

ABSTRACT

Title of Dissertation: AN EXPLORATION OF COUNSELORS' PERCEPTIONS
OF SPIRITUALITY

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This purpose of this study is to examine counselors' age, gender, years of training, and level of spiritual well-being as related to their (1) attitude about the importance of spiritual issues, (2) comfort with addressing spiritual issues, (3) frequency of use of spiritual interventions in the treatment process, and (4) attitude toward the use of spiritual interventions in the treatment process with individuals from different ethnicities and serious and persistent mental illness diagnoses.

Researchers suggest that attending to clients' spiritual issues is an important multicultural competency that has vital implications for the ethical delivery of mental health services, especially to those of different ethnicities and mental illness diagnoses. Research confirms that environment, family structure, and belief systems (political and spiritual) impact treatment issues.

Historically, the under-representation of spiritual issues in counselor training programs has resulted in a lack of sensitivity about these issues that has been passed from generation to generation of counselors.

Two hundred counselors from the American Rehabilitation Counselor Association and American Mental Health Counselor Association completed the General Attitude Scale (GAS), the Intervention Scale (IS), the Spiritual Well Being Scale (SWBS), and the Smith's Importance of Spirituality Scale (SISS). A short qualitative section consisting of open-ended phone interviews was conducted with five counselors asking them to speak about their feelings regarding the use of spirituality in the therapeutic process.

Results indicated that older counselors who had higher levels of spiritual well-being tended to have more positive general attitudes about the importance of using spirituality in the treatment process with clients diagnosed with serious and persistent mental illness. Older counselors with higher levels of spiritual well-being and less experience in counseling delivery tended to be more comfortable with addressing spiritual issues, as well as had a higher frequency of use of religious and spiritual interventions in the treatment process. A difference was found in the importance counselors attached to the use of spiritual interventions in the treatment process with clients from different ethnicities and severe and persistent mental illness diagnoses. This study discusses implications of the results in relationship to prior research, future research, training, and practice.

AN EXPLORATION OF COUNSELORS' PERCEPTIONS OF SPIRITUALITY

by

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Chapter One

Purpose of the Study

To date, there is limited research that examines mental health counselors and rehabilitation counselors' perceptions of spirituality. There is also a lack of research that studies the two groups of counselors' perceptions of spirituality when working with individuals from different ethnic and mental health diagnostic groups while they are undergoing individual or group counseling services (treatment process). Further, there is a total lack of research that examines the perceptions of spirituality among mental health and rehabilitation counselors while working with individuals in the treatment process who are diagnosed with serious and persistent mental illness (SPMI "defined for adults with functional limitations in activities for daily living, social interaction, concentration, and adaptation to change in the environment for 12 months or more "Coursey, Safajan, & Alford, 1997, p. 205).

This study, therefore, will first examine whether there is a significant relationship between a selection of potentially relevant demographic variables of counselors (i.e., age, gender, years in counseling delivery, and level of spiritual well-being) and their (1) attitude about the importance of spiritual issues, (2) comfort with addressing spiritual issues, and (3) frequency of use of spiritual interventions in the treatment process. Second, this study will examine the attitudes of counselors toward the use of spiritual interventions in the treatment process with individuals of different ethnicities. Third, this study will examine the attitudes of counselors toward the use of spiritual interventions in the treatment process with individuals with different mental illness diagnoses. Finally, a qualitative portion of this study will query five counselors in an unstructured interview

format, asking counselors to briefly describe their feelings about the use of spiritual interventions while conducting individual or group counseling services, with individuals diagnosed with mental illness. Participants in the study will be asked to indicate their willingness to be interviewed by phone, and list their phone number, as well as preferred time to call.

Introduction

Historically, mental health researchers and counselors have neglected the topic and role of spirituality for various reasons such as (a) the history of mental health treatment; (b) professional stereotypes; and (c) confusion and fears over the meaning of spirituality (Longo & Peterson, 2002). In spite of this neglect of the topic of spirituality in research literature, it has been considered an important factor in the lives of many people, including those with mental illness (Ruscinova, Wewiorski, & Cash, 2002; Murphy, 2001).

Recently, the role of spirituality in mental health has captured the interest of researchers and the topic is being studied in psychological literature. According to Walker (2003), 90% of the adults surveyed after the terrorist attacks of September 11, 2001, on the United States turned to religion as a coping reaction. This finding was consistent with findings by Elkins, Hedstrom, Hughes, Leaf, & Saunders (1988) that suggest spirituality is important to how individuals perceive the world. In spite of the perception of the importance of spirituality to many people there is a lack of evidence that counselors have used it as an intervention in treatment sessions. There is even less of a shred of empirical evidence that there is any potential benefit to interventions that

consider the topic of spirituality in the treatment protocol with clients, especially those diagnosed with mental illness.

Many people in our society suffer from a chronic mental disorder (Murphy, 2001). According to Sprafkin, Gershaw, & Golstein, (1993), the numbers of persons needing help overcoming mental health problems have increased over the years. Black (1988) states, “ Although there are many shortcomings and gaps in currently available morbidity and mortality statistics, those that are available are sufficient to illustrate the extraordinary increases that are expected in the numbers of persons who will be affected by major problems of disease and disability that are of concern to mental health. This includes persons in every age group, from young to old. This world wide increase in the prevalence of chronic disease may be best characterized as a rising chronic disease pandemic” (pp. 17-18).

The rising increase in chronic mental illness impacts individuals diagnosed with serious and persistent mental illness. Of the increasing numbers of persons that are of concern to the mental health field, it is estimated that there are at least four million people with serious and persistent mental illness (SPMI) (Yamada, Kormans, & Hughes, 2000).

These individuals often have an extensive history of psychiatric illness and require ongoing treatment that may persist for years. SPMI has been defined in terms of diagnosis, disability, and duration of a mental disorder (Goldman, Gattozzi, & Taube, 1981), and is characterized by periods of remission with apparent wellness, as well as episodes of relapse with flare-ups of acute symptoms and impaired psychosocial functioning (Bachrach, 1988). Many will require treatment and supportive services their entire lives (Lamb, 1984). The current medical model of treating individuals by

medicating them may not be the only intervention available to practitioners. Alternative treatment strategies (that can be associated with clients' experiences and ethnic identities) are often needed and spiritual activities (that will be listed later in this paper) appear to benefit some individuals with serious and persistent mental illness (Rusinova et al., 2002). As alternate health care practices and strategies are sought, the ethnicity of the individual (s) in counseling becomes a critical variable to keep in mind.

Every ethnic group has individuals to whom religion and spirituality are important, but there are groups of individuals to whom religious practices and spirituality are embedded in their day-to-day lives. Traditional counseling efforts have failed to meet the needs of minority groups (ability to talk about religious and spiritual matters) to whom religion and spirituality are often intimately tied to their ethnic identity (Frame & Williams, 1996; Matheson, 1996). Currently, professionals are giving more attention to discovering the best way to provide service delivery to increasing numbers of ethnic minorities and immigrant groups who are a part of the mental health systems in the United States and Canada (Lefley, 1990; Schaller, Parker, & Garcia, 1988).

Research confirms that cultural values relating to the environment, family structure, and belief systems (political and spiritual) impact treatment issues (Walsh, 1999). In spite of this, a consistent finding in recent literature is the under-utilization and premature termination of services by people from culturally diverse backgrounds, yet utilization rates are increased when the services provided are perceived as culturally appropriate, with sensitivity given to culturally specific concerns (Frame & Williams, 1996; Schaller et al., 1988).

There is current acknowledgement of spirituality as part of the broader sensitivity to diversity issues in all its aspects, namely, race, culture, socio-economic status, sexual orientation, and gender (Adams, 1995). “Client’s religious orientations are as important a consideration in clinical work as race, ethnicity, social class, culture and gender because the sine qua non of all various religions is their provision of worldviews, or interpretive lens, through which religious believers apprehend and order their experience and reality (both moral and social)” (Stewart & Gale, 1994, p.17). According to Adams (1995), spirituality is a foundational background of many people’s worldviews. He also suggests that the process of obtaining meaning from trauma, suffering, and disability can be viewed as a spiritual process.

Research supports the relevance of spiritual issues in clinical care and counseling (Bremer, 2003; Josephson, Larson, & Juthani, 2000; Tarko, 2002). Literature also reports that patients want clinicians and counselors to consider discussing spiritual issues (Miller, 1999) and spiritual commitments are associated with individuals coping more effectively with SPMI (Bremer, 2003; Pargament, 1997, Pollack, Harvin & Cramer, 2000; Tarko, 2002; Westgate, 1996). There is, however, a lack of research on the use of spirituality in treatment of patients in the fields of rehabilitation and mental health counseling (Muesser, Drake, & Bond, 1997).

There is some available literature that presents evidence that indicates spiritual components of adapted cognitive-behavioral interventions, meditation, 12 step fellowships, forgiveness interventions, and prayer contribute therapeutic value, especially when compared to standard treatments or treatment lacking a spiritual base (Harris, Thoresen, McCullough, & Larson, 1999; Piedmont, 2004). The studies for these

interventions need further replication with better design controls, yet the findings suggest that continued development and evaluating of spiritual interventions would be a worthwhile endeavor (Fallot, 1998). Most spiritual interventions (meditation, prayer, reading spiritual literature, etc.,) currently available have not been thoroughly evaluated to determine their efficacy, effectiveness, or clinical validity (Fallot, 1998).

There are some data that suggest that counselors' perceptions of spirituality affect their practice (Hickson, Housley, & Wages, 2000; Shafranske, 2000; Shafranske & Gorsuch, 1984; Shafranske & Maloney, 1990; Sheridan & Bullis, 1992). Shafranske and Maloney (1990) found that many psychologists indicated that religious and spiritual issues were important in clinical practice; however, only one third of these clinicians reported personal competence in counseling clients regarding these issues. Most studies of professionals have investigated either their religious beliefs or their use of spiritual interventions in the practice of psychotherapy (Bergin & Jensen, 1990; Shafranske & Maloney, 1990).

Shafranske and Gorsuch (1984) examined psychologists' perceptions of spirituality, religious affiliations, belief orientations, theoretical orientations and educational and training experiences to determine psychologists' preparedness to respond to the spiritual dimension or religiosity as experienced by their clients. The researchers asked questions seeking information about the extent psychologists recognize, respect, respond to, or influence the spiritual or religious values of their clients; the extent a psychologist's personal beliefs and personal history, in respect to religiosity, influence clinical work; the extent a psychologist's training prepares the practitioner to be aware of the religious orientations of clients and spiritual issues within psychotherapy; and the

extent to which a psychologist's theoretical orientation influences clinical work as related to religious or spiritual issues. They found that psychologists either ignored their clients' issues and behaviors that were associated with a spiritual context or using religious language, or they viewed it as relevant, when understood within their own personal spiritual framework. Their findings also suggested that in both instances, the therapeutic perspective was based on the personal rather than the clinical orientation of the psychologist. Whether or not specialized knowledge and "cultural sensitivity" of service providers improves consumers' prognoses and treatment may be a premature research question if specific knowledge is not first gained as to counselors' awareness of their own perceptions of alternative approaches to treatment and counselors' current frequency of use (Shafranske & Gorsuch, 1984).

A study conducted by Gonzales (2000), in an attempt to broaden the generalizability of Shafranske and Maloney's (1990) study of perceptions of spirituality in clinical practice, asked participants from a variety of professional backgrounds (psychologists, psychiatrists, social workers, marriage and family therapists) about their personal views of spirituality. They were also questioned about their attitudes related to addressing spiritual issues in their work and regarding their use of spiritual interventions in clinical practice. Participants were also surveyed about their formal training with regard to addressing spiritual issues of psychotherapy. The results of his research were consistent with Shafranske and Maloney's finding that positive personal life experiences with spirituality by mental health professionals are associated with their being more likely to use spiritual interventions. This study will build upon the work conducted by Gonzales (2000) by looking at the perceptions of spirituality of (1) counselors who work

with individuals diagnosed with SPMI, and (2) how they regard the use of spiritual interventions when working with this population.

Construct of Spirituality

Attempts at defining spirituality have often been confusing and ambiguous. Some authors view spirituality in the context of religious practices. According to Stroll (1989), spirituality is an abstract, multifaceted, human dimension that is part of every person whether religious, atheist, or humanist. Although spirituality is often equated with a religion or doctrinal belief, spirituality and religion are not synonymous. Rather, religious activities serve as a vehicle for the expression of one's spirituality.

Different writers have used the terms religion and spirituality interchangeably.

Elkins et.al., (1988) defined spirituality in the following terms:

Spirituality, which comes from the Latin, spiritus, meaning "breath of life," is a way of being and experiencing that comes about through awareness of a transcendent dimension and that is characterized by certain identifiable values in regard to self, others, nature, life, and whatever one considers to be the Ultimate - of extreme importance (p.10).

Ellison (1983) described the human spirit as that which enables and motivates individuals to search for meaning and purpose in life, to seek some meaning that transcends, and to wonder about their origins and identity. Miller (1999) describes religion as referring to the beliefs and practices of an organized church or religious institution. Thereby, religion is closely associated with an institutional base.

William James (1902/1961) regarded religion as the "feelings, acts, and experiences of individual men in their solitude...in relation to whatever they may

consider the divine” (p. 42). Thus, in essence, he equated religion with spirituality and ignored institutional religion (Hauerwas, 2001). William James related the spiritual to a person’s character, personality, or disposition, often with an emphasis on the person’s social and emotional style and manner of living (e.g., chronic anger or inner peace). Clearly human experience is central in understanding spirituality.

Secondly, spirituality includes a broad focus on the immaterial features of life, regarded as not commonly perceptible by the physical senses (e.g., sight, hearing) that are used to understand the material world. Major religions have used spiritual terminology to refer to that which is experienced and considered to be transcendent, sacred, holy, or divine (e.g., Holy Spirit) (Chandler, C. K., Holden, J. M., & Kalonder, C. A., 1992).

