may seek to better understand *why* social workers are overwhelmingly more spiritual and less religious compared with the general population, and whether mental and behavioral health clients have any preference regarding their clinicians' RS beliefs or practices (similar to Gregory et al., 2008).

Although our study has a number of strengths, it is not without limitations. As our sample was overwhelmingly white, female, and older, other races and ethnicities, genders, or age groups were underrepresented. Furthermore, as mentioned in Oxhandler et al. (2015), a majority of this sample is in private practice, disallowing us to generalize these findings to LCSWs in other settings or with other licenses. Still, social workers account for the largest proportion of clinically trained helping professionals across the United States (Substance Abuse and Mental Health Services Administration, 2010), and LCSWs hold many of these positions. Finally, given that the LCSW and GSS samples' data were collected at two different time points and used different methodologies, we are cautious to infer the results of the chi-square analyses. Future efforts to compare these groups should collect data from both groups simultaneously.

CONCLUSION

The current study is the first to describe the RS beliefs and practices of a large, national sample of LCSWs, to conduct a side-by-side comparison with the general U.S. population, and to examine how their affiliations compare based on region of the United States. Our findings suggest that there is significant likelihood that LCSWs will find themselves working with clients whose belief systems greatly differ from their own, or who engage in RS practices with which the LCSW is unfamiliar. As a result, there may be a need for increased education and practitioner self-awareness around issues related to the integration of RS into social work practice. SW

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Original manuscript received September 7, 2017
Final revision received February 3, 2017
Editorial decision February 13, 2017
Accepted February 14, 2017
Advance Access Publication November 9, 2017