Spirituality has popularly been defined in diverse ways, usually in distinction from material reality experienced by the physical senses (Thoresen & Harris, 2002). Spiritual is generally understood to transcend ordinary physical limits of time and space, matter and energy. Yet, some features of spirituality are quite observable (e.g., spiritual practices, the spiritual motivated behavior of caring for others). Some view spirituality as primal relational - a transcendent relationship with something/someone sacred in life (Walsh, 1999), or with something divine beyond the self (Emmons, 1999). The concept itself is multidimensional and defies simple clear-cut boundaries. Therefore, it should be no surprise that spirituality, as a term, tends to elude tight operational definition.

Groups of scientists working toward an operational definition of spirituality have agreed it is a complex phenomenon (e.g., Larson et al., 1998; Pargament, 1997). Spirituality is not dichotomous, where it is an attribute either present or absent in an individual. Similarly, attempts to define spirituality as a single linear dimension (e.g.,

something that one has more or less of) are greatly oversimplified and often misleading (due to the individual personalized nature of the concept). A broader understanding of spirituality is one that can be used to characterize all individuals, regardless of their affiliation (or lack thereof) with any formal religion.

In the methodological language of behavioral sciences, spirituality can be described as a latent construct, having conceptual underlying entities that are not observed directly but can be inferred from observations of some of its component dimensions. Latent constructs are complex and usually multidimensional, with no single measure or dimension being likely to capture their essential meaning.

Although no scientific consensus yet exists on the component dimensions that can be studied to develop an understanding of the broad domain of spirituality, substantial progress has been made within the past few years, and increasing attention is being given to the relationship between spirituality and spiritual well being (Ellison, 1991).

Spiritual Well-Being

Because terms such as “spirituality” and “well-being” appear to have subjective meanings, which are difficult to operationalize, behavioral scientists have in the past steered clear of the study of spirituality in relation to health, healing, disease, and rehabilitation. Building on the work of Campbell’s (1981) work with life satisfaction, Ellison (1983) suggested that an individual’s general well-being depends on satisfaction of four basic needs: (1) the need for having, (2) the need for relationships, (3) the need for being, (4) and the need for transcendence – need for something or someone bigger than oneself. The need for having refers to the possession of material goods and resources of life. The need for relationships refers to patterns of social interaction. The need to

belong, to experience intimacy, and to be needed is basic to human life. The need for being is more difficult to define but is related to feelings of competence, direction over one's life, and a sense of self-worth. Finally, the need for transcendence refers to finding purpose in life beyond one's self and others. Early quality of life research revealed that the greatest differences in well-being among people were related to interpersonal satisfactions rather than the acquisition of material goods. All but the first basic need for having may be considered a part of the spiritual domain of man, which suggests the importance of spirituality in well-being (Ellison, 1983).

Faced with belief systems, which are contradictory and confusing, it is important for counselors and counselor educators to have a definition of spirituality that is accurate in highlighting the essence of spirituality; it must be universal, related to observable and behavioral aspects of people's functioning and positive.

Statement of the Problem

Since the majority (95%) of the United States' population experiences spirituality as important (Gallup & Lindsay, 1999; Walker, 2003), and for some it is considered the integral constituent of their lives, further research is indicated to address issues of spirituality in particular areas of counseling (Miller & Thoresen, 2003). The field of research is wide open for examination of spirituality conducted in the treatment process of individuals with SPMI. Suggestions have been made for qualitative studies to be conducted to assess the role of spirituality in maintaining psychosocial functioning (Fallot, 1998). Randomized trials are needed to test hypotheses that address whether the inclusion of spiritual concerns adds something other than what is accomplished by traditional psychotherapy and medication management (Fallot, 1998). This is particularly

needed for those clients with a strong religious commitment or for those who view faith to be the “most important” factor in their lives (Ritsher, Coursey, & Farrell, 1997).

Even though a growing body of research more or less attests to the importance of spirituality in coping with life-threatening illness (Vash, 1994), depression and anxiety (Westgate, 1996), only a few have focused on the spirituality of persons with SPMI (Lindgren & Coursey 1995; Sullivan, 1993), and none on the perceptions of spirituality of counselors who work with individuals with SPMI.

It has been noted that in order to work with clients of different religious backgrounds, counselors cannot avoid the necessity of knowing something about their client’s belief systems and practices. “An awareness of individual and group world views can help us develop the skills needed for effectiveness in cross-culture counseling and psychotherapy” (Ibrahim, 1985, p.626). In the study of other religions, however, the problem exists for counselors to control their own values, bias, stereotypes, and assumptions as others’ worldviews are encountered. Counselors cannot do justice to their clients’ beliefs if their own belief systems are approached with ideological blinders (Georgia, 1994).

Significance of the Study

The literature acknowledges that greater consideration of spirituality in treatment for individuals with SPMI is feasible, justifiable, and increasingly important to a comprehensive view of the whole person in a cultural context, and the treatment process of individuals with serious mental illness (Fallot, 2001). This information can be used as a vehicle for bridging gaps between consumers and service providers, thus increasing understanding and enhancing trust and rapport. This would also increase and improve

outcome results and utilization of services by under-represented minorities.

Some African American (Hickson, Housley, & Wages, 2000) and Native American (Locust, 1985) clients view counselors as being unwilling to explore spiritual or religious issues. Also, professionals working with clients diagnosed with SPMI have opportunities to promote client strengths and facilitate development, mobilization, and utilization of self-care resources to adapt to changing circumstances. With clients self-reporting spirituality as a source of hope and a resource for coping with mental illness (Fallot, 1998; Lindgren & Coursey, 1995; Russinova et al., 2002; Sullivan, 1992; Tarko, 2002; Young & Ensing, 1999), the possibility exists that integrating spirituality into treatment programs with individuals diagnosed with SPMI may facilitate development of comprehensive, empowerment-focused, and culturally attuned treatment approaches enabling counselors to provide comprehensive services that consider the entire person.

One potential benefit of this research lies in its contribution to the field's attempt to improve delivery of mental health services to better serve all populations, but specifically underserved populations. Part of the process of improving delivery of counseling services entails assessing current practice. This assessment allows for determinations to be made about what needs to be changed or added in the training of counselors and in the provision of counseling. This study also contributes to the literature by providing additional information about counselors' spiritual beliefs and their use of spiritual interventions in treatment.

Finally, counselors working with people from cultural or ethnic groups with strong religious beliefs and practices need to be knowledgeable about the function and

meaning of commitments to belief systems. With knowledge and awareness of spirituality and its impact negatively and positively upon counselors and clients an opportunity may be created for exploration and pioneering in a search for new strategies that may lead to better, more cost-effective treatments for individuals with SPMI.

Research questions

The following questions will guide this study:

1. Is there a relationship between counselors' age and their general attitudes about the importance of spiritual issues in the treatment process when working with clients with serious and persistent mental illness?
2. Is there a relationship between counselors' gender and their general attitudes about the importance of spiritual issues in the treatment process when working with clients with serious and persistent mental illness?
3. Is there a relationship between counselors' years in counseling delivery and their general attitudes about the importance of spiritual issues in the treatment process when working with clients with serious and persistent mental illness?
4. Is there a relationship between counselors' level of spiritual well being and their general attitudes about the importance of spiritual issues in the treatment process when working with clients with serious and persistent mental illness?
5. Is there a relationship between counselors' age and their comfort with addressing spiritual issues in the treatment process when working with clients with serious and persistent mental illness?

6. Is there a relationship between counselors' gender and their comfort with addressing spiritual issues in the treatment process when working with clients with serious and persistent mental illness?
7. Is there a relationship between counselors' years in counseling delivery and their comfort with addressing spiritual issues in the treatment process when working with clients with serious and persistent mental illness?
8. Is there a relationship between counselors' level of spiritual well-being and their comfort with addressing spiritual issues in the treatment process when working with clients with serious and persistent mental illness?
9. Is there a relationship between counselors' age and their frequency of use of spiritual interventions in the treatment process when working with clients with serious and persistent mental illness?
10. Is there a relationship between counselors' gender and their frequency of use of spiritual interventions in the treatment process when working with clients with serious and persistent mental illness?
11. Is there a relationship between counselors' years in counseling delivery and their frequency of use of spiritual interventions in the treatment process when working with clients with serious and persistent mental illness?
12. Is there a relationship between counselors' level of spiritual well-being and their frequency of use of spiritual interventions in the treatment process when working with clients with serious and persistent mental illness?
13. Is there a difference in the importance counselors attach to the use of spiritual interventions in the treatment process for clients with the following diagnoses:

Alcohol and Substance Abuse, Schizophrenia and other psychotic disorders, Minor Depression, Mood Disorders (including Major Depression, Bipolar, and Dysthymia), Anxiety Disorders (including Phobia, Panic Disorder, and Obsessive Compulsive Disorder), Personality Disorders (Borderline Personality Disorder and Antisocial Personality Disorder), and Disassociated Disorders (Multiple Personality Disorder)?

14. Is there a difference in the importance counselors attach to the use of spiritual interventions in the treatment process for clients with serious and persistent mental illness from the following ethnic categories: Caucasians, African Americans, Asians, Hispanics, Native Americans, and other?

The following null hypotheses were generated in response to the questions stated above:

1. There is no relationship between counselors' (1) age, (2) gender, (3) years in counseling delivery, (4) level of spiritual well-being and their attitudes toward the importance of spiritual issues in the treatment process when working with clients with serious and persistent mental illness.
2. There is no relationship between counselors' (1) age, (2) gender, (3) years in counseling delivery, (4) level of spiritual well-being and their comfort with addressing spiritual issues in the treatment process when working with clients with serious and persistent mental illness.
3. There is no relationship between counselors' (1) age, (2) gender, (3) years in counseling delivery, (4) level of spiritual well-being and their frequency of use of spiritual interventions in the treatment process when working with clients with serious and persistent mental illness.

4. There is no difference between the importance counselors attach to the use of spiritual interventions in the treatment process for clients with the following diagnoses: Alcohol and Substance Abuse, Schizophrenia and other psychotic disorders, Mood Disorders (including Minor and Major Depression, Bipolar, and Dysthymia), Anxiety Disorders (including Phobia, Panic Disorder, and Obsessive Compulsive Disorder), Posttraumatic Stress, Impulse Control Disorders (Borderline Personality Disorder and Antisocial Personality Disorder, and Multiple Personality Disorder).
5. There is no difference in the importance counselors attach to the use of spiritual interventions in the treatment process for clients with serious and persistent mental illness from the following ethnic categories: Caucasians, African Americans, Asians, Hispanics, Native Americans, and other.

Table 1

Definition of Key Terms

For the purpose of this study spirituality will be defined by Elkins, et.al., (1988):

Key Term	Definition of Key Term
Spirituality	1. Belief in a transcendent dimension
Elkins et.al., (1988) conceptualized spirituality as comprised of nine elements:	2. Conviction that life has meaning
	3. Sense of purpose
	4. Belief that life is sacred
	5. Material values appreciated, but not overly emphasized
	6. Social action and helping others are important
	7. Sense of striving for ideas
	8. Pain and suffering in life are recognized and respected
	9. Spirituality has real impact on the individual's life and relationships
Perceptions of Counselor's Spirituality	measured by the Spiritual Well-Being Scale (SWBS), a 20-item Likert scale that is described in chapter three of this study.
Spirituality	Spirituality will be operationalized and described by two factors: spiritual well-being and religious well-being.
Spiritual Well Being	There are two dimensions of spiritual well-being: (1) a religious orientation - expression of a person's relationship to God (or the divine, or the transcendent, or that which is greater than oneself), using the language of religion, and (2) an existential orientation – expressed in a person's sense of life purpose and life satisfaction

and expressed in nonreligious terms. This variable was operationalized by scores on the Spiritual Well-Being Scale (SWBS; Bufford, Paloutzian & Ellison, 1991).

Existential Well-Being (sub-scale of SWBS) is a subscale of the SWBS and is an assessment of one's sense of life purpose and life satisfaction.

Religious Well-Being (sub-scale of SWBS) is measurement of one's relationship with God (Bufford, Paloutzian & Ellison, 1991).

Comfort Level level of ease a counselor experiences when working with his / her clients (Goncalves, 2000).

Mental Illness conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual that is associated with present distress, disability, or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom (Morrison, 1995). Commonly known mental disorders according to The American Psychiatric Association. Retrieved April 23, 2002, from http://www.psych.org/public_info/overview.cfm.html are Minor Depression, Alcohol and Substance Abuse, Schizophrenia and other psychotic disorders, Mood Disorders (including Major

Depression, Bipolar, and Dysthymia), Anxiety Disorders (including Phobia, Panic Disorder, and Obsessive Compulsive Disorder), Personality Disorders (Borderline Personality Disorder and Antisocial Personality Disorder), and Disassociated Disorders (Multiple Personality Disorder).

Serious and Persistent Mental Illness “defined for adults with functional limitations in activities for daily living, social interaction, concentration, and adaptation to change in the environment for 12 months or more “ (Coursey et.al., 1997, p. 205). Individuals considered as having serious and persistent mental illness are those diagnosed with Schizophrenia, Bipolar Disorder, Major Depression, Obsessive Compulsive Disorder, and Panic Disorder. Retrieved April 23, 2002 from http://phs.os.dhhs.gov/Library/MentalHealth/chapter2/sec_1.html

Religion beliefs and practices of an organized church or religious institution, thereby religion is closely associated with an institutional base (Miller, 1999).

Treatment Process individual or group counseling processes within a counseling setting such as a clinic, office, hospital, and/or mental health/psychiatric facility (Goncalves, 2000).

Clinicians	<p>Mental Health Counselors - Counsel with emphasis on prevention. Work with individuals and groups to promote optimum mental health. May help individuals deal with addictions and substance abuse; family, parenting, and marital problems; suicide; stress management; problems with self-esteem; and issues associated with aging and mental and emotional health. Includes Licensed Professional Counselors but excludes Social Workers, Psychiatrists, and Psychologists.</p> <p>Retrieved May 20, 2004 from http://stats.bls.gov/oco.pdf/ocos.067.pdf.</p>
Counselors	<p>Rehabilitation Counselors – Counsel individuals to maximize the independence and employability of persons coping with personal, social, and vocational difficulties that result from birth defects, illness, disease, accidents, or the stress of daily life. Coordinate activities for residents of care and treatment facilities. Assess client needs and design and implement rehabilitation programs that may include personal and vocational counseling, training, and job placement. Includes Certified Rehabilitation Counselors (http://stats.bls.gov/oco.pdf/ocos.067.pdf, Retrieved May 20, 2004).</p>
Years in counseling delivery	<p>Years in counseling delivery refers to the number of years spent working and utilizing counseling protocols on a full-time basis in the field of counseling; it includes classes or workshops taken as</p>

part of a university training program, continuing education program, or in-service training program (Goncalves, 2000)

- Spiritual Interventions (Goncalves, 2000)
- Discussing with clients about religious/spiritual implications of choices they make
 - Using counselors / clinicians spiritual beliefs to guide treatment process
 - Quoting religious / spiritual quotes
 - Challenging client's spiritual beliefs
 - Engaging in prayer / meditation with clients
 - Encouraging clients to pray outside the treatment process
 - Using guided imagery or relaxation containing some conscious use of healing energy
 - Reading with clients relevant religious / biblical texts during the session
 - Encouraging clients to read relevant religious / biblical texts on their own
 - Employing therapeutic interventions using spiritual language or symbolism
 - Encouraging clients to spend more time in their life on spiritual activities
 - Giving or suggesting to clients religious or spiritual material to read.

Conclusion

Presented in the chapter was an introduction to this study, the existence of a need to consider spirituality because of the worldviews of the minority population who are diagnosed with SPMI, the statement of the problem, the significance of this study, the purpose of this study, the definitions of terms for this study, and the research questions that will guide this study. Literature related to this study will be reviewed in Chapter Two.

Chapter Two

Literature Review

Introduction

This chapter will address the following: a) concerns of this study, b) approaches to spirituality, c) spirituality and culture, d) spirituality and social support, e) spirituality as a coping or problem solving resource, e) spirituality and mental illness, f) spirituality and serious and persistent mental illness, g) spiritual well-being, h) assessment of spirituality, i) previous research with the spiritual well-being scale, j) spiritual beliefs and values of counselors, k) counselors' spiritual values in the treatment process, l) problems in the literature, and m) conclusion.

Concerns of this study

Historically, little emphasis has been placed on culture in mental health examinations; yet information concerning a client's worldview can be ascertained with this knowledge, and this knowledge may be beneficial in establishment of treatment strategies and interventions. Although the Diagnostic and Statistical Manual for Mental Disorders [DSM-IV] (1994) includes an outline directing the clinician to write a narrative summary for cultural explanations of the individual's illness, cultural factors related to psychosocial, environment and levels of functioning; cultural elements of the relationship between the individual and the clinician; and overall cultural assessment for diagnosis and care, most clinicians perceive this kind of detailed cultural documentation only necessary for clients who are foreign born. This attitude may in turn minimize the consideration of American ethnocultural differences in the treatment process (Plummer, 1996). Furthermore, mental health counselors may lack the necessary training in order to

develop a cultural formulation (outlined in the DSM-IV appendix). This results in all Americans receiving traditional mental health practices regardless of racial or cultural background.

A new diagnostic category, Religious or Spiritual Problems is listed as Code V62.89 in the DSM-IV (American Psychiatric Association [APA], 1994) based on a proposal documenting the extensive literature on the frequent occurrence of religious and spiritual issues in clinical practice (Lukoff, 1998). The proposal grew out of the work of the Spiritual Emergence Network to increase the competence of mental health professionals to sensitivity to such spiritual issues.

This increased sensitivity to spiritual issues by mental health counselors and rehabilitations counselors is needed since a significant majority of Americans profess a belief in a spiritual reality, whether it is belief in a Supreme Being or order, life after physical death, an ultimate reality, or supernatural beings like angels or demons (Miller, 1999; Moberg, 1984; Wirth 1993). Since a significant majority of the American population professes a belief in a spiritual reality, it would lead one to think that individuals diagnosed with mental illness disorders would also profess a similar belief. Falot (1998) reports that consumers diagnosed with SPMI have reported that the spiritual dimension of human nature is important to them. Individuals with SPMI have credited spirituality as being a source of strength and direction in their lives (Lindgren & Coursey, 1995; Sullivan, 1992).

However, there is a lack of research that indicates using spirituality as an intervention is beneficial to clients with SPMI, even though it is considered a coping mechanism for many groups of people. There is also a lack of training in the use of

spirituality as an intervention in the counseling field. This lack of research and training in the area of spirituality limits the counselor's ability to provide services that are culturally appropriate.

Despite the growing awareness of the importance of spirituality by professionals and the public, research has just recently begun to explore the subject. Studies are needed on the perceptions of spirituality currently held by counselors and their attitudes about the use of spiritual interventions within the treatment process. If spiritual beliefs are important sources of meaning and resources of support for most people's lives, then it is important to know how counselors handle this arena when working with clients.

Approaches to Spirituality

There is agreement among researchers (Kelly, 1995b; Miller, 1999) that William James' (1902/1961) *The Varieties of Religious Experience* was ground breaking in demonstrating how the psychology of religion contributes to our understanding of the relationship of religion and spirituality to human development and human functioning. William James considered spirituality to be a fundamental type of human experience and a valid topic of study for the field of psychology. His interest in the religious facets of human life is not surprising when it is considered that philosophy, psychology, and theology arose out of attempts to make sense of mankind's place in the universe. Over the years, however, the field of psychology has striven to be established as a science, unclouded by superstition and theological dogma, and well supported by empirical data.

Many professionals shy away from discussing spirituality, considering it to be an abstract and elusive term with a lack of agreement as to definition. Until recently, most theories that explain spirituality have been relegated to sociologists, philosophers, or

theologians. Research conducted on spirituality by Elkins et al. (1988) presented a humanistic definition and description based on the writings of Abraham Maslow, John Dewey, William James, and Carl Jung. The authors interviewed five individuals considered by them to be highly spiritual, and to help validate the Spiritual Orientation Inventory (SOI), which is based upon four major assumptions (1) there is a dimension of human experience-which includes certain values, attitudes, perspectives, beliefs, emotions, which can be described as a “spiritual dimension” of “spirituality”, (2) spirituality is a human phenomenon and exists, at least potentially, in all persons, (3) spirituality is not the same as religiosity, and (4) it is possible to describe spirituality and develop an approach to its assessment.

Elkins et al. (1988) participants were drawn from the Buddhist, Catholic, Protestant, and Jewish traditions. The researchers gave the interviewees a list of the items listed in the SOI; a measure of spirituality based on their humanistic model that was designed to assess the spirituality of those not affiliated with traditional religion (organized churches). Elkins et al. attempted to define and describe spirituality, conceptualizing spirituality as being comprised of nine elements: (a) belief in a transcendent dimension, (b) conviction that life has meaning, (c) a sense of purpose, (d) the belief that life is sacred, (e) material values are appreciated but not overly emphasized, (f) social action and helping others are important, (g) sense of striving for ideas, (h) pain and suffering in life are recognized and respected, (i) spirituality has a real impact on the individual’s life and relationships. Elkins et al. developed the SOI to assess these phenomenological components of spirituality.

Even though spirituality has been often cited as one of the dimensions of health, ironically its study has proven to be highly problematic. A difficulty in addressing the concept of spirituality is related to its association with denominational religion and the cultural emphasis placed on the material realm. Modern Western culture has become expert at analyzing and manipulating the world that can be seen and touched with the physical senses. Great strides have been made in understanding and treating the physical aspects of illness yet unconsciously dismissing anything that is not of the physical world, and verifiable through the five outer senses.

According to Miller (1999) people have conceived of reality in a way that is outside the boundaries of sensory experience and intellectual knowledge for as long as they have been able to record their thoughts, with many cultures taking for granted that there is a spiritual dimension of reality and human nature beyond the world that is known through the five senses. Presently, in American culture there seems to be a heightened awareness and search for that which is transcendent in and beyond us.

Spirituality and Culture

Within the next 20 years, racial and ethnic minorities will become a numerical majority (Sue, 1992). Immigration rates are the highest in years, with 34% being of Asian ethnicity and others from African, Middle Eastern, and other non-White, or non-Christian societies (Georgia, 1994). To meet the demands of the changing environment, new approaches in conceptual framework, education and training, research opportunities, and direct service delivery are required. It is paramount that counselors familiarize themselves with their clients' varying orientations in terms of spirituality (Sue, 1992).

The growing diversity of the American population requires counselors to have an increased understanding of inter-and intracultural factors (relationships among those of the same culture and relationships between cultures). All clients have a cultural heritage and contextualized cultural variables can and do affect an individual's functioning. In order to be effective, counselors will need to incorporate cultural factors into their conceptualization of the individual's concerns and the treatment process.

The recent attention to diversity issues in counseling has underscored the need for training counselors to respond to the unique spiritual and religious needs of their clients (Myers & Truluck, 1998). Pate and Bondi (1992) outlined recommendations for ensuring that the spiritual beliefs of clients are addressed in counselor education training programs. Their recommendations include addressing spiritual and religious values in course content, experiential training relating to religious values, and collaboration with religious counselors in the training and supervision process. To fully implement Pate and Bondi's recommendations, an understanding of current perceptions and beliefs of counselors is needed.

African Americans and Spirituality. Prior to the early 1990's, the kinds of direct data regarding the frequency of psychiatric illnesses in the community necessary to make definite statements about racial differences did not exist (Adebimpe, 1997). The types of data needed to make reliable comparisons finally appeared in the early 1990's. The Epidemiologic Catchment Area Study (Robins & Regier, 1991) and the National Comorbidity Survey (Kessler et al., 1994), conducted in the late 1980's failed to show a higher rate of schizophrenia and a lower rate of affective disorder among African Americans than Caucasians, Hispanics, and other races. Previous clinic and hospital

based reports showed higher rates of schizophrenia and lower rates of affective disorder among African Americans than Caucasians, Hispanics, and all other races, in four different types of clinical settings (Adebimpe, 1997).

The two reports differed in the percentages reported for anxiety disorders. The Epidemiologic Catchment Area Study showed higher rates of anxiety-related disorders in African Americans that were not supported by the National Comorbidity Survey. The rates of antisocial personality disorder were equal in both African Americans and Whites. These two studies did not produce strong evidence of major ethnic or racial differences in the epidemiology of mental disorders. In light of this information that affective disorders are found less frequently among African Americans, the possibility exists that social support systems that include spirituality and religion may have been protecting African Americans from developing psychiatric illnesses from their undeniably traumatic life situations (Adebimpe, 1997).

Despite the consideration that spirituality and religion may have provided a social support system for this cultural group, the number of African Americans with disabilities shows a great disparity when compared to the population at large. According to the U.S. Bureau of the Census (1992), in 1990 while 8.4 % of European Americans had health problems or disabilities that prevented them from working or which limited the kind or amount of work they could do, 13.4 % of African Americans had the same problem. According to Atkins and Wright (1980) African Americans who attended public rehabilitation programs had lower employment rates and weekly earnings than Caucasians post service.

Transference (proclivity to distort perceptions of others), early self-termination (termination rate of African American clients after only one counselor/client contact is about 50 % as compared to 30% for European American clients) and a general inability to grow during the helping process are important implications to be dealt with during the counseling process (Feist-Price & Ford-Harris, 1994). Many African Americans are resistant to traditional forms of treatment (e.g., not talk about personal issues or often get angry when questioned) and often do not follow through on referrals to community mental health centers and clinics (Boyd-Franklin, 1989; Feist-Price & Ford-Harris, 1994). The presence of resistance and its related issues need to be considered in relation to the timing of different relevant interventions.

Drastic reductions in the availability of inpatient resources, while discouraging voluntary admissions to state and public facilities, have not only increased the number of homeless African Americans with mental illness, but also jail and prison populations. Not everyone with an emotional problem seeks professional help, much less mental health counseling. Mental health seeking behavior undoubtedly reflects cultural beliefs about mental illness, demon possession, myths, as well as economic considerations. African Americans use emergency rooms for many nonphysical health problems that could be managed by mental health professionals or social workers (Carter, 1991).

Federal reports and academic studies have documented the prevalence of mental disorders among people who are homeless. Also noted has been the alarming rate among the homeless people of alcoholism and substance abuse. Garretson (1993) reports African Americans are incorrectly diagnosed when assessed for mental disorders. African Americans are often diagnosed with schizophrenia. These trends, along with drastic

reductions in the availability of inpatient resources, have increased the number of African Americans who have been diagnosed with homelessness and mental illness (Carter, 1991).

There are a myriad of issues that can interfere with the counseling process of African Americans that suggest the need for using alternate resources, the implementation of creative strategies, and culture-sensitive interventions. Though perceptions may be wrong, African American clients may assume that there is a lack of concern and understanding regarding their lifestyle and worldview by counselors who are not of their ethnicity. Some of the problems that may occur due to this misunderstanding of African American problem-solving styles are: (1) resistance to the rehabilitation process (e.g., lack of self-disclosure and/or anger), (2) transference, (3) early self-termination, and (4) a general inability to grow during the helping process which is related to the first three problems listed (Feist-Price & Ford-Harris, 1994).

Despite their heterogeneity, African Americans share many cultural characteristics that evolved from various historical experiences (Boyd-Franklin, 1989; Frame & Williams, 1996). Spirituality and religion have been essential components of the cultural heritage of African Americans, stemming from African ways of life (Constantine, Lewis, Conner, & Sanchez, 2000). Many African Americans have an internalized sense of spirituality but may not be a part of an organized religion or church (Boyd-Franklin, 1989). The African American community is diverse, and counselors encounter variability on the issue of spirituality, which may manifest as a deeply ingrained personal belief system, as a formalized set of religious beliefs and institutional

practice, or as a combination of both. African Americans do not possess a uniform set of beliefs.

To survive 400 years of oppression, African Americans have developed and perfected a constellation of coping skills. These skills have been restructured and modified to meet the stresses of being different in American society. For African Americans, the church and spirituality provide support and an adaptive mechanism for coping with stress that could be beneficial if recognized and incorporated into the therapeutic process (Boyd-Franklin, 1989). According to Frame & Williams (1996) African Americans' concept of spirituality takes into consideration community relationships. Spirituality is also a way for them to construct meaning in their lives.

Native Americans and Spirituality. Another minority group to whom religion and spirituality is tied to ethnic identity is American Indians. Unemployment, alcoholism, and other social and psychological problems have had a detrimental effect on the American Indian. A 1990 report to the Senate select Committee on Indian Affairs stated that American Indians, particularly adolescents, have more serious mental health problems than are reported for all other race populations in the United States (U. S. Office of Technology Assessment [OTA], 1990). The problems listed include developmental disabilities, depression, suicide, anxiety, alcohol and substance abuse, self-esteem and alienation, running away, and dropping out of school (results of mental health problems). Forced acculturation, racism, and discrimination are examples of threats to the American Indians' personal integrity. The product of these actions has been classified as intergeneration Post Traumatic Stress Disorder (PTSD) (Choney, Berryhill-Paapke, & Robbins, 1995).

In an attempt to alleviate the sense of hopelessness and loss of identity brought about by intergenerational PTSD, acculturative stress, and other problems, alcohol has become a coping mechanism (Choney et al., 1995). Native Americans have higher rates of alcohol consumption than any other ethnic group in the United States (Weisner, Weibel-Orlando, & Long, 1984). Indian communities experience high rates of alcoholism, suicide, murder, accidental death and injury, assault, theft, social discord, unemployment, and divorce. The survival and functioning of future generations of American Indians are threatened by fetal alcohol syndrome and fetal alcohol effect (Choney et al.).

Native Americans build their unique religions on a set of shared metaphysical premises. These abstract philosophical premises undergird Native Americans' health-related beliefs and practices, which differ from those of the dominant culture. The National Institute of Disability and Rehabilitation Research (NIDRR) funded a study that identified 10 fundamental premises: (a) Native Americans believe in a Supreme Creator and in lesser beings, (b) humans are threefold, made up of a body, a mind, and a spirit, (c) plants and animals, like human beings, are parts of a spirit world that exists side by side and intermingle with the physical world, (d) the spirit existed before it came into a physical body and will exist after the body dies, (e) illness affects the mind and spirit as well as the body, (f) wellness is harmony in body, mind, and spirit, (g) unwellness is disharmony, (h) natural unwellness is caused by violation of a sacred or tribal taboo, (i) unnatural wellness is caused by witchcraft, and (j) each of us is responsible for our own wellness (Vash, 1994). All of these premises are also embedded in the Judeo-Christian philosophy.

In most Native American cultures, healing is not separated from social behavior or other aspects of culture, or even from sacred narratives and “religion” (Locust, 1985). Because spirituality is integral to all life activities, there is no word for a separate conceptual entity of “religion” in the dominant culture’s sense. Healing ceremonies are aspects of community experience. Observers have been unable to distinguish healing from worship. Numerous tribes view the body as an instrument by which the spirit may express itself, learn spiritual lessons, and progress toward the ultimate goal of being united with the Supreme Creator. The physical body is a dwelling place for the spirit, and the mind has awareness and functions as a link between the body and mind (Locust, 1985).

Western European culture medicine is often only symptom relief to the American Indian, who believes the underlying cause must be treated. A medicine man may be consulted who aids healing by restoring harmony between the body, mind, and spirit. Treating the spirit is a process of finding out why illness has occurred, understanding the events in a spiritual rather than a physical sense, and beginning the process of changing whatever that was in the body, mind, or spirit that was out of harmony. Sometimes the medicine person helps an individual to see how spiritual needs or mental conditions have affected the physical body (Locust, 1985). Just as therapy and assistive devices help the body, so do ceremonies, songs, herbs, prayers, and rituals help the mind and spirit to heal, in the Native American culture (Vash, 1995).

Native Americans face many issues amenable to psychosocial interventions. Unfortunately, reports suggest that mental health services are underutilized because of lack of awareness of availability, fear and mistrust, and negative attitudes toward non-

Indian psychologists (Choney et al., 1995). For many traditionally oriented Native Americans, there is no separate concept for mental health. A person is either in harmony or in disharmony, a condition that encompasses physical, emotional, environmental, and cognitive aspects of self (Locust, 1985), with everything being viewed in the context of the community.

Native Americans have lived through a history of religious persecution and denial of their religious rights that, coupled with public exposure of their beliefs and practices, have led to a sheltering of Native spirituality from the public eye. They also have developed mistrust of those who are not of their culture (Lee, 1996). According to Choney et al. (1995), it is difficult to provide culturally appropriate services without knowledge of Native American culture or the ability to distinguish a culturally adaptive response from one that indicates psychopathology.

Spirituality as a Coping or Problem-Solving Resource

Much attention has focused on the role of spirituality as a buffer from the impact of negative life events as well as a coping mechanism to deal with life's strains and hassles (Sullivan, 1993). Pargament, Falgout, Olsen, Reilly, Haitsma, & Warren, (1990) describe coping as "a process through which individuals try to understand and deal with significant or situational demands on their lives" (p. 795). According to these researchers three factors are recognized as basic to the coping process: (1) the life situation or event, (2) the appraisal of the event, and (3) the actual coping activities.

The prevailing situation or event in terms of coping with mental illness provides a significant challenge to this population, given the unpredictable course of the illness, and the lack of understanding of the etiology of the disease. Therefore, the desire of some to

employ a higher power for help and guidance has inherent logic. The appraisal of the event, in this case mental illness, can also be shaped by one's spiritual orientation. According to Sullivan (1993), spirituality provides assurance that there is a limit to the depths to which they might descend.

Sullivan (1993) conducted a study that described the importance of spirituality from the perspective of current and former consumers of services. Interviews were conducted with 40 individuals who at some point in their lives met the criteria used to classify people as serious and persistently mentally ill. Forty-eight percent of the individuals interviewed specifically mentioned spiritual beliefs or practices as central to their success. Vocational activity, medication, and support from friends were more frequently mentioned factors than spirituality, yet 48% of the respondents interviewed specifically mentioned spiritual beliefs or practices as central to their success.

This study has the limitations that exploratory studies have, which are that the questionnaires and interviews are subject to bias. This was a small group from the Midwest and retrospective analysis when dealing with feelings, emotions, and reconstructed events have limitations. Also all the participants were from traditional treatment facilities.

Many participants reported that prayer was an essential part of their lives, particularly when anxious about their illness. Many echoed the sentiments of one, who suggested, "I can pray and ask the Lord to get rid of the voices and to help me relax" (Sullivan, 1993). For others, reading the Bible or a book of spiritual sayings, singing hymns, and attending formal religious services were important.

In this study the differences between religion and spirituality were not clear. Religion was generally defined by the activities that people participated in that were an expression of their belief system. Spirituality on the other hand may or may not have included the concept of religion

Pargament et al. (1990) examined the role various religious coping efforts serve in dealing with negative events. They used a sample of 586 members of Christian churches who turn to religion in coping. Their sample was selected from 10 midwestern churches representing a range of denominations: Lutheran, Presbyterian, Episcopalian, American Baptist, Roman Catholic, and non-denominational groups. These congregations were drawn from rural, urban, and suburban areas and varied in size, age, and stability.

The sample was composed of 66% female, 96% white, 38% college educated, and 64% married. Thirty percent of the sample had an average family income of less than \$24,999 a year, 38 % had an income between \$25,000 and \$49,999 and 32% had an income of \$50,000 or more. The average age in the sample was 46. The sample generally endorsed mainline Christian beliefs; 87% reported a belief in the existence of a just and merciful personal God, and 84 % strongly endorsed a belief in life after death.

The participants completed a lengthy battery of measures to assess negative events, religious involvement in coping, non-religious coping activities, and outcomes. With the exception of the newly developed scales of religious involvement in coping, these measures demonstrated evidence of reliability and validity in other studies.

The authors generated a list of 31 religious coping activities through interviews with clergy and other adults on their uses of religion in coping, the empirical literature, and the written personal accounts of those who turned to religion in times of stress. These

items dealt with several dimensions of religious coping: interpersonal, spiritual, cognitive, emotional, behavioral, social, avoidance, passive, and collaborative.

Pargament et al. (1990) attempted to go beyond the basic question of whether religion is helpful to examine more comprehensively the kinds of religiousness that are more or less helpful in coping. To this end they included a number of measures of religious dispositions in the study and developed measures of religiousness tied to the coping framework: religious appraisals, religious coping activities, religious purposes, and religious outcomes. The factor analyses of the religious coping activities and religious purposes dimensions reveal that religious involvement in coping can take a variety of forms: interactional, interpersonal relations with others, (religious support) or with God, (spiritually based coping activities); behavioral changes in life-style, requests for divine intercession, or participation in religious services and rites (good deeds); emotional: feelings of love or anger (discontent) to God; or motivational: a religiously based search for spiritual development (spiritual purpose), personal growth (self development), the resolution of problems (resolve), closeness with others (sharing), and emotional/behavioral control (restraint). The authors concluded that religious coping efforts appear to be multidimensional. In this study religious coping activities represented an important element of the coping process, at least among the religiously involved. The authors concluded that the findings of this study underscored the need for an integration of the religious dimension into the coping literature.

There are several limitations to this study. It was conducted on a representative sample of mainstream, denominational Christians. The Christians that were participants

were not homogeneous, reporting a range of religious views and practices. Other religious group studies need to be examined for their coping processes.

This study was also limited by its cross-sectional design. The two classes of measures were taken at the same point in time. It is possible that the perceptions of the outcome influenced the individual's reconstruction of his/her coping efforts. The reliability of three of the scales was low, thus reducing the magnitude of some of the findings.

Throughout this study, the concept of spirituality was used when questions were asked that included a reference made to God. The term religion referred to interactional and interpersonal relations with others or participation in the performance of good deeds and rituals.

Spirituality and Mental Illness

Despite the sharp increase in the number of articles concerning spirituality and spiritual issues written over the past decade, there are several limitations that have been noted especially with reference to individuals with mental illness. While there has been a vast amount of research that has explored factors associated with relapse and recidivism rates among individuals who face SPMI, less attention has been given to those factors that account for successful adjustment (Clare & Singh, 1994). One problem has been the scarcity of attention given to spiritual matters by counseling as a behavioral science and a helping profession (Kehoe, 1999). Empirical research has indicated that the role of spirituality in the lives of individuals challenged with mental illness is complex and varied, ranging from a primary coping (Ellison, 1991; Michello, 1988; Pargament et al., 1990; Pargament, et al., (1988); Pollner, 1989), to an essential aspect of a personal social

support network (Ellison, 1991; Hathaway & Pargament, 1990; Maton, 1989; Pollner), to sustaining a sense of meaning and coherence in life (Allport, 1963; Ellison; Titone, 1991).

Religious commitments, beliefs, and practices of psychiatric patients have been found to be similar to, or stronger than, those of non-psychiatric populations (Knoll & Sheehan, 1989; Neeleman & Lewis, 1994). Neeleman and Lewis (1994) refer to some of the beliefs strongly endorsed by their participants as ‘comfort beliefs’ because they reflect religion’s capacity to reassure and offer solace. In Coursey and Lindgren’s (1995) interviews with people in psychosocial rehabilitation programs, 80% said that spirituality or religion had been helpful to them. Spiritual-philosophical was listed as a scale in a research conducted by Pollack, Harvin, and Cramer (2001) with 42 African American and 80 white patients hospitalized for bipolar disorder. Each individual completed the Coping Resources Inventory. African Americans scored higher than White patients on the three scales indicating internal resources-cognitive, emotional, and spiritual-philosophical, with the possible indication that cultural orientations may be an explanation for the differences between the two groups on perceptions of their coping resources.

First person and qualitative reports on spirituality. Consumers have written reports that included numerous examples of the relationships between their experiences of mental illness and spirituality. Sullivan (1998) interviewed people diagnosed with SPMI who had not been hospitalized for over two years, lived at least semi-independently, and were involved in some form of vocational activity. Sullivan talked with clients, asking about the factors that contributed to their success in dealing with their

psychiatric problems, and reported three findings relevant to spirituality. First, spirituality played a positive role in coping with stress and in decision-making. Prayer, avoidance of negative activities such as drug use, and reliance on religious role models were mentioned often in the interview. Second, religious involvement enhanced social support, both tangible and emotional. Relationships with a higher power contributed a unique, often reinforcing dimension to this experience of support. Third, spirituality often strengthened a sense of personal coherence, of being a whole person.

Spiritual Well-Being / Spiritual Wellness

Spiritual well being is considered to function as one of the states of spirituality and may be understood as a measurement of the state of one's spirituality or one's spiritual health. Ellison (1983) noted that spiritual well being is an expression of spiritual health much like one's blood pressure is an expression of physical health. Ellison (1983) also wrote that such a conception of spiritual health was composed of many dimensions, just as there may be many dimensions to physical and mental health.

The terms spirituality and spiritual wellness are often used interchangeably but actually have overlapping yet distinct meanings. Spirituality represents beliefs and values, whereas the term spiritual wellness has its roots in the medical wellness movement, rather than the counseling field. Spiritual wellness represents the openness to the spiritual dimension that permits the integration of one's spirituality with the other dimensions in life, thus maximizing the potential for growth and self-actualization (Westgate, 1996).

According to Westgate (1996) there are five authors (Banks, 1980; Chandler et al., 1992; Hinterkopf, 1994; Ingersoll, 1994; Myers, 1990) who delineate components of

spirituality and spiritual wellness, with four broad dimensions emerging: meaning and purpose in life, intrinsic values, transcendent beliefs/experiences, and community relationship. These authors theorized that the dimension of meaning and purpose in life is considered an innate need. According to them the self-actualized person is considered to have found meaning in life. Westgate (1996) reports studies have been documented that indicate clients suffering from depression have not found meaning and purpose in life.

In the article by Westgate the second dimension is having an intrinsically held value system, which is considered necessary to avoid sickness and to achieve one's maximum potential. The third dimension is transcendence and focuses on a relationship with a higher being or force, a conscious being, or creator of the universe. The fourth dimension is a spiritual community of shared values and support that is considered a natural outgrowth of intrinsic values and a transcendent perspective. The desire is to share those values with others. The authors unanimously agreed on the inclusion of a sense of or search for meaning and purpose as one dimension of spiritual wellness, and three agreed to the inclusion of community relationship.

Spiritual and Religious Beliefs and Values of Counselors

People have often thought of reality in a way that is not limited to personal experiences and intellectual acuity. There are groups of people whose worldview includes a spiritual dimension of reality and human nature that is beyond what is known by the five senses. There has occurred within the American culture, a focus on that which is transcendent and beyond human experience.

Research, at present, is limited on the effectiveness of spiritual interventions for health problems; however, evidence is accumulating that emphasizes the importance of

incorporating spirituality into overall health care and mental health care (Miranti & Burke, 1998; Wilson & Moran, 1998). Fallot (1998) reports that clinicians need to be more fully aware of the broad network of community activities involving spirituality and religion, and to develop a more differentiated view of activities so that referrals can be made with specificity and cultural sensitivity. He suggests that developing relationships with faith-based communities is one step in expanding clinicians' sense of the universe of possibilities. Mental health agencies and psychiatric treatment programs may also decide to offer services related to spirituality in their own programs (Fallot, 1998).

A survey of counselor values, based on a nationally representative sample of counselor members of the American Counseling Association, showed that almost 64% of the respondents believe in a personal God, while 25% believe in a transcendent or spiritual dimension to reality (Kelly, 1995a). In this study 70% of the respondents expressed some degree of affiliation with organized religion. Forty five percent indicated that they were highly interactive or regularly participate in religion. Those who identified themselves as religious also expressed a greater intrinsic than extrinsic religious orientation, meaning they value religion more for its importance as a guide in life than for its socially beneficially or personally comforting aspects. According to Kelly the preceding finding suggests that counselors who are religious tend to have a religiousness grounded in a spiritual orientation toward life.

When the spiritual and religious beliefs of counselors are compared with those of the general population, it was discovered that counselors' overall beliefs and rates of affiliation and participation seem almost identical to those of the general population. Ninety percent of the general population report that they never doubted the existence of

God (Gallup & Castelli, 1989), while 89 % of counselors indicate a belief in a personal God or a transcendent dimension to reality. Both professional counselors and the general population, as well as other mental health professionals, report about a 70% level of some affiliation with organized religion, with 40% reporting a high to moderate level of participation; however, these self-reports may be subjective overestimations of actual participation (Hadaway, Marler, & Chaves, 1993). The survey demonstrated that 30% of the clinical psychologists who believe that God or the divine are illusory notions contrasted with 90% of the general population who report a belief in God. (Beit-Hallahmi, 1989). The accumulation of recent evidence indicates that a substantial majority of major mental health professionals appear to believe in the validity and value of spiritual dimension to reality (Bergin & Jenson, 1990; Kelley, 1995), with moderate numbers of these reporting affiliations with organized religion in percentages not much different from the general population. Given the information about the importance of counselors, mental health professionals' values, and client values to the treatment process, and given the clear lack of consensus spiritual values, it would seem this area is ripe for research.

Assessment of Spirituality

Research or scientific study of spirituality can be undertaken only if appropriate instruments are developed to conceptualize and operationally measure spirituality or spiritual well-being (Moberg, 1984). According to Moberg, spirituality is assumed to be a multidimensional phenomenon and research will proceed better by identifying and analyzing its respective elements than by treating it as if it were unidimensional. Some dimensions, such as people's relationship with their God, are beyond the finite

boundaries of directly observer able phenomenon. In spite of this, attempts have been made to establish instruments to measure spirituality or spiritual well-being (Ellison, 1983; Moberg, 1984).

The development of instruments to measure spirituality seems to have come from a combination of the growing interest in religion and spirituality in counseling and the lack of instruments to provide sufficient measurements of the construct of religion or spirituality (Kelly, 1995b). There are two instruments that were designed that include a humanistic-phenomenological philosophical base, the Spiritual Orientation Inventory (SOI) (Elkins et.al., (1988) and the Spiritual Experience Index (SEI), a developmentally based measure of spiritual maturity (Genia, 1991). Both the SOI and the SEI appear to be well designed instruments, however they do not have the research background or reliability and validity of the SWBS used in this study. The SOI is based on a humanistic model of spirituality and the SEI is based on a developmental model of spirituality.

Previous Research with the Spiritual Well-Being Scale

The Spiritual Well-Being Scale (SWBS) has the potential to assist the counselor in differentiating the degree of sense of purpose or well-being in a client (Ellison, 1983). Its brevity (20 items) makes it attractive for relatively nonintrusive integration into the ongoing counseling process (Bufford, Paloutzian & Ellison, 1991). For those whose spirituality includes an acceptance of the concept of God, its nonsectarian content makes it appropriate for people with diverse spiritual beliefs and may even be appropriate for people whose spirituality includes a sense of the transcendent but do not define it as a concept of God. The three subscale scores of the SWBS include the overall spiritual well-being (SWB), existential well-being (EWB), and religious well-being (RWB), and might

serve as a tentative starting point for the counselor to explore deeper aspects of the client's spirituality (Ledbetter, Smith, Vosler-Hunter, & Fisher, 1991). The individual test items also provide the opportunity for counselors to explore spiritual attitudes pertinent to the client's presenting and emerging counseling issues.

Counselors' Spiritual Values in the Counseling Process

As stated in previous sections spirituality is an important factor in the lives of many counselors, clinicians and Americans. It has been suggested by McCullough & Worthington (1994) that highly religious clients (those who view their life as directed by their spiritual beliefs) would perform better in counseling and be less likely to drop out of counseling if counselors consider the spiritual values of their clients as relevant to counseling. The counselor's personal spirituality may prompt the counselor to be more sensitive to the spiritual aspects of client issues. Given that survey findings indicate a substantial number of counselors value spirituality, a possibility exists that clients who desire to incorporate their spirituality into counseling would have a good chance of matching their spiritual interests with those of a counselor. This type of matching is easy in counseling settings offering spiritually oriented counseling. Also, according to Kelly (1995a) the large numbers of counselors who value spirituality irrespective of their work setting give credence to the likelihood that spiritually oriented clients might receive counseling that is explicitly attuned to the spiritual dimension.

Due to the limited number of articles pertaining to counselors, this literature review has been extended to include clinicians and research conducted concerning their spiritual values. Religious and nonreligious clinicians have been found to make very similar clinical judgments about religious, moderately religious, and nonreligious clients

(Houts & Graham, 1986), not to differ in their diagnoses according to clients' religious affiliation (Wadsworth & Checketts, 1980) or their religious beliefs (Hillowe, 1985), or to differ in their perception of the therapy process (Gibson & Herron, 1990).

Some clinicians have made reference to spiritual issues in their work (Bergin & Jensen, 1990; Shafranske & Maloney, 1990; Richard & Potts, 1995). A study conducted by Sheridan and Bullis (1992), examined the attitudes and behaviors of social work practitioners toward religion and spirituality. They conducted a study of 328 randomly selected Virginia licensed clinical social workers (LCSWs), psychologists, and licensed professional counselors (LPC's). Of the respondents, 186 (57%) were females and 142 (43%) were males. Respondents were mostly white (97%, n = 313), and had an average age of 43 years (ranging from 28 to 70 years). The primary work setting reported by the majority of respondents was private practice (60%, n = 197), with "other" (primarily educational settings) reported next (15%, n = 49), followed by community mental health centers (12%, n = 39), hospitals (7%, n = 23), substance abuse agencies (3%, n = 10), and justice agencies (3%, n = 10). Years spent as a clinician ranged from less than 1 year to 50 years, with a mean length of time of 12 years. Weekly hours providing counseling services ranged from 1 hour to 50 hours, with an average time of 23 hours per week.

Sheridan and Bullis (1992) sent a multifaceted questionnaire representing a modified replication of Shafranske and Maloney's (1984) study of clinical psychologists. The researchers included an ideological question adapted from Lehman (1974), which measured degrees of belief in a personal God; External Means, Internal End, and Interactional Quest scales, which measured orientation toward religious or spiritual affiliation and involvement; a newly developed scale that assessed attitudes toward

religion and spirituality in clinical practice; a series of items that measured religious or spiritual counseling interventions; a case vignette that investigated clinician bias toward religious or spiritual clients; and items related to education and training in the area of religion or spirituality.

Analyses revealed significant differences among the three professional groups in both their professional and personal orientation to religion and spirituality. The position of the three groups generally followed the same pattern across variables. Specifically, LPCs merged as having the most traditional approach to religious or spiritual belief, the highest involvement and affiliation with organized religion, and the highest involvement and the most evidence of a spiritual or religious orientation to practice. Psychologists fell at the opposite end on this continuum, with LCSWs generally falling in the middle. However, both LCSWs and LPCs were significantly less satisfied with their clinical training and education than psychologists were. Additionally, LCSWs reported the highest frequency of referring clients to 12-step programs.

This study had several limitations. The authors noted that the sample was only representative of licensed practitioners within Virginia, and thus, the results could not be generalized to nonlicensed practitioners in Virginia or to practitioners in general from other regions in the United States. Also, while there were no significant differences in professional discipline or geographical location between respondents and nonrespondents, there is a possibility that there were demographic and internal differences that may have affected results. There was also a high number of respondents with degrees in religion or theology within the LPCs in Virginia, and thus may have

rendered a false picture of this group. As a whole, respondents were found to value the religious and spiritual issues in their practice with clients.

A study conducted by Hickson, Housley, and Wages (2000) investigated the attitudes of 147 LPCs in Georgia and Mississippi concerning spirituality in the therapeutic process. They sent a survey instrument to a random sample of 300 LPCs. The researchers had a 51% return of their survey. They had 147 usable responses, of which 90 were women and 57 men; 107 respondents were from Georgia and 40 were from Mississippi. The majority of respondents fell into the 41-59-age category ($n = 98$), followed by 37 respondents in the 25-30-age category. Only 12 respondents were in the age 60-75 category. The sample contained 15 items concerning counselor attitudes and perceptions toward spirituality and the counseling process.

The study is limited in its applications of results because the sample was drawn from the Southeast region of the United States, where religiosity is viewed as an important component of Southern lifestyle. In analyses of the results of counselor attitudes regarding spirituality and the counseling process, five items received greater than 85% of responses of strongly agree-agree. The study's findings indicate that LPCs in these two states indicate the importance of being aware of their own spiritual beliefs in the counseling process. They further believed spirituality is a universal phenomenon that can act as a powerful psychological agent within their counseling practice.

LPCs believed that the spiritual phenomenon is not experienced differently as a function of gender. However, the results of the study indicated that counselors perceive that women and men express their spirituality as a function of gender. There was a 58% variance on the scores on the item concerning expression of spirituality. There was a 63%

disagreement of counselors on the survey item asking whether the spiritual dimension in the counseling process is more important for an older client than a younger client. The responses varied as follows: strongly agree/agree (42%), no opinion (33%), and strongly disagree/disagree (26%). In describing their positions on including spirituality in their own counseling practice, the majority of counselors (n = 105) indicated that using a spiritual component in a therapeutic relationship is either vitally important or important (73%). Twenty-one percent (n = 30) believed this to be somewhat important. Only 6% (n = 9) described their position as not important. Other limitations of this study, besides the lack of generalizability beyond the two states, were the responses might not be representative of diverse cultures because the majority of respondents were Caucasian. Also, the majority of respondents were 40-59 years old, and other age groups were not represented. Counselors' settings were unknown.

Shafranske and Maloney (1990) conducted a study that examined the relationships between the religious and spiritual orientations of a sample of clinical psychologists and their practice of psychotherapy. Seventy-four percent of the study's participants reported a belief that religious and spiritual issues should be considered in the field of psychology. The majority of the participants indicated that psychologists in general do not have the knowledge or skills to help clients with their religious or spiritual development. One third did express a belief of personal competence based on personal experience and theoretical orientation. This is in keeping with research findings that the perceived relevance of spirituality in a psychologist's clinical practice is related to spirituality's relevance for the psychologist's personal life and experience (Shafranske &

Gorsuch, 1984). The majority of the participants also did not think participatory and overtly religious activities as appropriate for their psychological practice.

Richards and Potts (1995) investigated the frequency of use of spiritual interventions by Mormon psychotherapists. Inquiries were also made about the types of interventions used and which ones were considered successful. Two hundred and fifteen responses were received from the three hundred Mormon psychotherapists that were randomly selected from the Association of Mormon Counselors and Psychotherapists (AMCAP) membership directory. The researchers discovered that many Mormon therapists used spiritual interventions and the most commonly used ones were similar to those used by other Christian denominations. The spiritual interventions were not used often.

The literature to date has shown that there are a significant number of counselors who tend to view spirituality as being relevant to their professional lives, with the majority of professional counseling and psychotherapy taking place in the secular domain, clinics, human service agencies and nonaffiliated private settings. According to Kelly (1995a), secular counseling settings have been characterized by “passive neutrality,” a mark of American society in which the typical cultural norm is that an individual’s spirituality is a private matter, usually confined to a religious setting. The thought process of not including spirituality in the secular counseling setting is mirrored in the omission of spiritual issues in the training of counselors and other mental health professionals.

To summarize the preceding paragraphs, the data suggest that there are a significant number of counselors and clinicians who tend to view spirituality as being

relevant to their professional lives. The degree to which spiritual factors are judged as relevant to providing treatment seems to be related to professionals' personal experience with spirituality and their theoretical orientation. Despite the reported perceived importance of spiritual factors, psychologists and counselors are not trained to work with spiritual issues. Some psychotherapists and counselors are using spiritual interventions; however they are using these interventions sparingly. The more overtly religious and participatory the intervention, the less likely counselors and psychotherapists are using the intervention in their practice.

Goncalves (2000) sought to expand the representativeness of the samples of the groups of participants in the previous researches on personal spiritual beliefs by exploring the role of mental health professionals' personal spiritual beliefs in their use of spiritual interventions in clinical practice. He conducted this study by asking participants from a variety of professional backgrounds about their personal views of spirituality. Goncalves developed the General Attitude Scale and the Intervention Scale to assess mental health professionals' attitudes about addressing spiritual issues in their work and regarding their use of spiritual interventions in their clinical practice. Administration of the two scales was carried out on psychologists, psychiatrists, social workers, and marriage and family therapists. He found that mental health professionals agreed that it is appropriate to discuss spiritual issues with clients and denied any discomfort in discussing client's spiritual beliefs. They also were favorably disposed to utilizing interventions that were covertly spiritual or only required talking about spiritual issues. More active interventions such as laying on of hands (touching a person to pray for them), or reading biblical texts in session were less frequently used.

Much of what is known in the field of spirituality concerns religious (mostly Protestant, Mormon, and Jewish) professional mental health counselors (Goncalves, 2000, Richards & Potts, 1995, Shafranske & Maloney, 1990). An attempt was made by Goncales to address this shortcoming in previous research. He explored the role of spirituality in clinical practice by asking participants from a variety of professional backgrounds (psychologists, psychiatrists, social workers, and marriage and family therapists) about their personal views of spirituality. He also asked them about their use of spiritual interventions in their clinical practice, as well as their formal training with regard to addressing spiritual issues in psychotherapy.

Research packets were sent to eight hundred mental health professionals in the Commonwealth of Pennsylvania. The packets contained a demographic survey as well as an 85-item research form that sought to measure the spirituality of an individual. There were nine subscales, which addressed hypothesized dimensions of spirituality such as a belief in a transcendent dimension. The authors, Elkins et al. (1988), reported alphas ranging from .75 to .95 on the measure's scales. Participants were requested to fill out the surveys and return them along with a business reply postcard. A non-participant packet was sent to those who did not return the business reply postcard. Goncalves received a 27% return for the initial mailing with a 19% return rate for non-participant forms.

The average age of the participants was 51 years and non-participants average age was 53 years. Of the 214 participants, 19 did not indicate their gender, 115 were female and 80 were male. Of the non-participants, 114 were female and 47 were male. Individuals with Ph.D., M.D., and M.S.W. as their degree predominate for both participant and non-participant groups. There were six participants who had religious

degrees. The largest percentage of religious affiliations identified was from Protestant, Catholic and Jewish denominations. Fifty percent of the participants identified solo private practice as their work setting, with cognitive theory as the most commonly cited theoretical influence. The participants reported working with mood disorders and anxiety disorders the most. Nineteen percent of the participants report they had no graduate training in either religion/spirituality as cultural factor or religious/spiritual interventions.

Goncalves (2000) assessed the degree of importance that participants assign to religious and spiritual issues in the provision of mental health services, with items ranked on a 7-point scale from “Intensely Disagree” to “Intensely Agree”. The participants ranked the following item as a 6.0 on a 7-point scale: “A client’s religious or spiritual beliefs can have a significant impact on the course of treatment.” The participants agreed that it is appropriate to discuss spiritual issues with clients and denied discomfort in discussing spiritual beliefs. Marriage and family therapists had the highest score viewing spirituality as relevant to treatment and feeling comfortable addressing spiritual issues. The data also suggested that participants were more likely to utilize spiritual interventions. Nonparticipants were sent a short questionnaire, which showed that there was a significant difference in their frequency of participation in religious/spiritual activities other than services and that of participants.

Women scored significantly higher (472.6) than men (440.4) on the Spiritual Orientation Survey (SOI), with the maximum score achievable being 595. In general, a higher score indicates a greater degree of spirituality. Marriage and family therapists received a SOI score of 502.2, followed by social workers, psychologists, and

psychiatrists, respectively. An analysis of variance found significant differences between groups, $F(3, 197) = 6.728, p < 0.001$.

The original hypotheses of this study suggested that the total SOI score would be the biggest predictor of “attitudes about spirituality in psychotherapy” and “comfort with addressing spiritual issues”; with these two scales later being combined into one “General Attitude Scale”. Regressing attitude scores on SOI scores indicate that the total SOI score was a significant predictor, accounting for 36.1% of the variance.

It was also hypothesized that personal spirituality, as measured by the SOI, would be the best predictor of the frequency with which professionals utilize religious or spiritual interventions in clinical practice, as measured by this study’s Frequency of Use of Spiritual Interventions scale. It was determined that field of training and frequency of participation in religious / spiritual activities (other than services), and SOI are significant predictors, with the SOI score being the biggest single predictor of the three. It predicted 35.6% of the variance. Goncalves (2000) concluded that his study was consistent with the findings of Shrafranske and Maloney (1990), who reported that positive experiences with religion or spirituality by mental health professionals are associated with their being more likely to use religious interventions. A relationship also drawn by Goncalves was between the ability of the SOI score to be a significant predictor of attitudes and frequency of spiritual intervention use, giving credence to its claim to measure spirituality, and the degree to which participants believe spirituality is relevant to their work and is related to the degree to which they find it relevant in their personal lives. Thus a suggestion is being made for greater confidence in the idea that the personal

spirituality of the mental health professional is related to their attitudes towards spirituality in clinical practice and to the use of spiritual interventions in clinical practice.

A holistic approach in counseling is important to mental health. The United States has expanded to include many different cultures. Multiculturalism is a well-established concept and must be accommodated, especially as emphasis is placed on it as a fourth force in psychology. New-age spirituality, renewed enthusiasm by Christians with conservative views, and the influx of immigrants from a variety of religious traditions has increased interest in spirituality and religion. In addition, religious pluralism forces counselors to deal with other spiritual traditions and to formulate positions about interaction between their own spiritual beliefs and values and those beliefs and values of their clients.

Problems in the literature

Investigations of spirituality and perceptions of spirituality have increased. Yet, spiritual counseling in the public mental health setting has been ignored (Worthington et al., 1996). Individuals with SPMI move within the public mental health system among community service boards, institutions, halfway houses, and outpatient counseling. Families, communities, and providers of services join mental health consumers in desiring better services to consumers, many who have spiritual values and concerns. Research so far has been concerned with the spiritual perceptions of those who work with clients. One difficulty with the findings describe in the previous section is the representativeness of the samples used in the studies. Specifically, the two studies that looked at spiritual values and treatment used circumscribed groups of participants (e.g., one study used LPCs from Georgia and Mississippi, while the other used LCSWs). The

participants described in the Bergin and Jensen (1990) paper were psychotherapists from a variety of professional backgrounds, yet the frequency of use of spiritual interventions was not a consideration of the paper.

Another aspect of the cited research is the manner in which spiritual values has been assessed. One common approach has been to treat spirituality as a monolithic construct and ask a question such as “To what degree is spirituality important in your life?” In an attempt to provide a model of spirituality that would promote an understanding of spirituality that would be sensitive to those not affiliated with traditional religion, Elkins et al. (1988) conceptualized spirituality as being comprised of nine elements: (a) belief in a transcendent dimension, (b) conviction that life has meaning, (c) a sense of purpose, (d) the belief that life is sacred, (e) material values are appreciated but not overly emphasized, (f) social action and helping others are important, (g) sense of striving for ideas, (h) pain and suffering in life are recognized and respected, (i) spirituality has a real impact on the individual’s life and relationships. The Spiritual Orientation Inventory (SOI) was developed by Elkins et al. (1988) to assess these phenomenological components of spirituality. The SOI consists of nine scales, one for each of the nine elements listed above. The SOI was used in the study conducted by Goncalves (2000). This study will use the General Attitude Scale and the Frequency of Use of Spiritual Intervention scale developed by Goncalves (2000) as well as the Spiritual Well Being Scale (Ellison, 1983) to examine the spiritual perceptions of those who work with the population with SPMI; one that has been ignored in research studies.

Conclusion

The historical under-representation of spiritual and religious issues in counselor training programs has resulted in a lack of sensitivity about these issues that has been passed from generation to generation of counselors (Miller, 1999). Because some mental health counselors receive limited education and training in the areas of spirituality and religion (Shafranske & Malony, 1990), they may be unequipped to deal with clients' religious or spiritual issues. Some counselors may be unclear about their own spiritual ideologies, and may consciously or unconsciously fail to explore spiritual issues with clients. Some counselors may also hesitate to explore their clients' spiritual beliefs for fear that they will be unable to reconcile this information with their own understanding of human behavior (Richardson & June, 1997). Attending to clients' spiritual and religious issues is an important multicultural competency, and has vital implications for the ethical delivery of mental health services (Miller, 1999).

Chapter Three

Research Design and Methodology

Introduction

Counselors have not been adequately trained to provide treatment in the area of spirituality or to utilize spirituality for clients with serious and persistent mental illness. They have contributed very little to the development and assessment of spiritually oriented awareness for clinical practice and professional improvement. This lack of research and training in spirituality with individuals with SPMI limits the counselor's ability to adequately assess and provide culturally appropriate services, especially to clients to whom spirituality is a major coping resource.

The purpose of this study was to examine whether there is a significant relationship between selected demographic variables of counselors and their attitudes about the importance of spiritual issues, comfort with addressing spiritual issues, and their frequency of use of spiritual interventions when working with clients with serious and persistent mental illness. A survey methodology was used to collect data. These data was analyzed quantitatively using regression analyses. Multiple regression analysis allows researchers to explain the amount of variance in dependent or outcome variables due to the influence of two or more variables. Multiple regressions analyses produce an equation that provides the best prediction possible for an outcome variable, given the correlations among all variables in the analyses (Pedhazur & Schmelkin, 1991).

This study examined whether there is a difference in the importance counselors attach to the use of spiritual interventions in the treatment process for clients with varying diagnoses and different ethnicities. Specifically, the diagnostic categories included Minor

Depression, Alcohol and Substance Abuse, Schizophrenia and other psychotic disorders, Mood Disorders (including Major Depression, Bipolar, and Dysthymia), Anxiety Disorders (including Phobia, Panic Disorder, and Obsessive Compulsive Disorder), Personality Disorders (Borderline Personality Disorder and Antisocial Personality Disorder), and Disassociated Disorders (Multiple Personality Disorder). The ethnic categories included Caucasians, African Americans, Asians, Hispanics, Native Americans, and others. Counselors were asked to rate the importance of using spirituality with clients for each diagnostic and ethnic category. Two repeated measured analyses of variance (ANOVA) were used as the design in this portion of the study since each counselor completed the ratings across categories.

With regard to the independent and dependent variables associated with the hypotheses used in this study, predictors (independent variables) for the regression portion are counselors' age, gender, years in counseling delivery, and level of spiritual well being. The outcome measures are attitude about the (1) importance of spiritual issues, (2) comfort with addressing spiritual issues, and (3) frequency of use of spiritual interventions in the treatment process.

For the repeated measures analyses the independent variables are ethnic category (6 subcategories), and mental diagnostic category (7 subcategories). The dependent variable in each analysis is the degree of importance of the use of spiritual interventions score.

Finally, a short qualitative section was incorporated into the study consisting of open-ended phone interviews conducted with five counselors asking them to speak about their feelings regarding the use of spirituality in the therapeutic process. Each interview

took about 10 minutes, with the interviewee answering 24 questions. This data was gathered in order to enrich the quantitative findings and possibly detect areas of concern for future research.

Population and Sample

In order to obtain a representative sample, a random sample of 700 counselors was generated from a listing of mental health counselors and rehabilitation counselors belonging to the American Mental Health Counseling Association (AMHCA) and American Rehabilitation Counseling Association (ARCA). The American Counseling Association (ACA) and the AMHCA provided the random listing. All potential participants were sent research packets which contained a cover letter advising them of the purpose of the study and that their return of the completed materials registered their consent to participate in the study. If an adequate response had not been received within two weeks of mailing the surveys, a second mailing would have been conducted to ensure an adequate return of at least 122 participants. This sample size was arrived at via a power analysis (Pedhazer & Schmelkin, 1991), based on an estimated population effect size equal to .11. Thus, a sample size of 122 participants is needed to detect an $R^2 = .10$, using 5 predictors, with a 20% risk of a Type II error (Beta = .80) and 5% chance of a Type I error (Alpha = .05). A business reply postcard was also sent requesting the potential participant to please return it if they do not wish to participate in this study.

Instruments

The Spiritual Well-Being Scale (SWSB), The Participant Survey (a demographic form), The General Attitude Scale, The Intervention Scale, and The Smith's Importance of Spirituality Scale were used for the purpose of this study, which is to examine the

perceptions of spirituality among clinicians and counselors in working with individuals in the treatment process from different ethnic and diagnostic groups; specifically groups diagnosed with severe and persistent mental illness.

Spiritual Well Being Scale

Ellison (1983) developed the Spiritual Well Being Scale (SWBS) to measure two dimensions of spirituality; religious well being and existential well being. Preliminary versions of the SWBS were tested and revised to a final version that contains 10 religious and 10 existential items. Initial work on the SWBS began by examining data obtained from 206 students at three religiously oriented colleges in the Midwest and Northwest United States. A factor analysis using Varimax rotation of the SWB scale revealed that the items clustered together as expected. All the religious items loaded on the RWB factor. Existential items appeared to load into subfactors, life direction and life satisfaction. A significant correlation between the RWB and the EWB subscales was found.

The (SWBS) (Ellison, 1983) is a general indicator of well being, providing an overall measure of spiritual quality of life, as well as subscale scores for Religious and Existential Well-Being. The Religious Well-Being Subscale provides a self-assessment of one's relationship with God, while the Existential Well-Being Scale gives a self-assessment of one's sense of life purpose and life satisfaction.

The SWBS is a 20 item Likert scale that yields three scores; (1) a total Spiritual Well-Being Scale score (SWBS), (2) a Religious Well-Being Scale score (RWBS), and (3) an Existential Well- Being Scale score (EWBS). It takes approximately 10 minutes to complete. The items are rated along a six- point scale with respondents indicating (6)

Strongly Agree, (5) Moderately Agree, (4) Agree, (3) Disagree, (2) Moderately Disagree, and (1) Strongly Disagree. Some of the statements are positively worded while others are negatively worded.

The RWBS has reported test-retest reliability coefficients of .96, .99, .96, and .88. Testing was conducted across four studies, with 1-10 weeks between each testing. The reliability coefficients for the EWBS are .86, .98, .98, and .73. For total SWBS, the coefficients are .93, .99, .99, and .82. These findings suggest the SWB and its subscales have high reliability (Bufford, Ellison & Paloutzian, 1991).

Examination of the item content of the SWBS suggests good face validity. Research has shown that the items cluster as expected into the RWBS and EWBS subscales. The SWBS is also a good indicator of well-being, and is especially sensitive to lack of well being. Negative correlations were found between the SWBS, RWBS, and EWBS and the UCLA Loneliness Scale (Russell, Peplau, & Ferguson, 1978). The SWBS, RWBS, and EWBS were positively correlated with the Purpose in Life Test (Crumbaugh & Maholick, 1969), Intrinsic Religious Orientation (Allport & Ross, 1967), and self-esteem (Campise, Ellison, & Kinsman, 1979).

Eleven of the 20 items on the SWBS scale are worded positively, while the remainder was worded in the negative. Reverse scoring was employed for the negative items so that when the scores are totaled, higher scores reflect a greater degree of spiritual well being.

The Participant Survey

The participant survey contains demographic items pertaining to information such as participant age, gender, degree, field of training, ethnicity, years in counseling

delivery, theoretical orientation and religious affiliation. These survey items were created and asked to assess what attitudes counselors have about spirituality in the treatment setting. The participant survey contains 20 questions and takes approximately 10 minutes to complete. At the bottom of this survey a final item asks participants to indicate their willingness to be interviewed and tape recorded by phone concerning their feelings about using spirituality in the treatment process, and if so, to indicate their phone number and a preferred time to call (mornings, afternoons, evenings).

The General Attitude Scale

Goncalves' General Attitude Scale (GAS) was used to measure the degree of importance that participants assign to religious and spiritual issues in the provision of mental health services, and to assess the comfort level of participants in addressing religious and spiritual issues in the treatment process. Participants were to use this scale considering clients diagnosed with the following mental illness diagnoses: Minor Depression, Alcohol and Substance Abuse, Schizophrenia and other psychotic disorders, Mood Disorders (including Major Depression, Bipolar, and Dysthymia), Anxiety Disorders (including Phobia, Panic Disorder, and Obsessive Compulsive Disorder), Personality Disorders (Borderline Personality Disorder and Antisocial Personality Disorder), and Disassociated Disorders (Multiple Personality Disorder).

The General Attitude Scale contains 9 items that were created for the purpose of Goncalves' exploratory study of the spiritual orientation of mental health professionals. Items on this instrument were assigned to one of three scales. Goncalves gives credit for several of the items to models taken from the work of Richard and Potts (1995). The scale attempts to assess attitudes about spirituality as it pertains to counseling.

Specifically, the scale attempts to assess participants' degree of comfort with addressing spiritual issues in counseling. The scale is comprised of statements that ask participants to rate their level of agreement according to a 7-point scale ranging from "Intensely Disagree" to Intensely Agree." It takes approximately 5 minutes to complete.

The GAS was subjected to internal consistency analyses to determine whether the a priori assignment of items was appropriate. The items were originally from two scales, the "Importance of Religious / Spiritual Issues" scale and the "Comfort with Addressing Religious / Spiritual Issues" scale. Initially the scales were rated individually and the items on the "Importance of Religious / Spiritual Issues " scale yielded an alpha of 0.73, while the items on the "Comfort With Addressing Religious / Spiritual Issues" scale had an internal consistency score of alpha = 0.70. Goncalves combined the items into one scale, which yielded an alpha of 0.75. Item 7 (I would need specialized training before I would feel comfortable discussing religion or spirituality with a client) was removed from the original scale because of its relatively low corrected item-total correlation of 0.29 and a slightly improved alpha of 0.76.

Reversed scoring was needed for three items (items 5, 6, and 8) in this survey because they were worded negatively. High scores on this scale indicate better general attitudes toward using spirituality in the treatment process.

The Intervention Scale

Goncalves' Intervention Scale (IS) was used to assess the frequency of religious and spiritual interventions used by counselors in the treatment process (Goncalves, 2000). The Intervention Scale contains 17 items that attempt to determine the frequency that participants rate each item on a 7-point scale ranging from "Never" to "Very Frequently."

For example, one item asks participants how often they “teach clients about spiritual issues and concepts.” The Intervention Scale was subjected to internal consistency analyses to determine whether the a priori assignment of items was appropriate. The Intervention Scale was initially composed of Items 29 through Item 51 of Goncalves’ supplementary survey. These items consisted of descriptions of possible interventions. Participants rated their frequency of use on a 7-point scale from “Never” to “Very Frequently.” The initial scale yielded a 0.89 alpha. Items that had low corrected item-total correlations and low squared multiple correlations were selected for removal. The items on the final Intervention scale had an alpha of 0.91. This scale takes approximately 10 minutes to complete.

Smith’s Importance of Spirituality Scale

This author developed the Smith’s Importance of Spirituality Scale (SISS) to assess counselors’ attitude about the importance of using spirituality in the treatment process of individuals with mental illness, who are from different ethnic groups and diagnostic categories. Participants will be asked to rate their level of importance of using spirituality in the treatment process of individuals who are mentally ill according to a 5-point scale ranging from “Don’t Know” to “Most important.”

The Smith’s Importance of Spirituality Scale contains 13 items that were created for the purpose of this exploratory study of counselor’s perceptions of spirituality in the treatment process among individuals with mental illness. The scale attempts to assess counselor’s attitude about the importance of using spirituality in the treatment process of individuals who are mentally ill from the ethnic categories of Caucasians, African Americans, Hispanics, Native Americans, Asians, and other. It also attempts to assess

counselor's attitude about the importance of using spirituality in the treatment process of individuals who are mentally ill from the following diagnostic categories: Minor Depression, Alcohol and Substance Abuse, Schizophrenia and other psychotic disorders, Mood Disorders (including Major Depression, Bipolar, and Dysthymia), Anxiety Disorders (including Phobia, Panic Disorder, and Obsessive Compulsive Disorder), Personality Disorders (Borderline Personality Disorder and Antisocial Personality Disorder), and Disassociated Disorders (Multiple Personality Disorder). The scale is comprised of statements that ask participants to rate their level of importance of using spirituality in the treatment process of individuals who are mentally ill according to a 5-point scale ranging from "Don't Know" to "Most important." After the development of the items, feedback on the content and the format of the survey was solicited from several individuals noted for their expertise in rehabilitation and mental health counseling. As a result of their recommendations, several wording changes were made to the initial survey. This scale takes approximately 5 minutes to complete.

Test-retest reliability. The test-retest reliability was assessed with two separate administrations on the Smith's Importance of Spirituality Scale over a three-week time period, with 16 counselors participating. Pearson correlations between the scores derived from the two administrations for items 1, 2, and the total score were respectively, .65, .76, and .79, suggesting adequate reliability over time. It should be noted that all three correlations were significant at the .01 levels. Internal consistency was also assessed using the Cronbach's Alpha. Results indicated excellent internal reliability with the following coefficients for items 1, 2, and the total score: .80, .94, and .93.

Procedure

Permission was obtained from the Institutional Review Board at the University of Maryland to conduct the study. The American Counseling Association (ACA) was contacted and a random sample of 1000 rehabilitation counselors' names and addresses from different regions of the country was obtained. The American Mental Health Counseling Association (AMHCA) was contacted and a random sampling of 2000 (the association sold labels in quantities of 2000) mental health counselors' names and addresses was also obtained from different regions of the country. Research packets were sent to 700 (350 to AMHCA and 350 to American Rehabilitation Counseling Association (ARCA)) potential participants on the list containing the following items:

- a) Cover letter describing the study and extending an invitation to participate. The letter informs the potential participants that the return of completed materials will register their consent to be a participant in the study. Respondents were asked to return the surveys within one week of receipt of materials.
- b) Informed consent form
- c) The General Attitude Scale.
- d) The Intervention Scale.
- e) The Spiritual Well Being Scale.
- f) Smith's Importance of Spirituality Scale
- g) Participant survey containing demographic items.
- h) Business reply return envelope.
- i) Business reply postcard indicating a wish to not participate and to not be contacted again.

Copies of the cover letter, informed consent, the General Attitude Scale, The Intervention Scale, The Spiritual Well Being Scale, The Smith's Importance of Spirituality Scale, and participant survey can be found in Appendix A. Participants were asked to fill out the surveys and return them in the business reply envelope. The investigator informed the potential participants that their name will be placed in drawings for \$300.00, \$200.00 and \$100.00, respectively.

If at least 122 surveys were not returned within two weeks of the initial mailing, a second mailing would be sent to those who did not complete the survey or return the return the card indicating their wish not to participate in the study. Over two hundred surveys were returned within the first three weeks.

When all surveys had been collected, five phone numbers were randomly selected from the phone numbers of all volunteers who indicated their willingness to be interviewed by phone. These volunteers were contacted at the time slot they indicated as convenient, and were asked once again for their permission to be audio taped. Each interview took about 10 minutes, with the interviewee answering 24 questions.

Statistical Analysis

Descriptive statistics were used to summarize the data gathered. Frequency distributions were constructed for all nominal data on the demographic form (ethnicity, gender, religious affiliations, years in counseling delivery, certifications and licenses of the counselors/clinicians). Means and standard deviations were calculated for ratio and interval data on the demographic form as well as for the total and subscale scores on the Spiritual Well Being Scale and the scores on The General Attitude Scale and The Intervention Scale.

The first thirteen research questions were analyzed using multiple regression analyses. Prior to running regressions, tolerances were checked to avoid the problem of multicollinearity. In addition, residual scatter plots were examined to assess any violations of assumptions. A simultaneous entry method was used since there is not enough theory in the literature upon which to base a hierarchical entry method, and it is, therefore, important to gauge the relative contribution of all the variables. If any significant multiple R value (s) were obtained, the beta weights associated with each variable would be examined for their relative contribution to the prediction equation.

Research questions fourteen and fifteen were analyzed with a repeated measures analysis, since counselors repeatedly make ratings on the same scale. The alpha level was set at .05 for all inferential analyses.

Finally, a written analysis summarized the data obtained by the interview tapes and is listed in a table format as part of the analysis conducted by interviewees responses to 24 questions.

Conclusion

This chapter contained the introduction to this study, the participants involved, the instruments that were used, the procedure, and statistical analysis. The results of the statistical analysis for this study will be reviewed in Chapter Four.

Chapter Four

Findings

The purpose of this study was to examine whether there is a significant relationship between any of a group of potentially relevant demographic variables of rehabilitation and mental health counselors (i.e., age, gender, years in counseling delivery, and level of spiritual well-being) and their (1) attitude about the importance of spiritual issues, (2) comfort with addressing spiritual issues, and (3) frequency of use of spiritual interventions in the treatment process. Second, this study examined the attitudes of counselors toward the use of spiritual interventions in the treatment process with individuals of different ethnicities. Third, this study examined the attitudes of counselors toward the use of spiritual interventions in the treatment process with individuals with different mental illness diagnoses. This chapter will first summarize the findings of the study pertaining to the characteristics of the sample and the inventory scores via descriptive statistics, followed by a summary of the inferential statistics used to test the five null hypotheses generated for this research.

Descriptive Statistics

Participants. Seven hundred packets were mailed (350 to the AMHCA and 350 to ARCA) and 265 were returned. Of the 350 packets sent to the AMHCA group, 104 were complete and useable, 3 were undeliverable, 17 were incomplete, and 4 refused to participate. Of those packets sent to the ARCA group, 96 were complete and useable, 10 were undeliverable, 29 were incomplete, and 2 refused to participate. Two hundred packets were returned that could be used for the analyses. The final sample size was 200.

Table 2 below presents a frequency distribution of relevant personal characteristics of the participants.

Table 2

Frequency distribution of participant demographics per participant survey (N = 200)

Variable		<i>f</i>	%
Group	ARCA	96	48.0
	AMHCA	104	52.0
Gender	Male	60	30.0
	Female	140	70.0
Race	Asian	2	1.0
	Latino	4	2.0
	Black / African	8	4.0
	American		
	White	182	91.0
	Other	4	2.0
Professional	LCSW	5	2.5
	D Min	4	2.0
	MSW	3	1.5
	PhD	33	16.5
	MS	40	20.0
	PsyD	1	.5
	MA	73	36.5

	EdD	5	2.5
	Med	25	12.5
	MFT	1	1.5
	Other	10	5.0
Training	Addiction	5	2.5
	Clinical Psychology	6	3.0
	Counseling	33	16.5
	Counseling	24	12.0
	Psychology		
	Family	2	1.0
	Geriatrics	1	.5
	Guidance	3	1.5
	Guidance Rehab	1	.5
	Health Psychology	1	.5
	MH Counselor	15	7.5
	Pastoral Counseling	3	1.5
	Psychology	6	3.0
	Psychotherapy	3	1.5
	Rehab Counseling	70	35.0
	Sport Psychology	1	.5
	Social Work	4	2.0
	Trauma	2	1.0
Licensed	Licensed	110	55.0

	Non-licensed	90	45.0
Certification status	Certified	134	67.0
	Non-certified	66	33.0

As can be seen from the table above, a slight majority of the participants were from the American Mental Health Counseling Association (52.0%). Females represented 70% of the respondents, and almost all respondents were white (91.0%). Greater diversity in ethnicity was expected since the recipients of the mailing were randomly chosen. The resulting lack of diversity, however, precludes using ethnicity as a variable in the study (ethnicity was to be an independent variable initially). A total of 71.0% of participants had Masters Degrees as their highest professional degree. Fifty-five percent were licensed and sixty-seven percent were certified. With regard to respondents' training, the largest category was rehabilitation counseling (35.0%), followed by counseling (16.5%), and counseling psychology (12.0%).

Table 3 provides a summary of participants' workplace. It should be noted that this table is not a frequency distribution, since the categories were not mutually exclusive and it was possible to provide multiple responses to this item.

Table 3

Summary of participants' workplaces

Workplace	N	<i>f</i>	%
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Solo practice	200	98	49.0
Public rehab facility	200	46	23.0
Hosp outpatient	200	19	9.5
Public MH clinic	200	39	19.5
For- profit psychiatric facility	200	9	4.5
Non-profit psychiatric facility	200	16	8.0
Hospital inpatient	200	14	8.0
Other	200	83	41.5

An examination of the table above reveals that 49% of participants were in solo practice. Of those who were not, a total of 42.5% worked in either a public rehabilitation or mental health facility. It is also interesting to note that 41.5% of respondents indicated “Other” as a workplace descriptor. A review of their comments indicated that the “Other” category included the following types of work settings: solo bono practice (1), ministry / outreach (6), government / VA facilities (7), group private practice (8), industry (4) public substance abuse clinic (4), community college (23), university (22), court / jail (1), private rehabilitation facility (1), not for profit medical center (1), non profit supported employment (2), insurance company (1), and community services for the blind (1).

Data were also collected regarding the types of problems respondents typically helped clients with. Table 4 gives a summary of these data.

Table 4

Summary of types of client problems

Type of Problem	N	<i>f</i>	%
Substance abuse, addictions (including alcohol)	198	134	67.7
Schizophrenia / other psychotic disorders	200	78	39.0
Anxiety disorders (Phobia, Panic Disorder, Obsessive Compulsive Disorder)	200	178	89.0
Posttraumatic stress	200	156	78.0
Mood disorders (Minor and major depression, Bipolar, Dysthymia)	200	170	85.0
Impulse control	200	115	57.5

(Personality
Disorders and
Disassociated
Disorders)

As Table 4 shows, respondents work with all types of client problems, but the largest categories of problems were as follows: anxiety (89.0%), mood disorders (85%), and posttraumatic stress disorder (78.0%).

Participants were further asked to indicate the type of populations they typically work with. These data are presented in Table 5.

Table 5

Summary of types of client populations

Type of Client	N	<i>f</i>	%
Children	200	60	30.0
Adolescence	200	90	45.0
Adults	200	187	93.5
Families	200	87	43.5
Highly religious	200	30	15.0
Geriatric adults	200	40	20.0
Patients/general medical unit	199	8	4.0
Offenders/referrals from judicial system	199	54	27.1

Table 5 shows that participants work with a wide variety of clients that are reported with the following percentage rates: adults (93.5%), adolescents (45.0 %), families (43.5%), and (children (30.0%). The smallest reported categories participants worked with were patients in general medical units (4.0%) and with geriatric adults (20.0%). It is important to note that only 15% of the respondents work with clients they considered to be highly religious (covertly demonstrating adherence to beliefs and practices of an organized church or religious base).

Variables pertaining to participants' religious background and their training regarding using religion in their practice are summarized in Table 6.

Table 6

Frequency distribution of current and childhood religious factors (N= 200)

Variable	<i>f</i>	%
Current religious identification		
Protestant	50	25.0
Catholic	63	31.5
Jewish	24	12.0
Unitarian	9	4.5
Buddhist	6	3.0
Hindu	1	.5
Agnostic	6	3.0
Atheist	4	2.0

Other	37	18.5
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The Other category included the following: non-denominational Christian, Self-Realization, and Latter Day Saints.

Childhood religious identifications

Variable	<i>f</i>	%
Childhood religious background		
Protestant	76	38.0
Catholic	79	39.5
Jewish	23	11.5
Unitarian	4	2.0
Hindu	1	.5
Agnostic	1	.5
Atheist	3	1.5
Other	12	6.0

Table 6 presents the current and childhood religious affiliations for participants. The data are presented as the percentage of respondents who identified with each religious affiliation. The table above shows that Catholic (63), Protestant (50), Other (37), and Jewish (24) denominations are clearly the largest participant groups in the current religious affiliation. The Protestant, Catholic, and Jewish denominations had childhood affiliations that were higher than the corresponding current affiliations. All of the other religious designations showed an increase in the percentage of participants' involvement

in the current affiliation over the childhood affiliation. Also of note is the religious affiliation of Buddhism was added to the current list of affiliation, while it was missing from the childhood affiliation.

Participants were asked to indicate how much formal training they have received regarding (a) “religion / spirituality as a cultural factor in clinical practice,” and (b) how to use “religious / spiritual interventions in treatment.” As can be seen from the table, 33.5% of the participants have received training in either religion / spirituality as culture factor, and 30% received training in religious / spiritual interventions. This training took place at one or more workshops or conferences outside of a graduate program. The smallest percentages of training took place in a graduate training program.

Table 7

Frequency distribution regarding amount of training counselors received

Variable	<i>f</i>	%
Training regarding religion/spirituality in clinical setting		
None	53	26.5
Workshop (s) conferences/outside grad program	67	33.5
Portion course (s) in grad program	47	23.5
Entire course (s)	20	10.0

Variable	<i>f</i>	%
grad program		
Focus grad training	13	6.5
<hr/>		
Training regarding		
religious/spiritual		
interventions in		
treatment		
None	84	42.0
Workshop (s)	61	30.5
conference/outside		
grad program		
Portion course (s) in	30	15.0
grad program		
Entire course (s)	11	5.5
grad program		
Focus grad training	14	7.0

Other items relating to participant demographics were measured as continuous variables. These variables are, therefore, summarized with means and standard deviations. Table 8 presents a summary of these descriptive statistics.

Table 8

Summary statistics of participants' demographics per selected demographic variables

Variable	N	Minimum	Maximum	Mean	SD
Age	199	26.00	82.00	50.59	12.26
Yrs/counseling field	200	1.00	54.00	17.39	11.58
Yrs of counseling delivery	200	.50	54.00	16.04	11.38
Frequency (1-7 scale) attend religious services	200	1.0	7.00	2.95	1.52
Frequency (1-7 scale) participate religious activities	200	1.0	7.0	3.86	2.0

The table above shows that the mean age of respondents was 50.59 years. The mean number of years participants were in the counseling field (M = 17.39) and provided counseling services (M = 16.04) indicates that, on average, respondents were experienced practitioners. With regard to respondents' mean scores on their religious attendance (M = 2.95) and participation in religious activities (M = 3.86), it should be noted that the

frequency scale ranged from 1 – 7, with the midpoint at 3.5. The mean frequency of religious attendance, therefore, was below the midpoint of the scale, indicating less than moderate frequency, while the mean frequency of participation in religious activities was slightly above the midpoint, indicating greater than moderate frequency.

Participants were asked to rank the three greatest influences on their counseling orientation from a list of the most common counseling systems typically taught in counseling programs. The mean rankings are presented in Table 9.

Table 9

Mean rankings of counseling influences (N = 190)

Orientation	Mean	SD
Psychodynamic	.42	.87
Counseling (person-centered)	.76	1.06
Existential/humanistic	.66	1.03
Cognitive	1.23	1.12
Transpersonal	.66	1.08
Behavioral	1.07	1.20
Family systems	.68	1.10
Biomedical	.31	.86
Other	.22	.63

The two largest mean rankings were found for the cognitive (M = 1.23) and behavioral (1.07) influences. The smallest mean rankings were found for biomedical (.31) and “other” (.22). Cognitive behavioral / treatment, vocational, and solution-focused

were categories that were also considered by respondents as among the three major influences to their counseling orientations. Finally, respondents were asked to provide the approximate percentage of professional time spent at a variety of activities. Table 10 gives the mean percentages.

Table 10

Mean percentages of professional activities (N = 194)

Activity	Minimum	Maximum	Mean	SD
Treatment	.00	100.00	40.05	31.81
Teaching	.00	90.00	10.52	19.30
Receiving supervision	.00	55.00	3.97	7.42
Assessment	.00	100.00	13.95	17.05
Consulting	.00	95.00	9.05	15.88
Administration	.00	100.00	12.19	16.59
Providing supervision	.00	75.00	4.38	10.21
Other	.00	80.00	4.87	13.16

The greatest mean percent of time is spent in providing treatment (M = 40.05), while receiving supervision (M = 3.97), and providing supervision (M = 4.38), and “other” activities (M = 4.87) account for the smallest percentages of professional time. Case management is an activity that counselors listed that they spent time performing under the other category.

In order to assure the two participant groups did not differ in relevant predictor and demographic variables t-tests and chi-square tests were conducted, which follows:

Table 11

Group statistics comparing age, number of years in counseling field, and number of years in counseling delivery

Predictor variable	Group	N	Mean	Std. Deviation	Std. Error Mean
Age	ARCA	96	48.98	12.59	1.25
	AMHCA	03	52.09	11.81	1.16
# of years in counseling field	ARCA	96	17.63	12.29	1.25
	AMHCA	104	17.17	10.94	1.07
# of years in counseling delivery	ARCA	96	15.91	11.89	1.21
	AMHCA	104	16.16	10.94	1.07

Levene's Test for
Equality of Variances

t-test for Equality of Means

<i>f</i>	<i>p</i>	<i>t</i>	<i>df</i>	<i>p</i> (2-tailed)	Mean Difference
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Age	.782	.378	-1.797	197	.074	-3.11
# yrs counseling field	.911	.341	.278	198	.781	.46
# yrs counseling delivery	.073	.787	-.159	198	.874	-.26

Table 12

Group statistics comparing gender

Group	Gender		Total
	Male	Female	
ARCA	33	63	96
AMHCA	27	77	104
Total	60	140	200

Table 13

Group statistics comparing race

Group	Race					Total
	Asian	Latino	Black/African American	White	Other	
ARCA	1	3	3	86	3	96
AMHCA	1	1	5	96	1	104

Total 2 4 8 182 4 200

Table 14

Group statistics comparing current religious identification

Group	Current Religious Affiliation									Total
	P	C	J	U	B	H	Ag	At	Other	
ARCA	25	29	12	3	4	1	4	2	16	96
AMHCA	25	34	12	6	2	0	2	2	21	104
Total	50	63	24	9	6	1	6	4	37	200

Note. P = Protestant; C = Catholic; J = Jewish; U = Unitarian; B = Buddhist; H = Hindu; Ag = Agnostic; At = Atheist.

Table 15

Group statistics comparing childhood religious background

Group	Childhood religious background								Total
	P	C	J	U	H	Ag	At	Other	
ARCA	35	37	12	1	1	0	2	7	95
AMHCA	41	42	11	3	0	1	1	5	104
Total	76	79	23	4	1	1	3	12	199

Note. P = Protestant; C = Catholic; J = Jewish; U = Unitarian; H = Hindu; Ag = Agnostic; At = Atheist.

Table 16

Group statistics comparing how frequently participants attend religious services

Group	How frequent attend religious services							Total
	1	2	3	4	5	6	7	

ARCA	17	23	16	19	13	6	2	96
AMHCA	21	33	19	16	12	2	1	104
Total	38	56	35	35	25	8	3	200

Table 17

Group statistics comparing how frequently participants frequent other religious activities

Group	Frequency participate other religious activities							Total
	1	2	3	4	5	6	7	
ARCA	14	17	12	12	13	8	20	96
AMHCA	10	24	19	16	15	7	13	104
Total	24	41	31	28	28	15	33	200

The previous t-tests and chi-square tests results indicate there are no significant differences between the two participant groups, ARCA and AMHCA. Due to a lack of significant difference between the two groups on demographic and predictor variables, the two groups were classified as one for statistical analysis of the null hypotheses.

Null Hypotheses Testing

Five null hypotheses were tested, as cited in chapter 1. These five null hypotheses were used to test the generalizability of results from the sample to the population. They also took into account all fifteen research questions. The first three null hypotheses were subjected to multiple regression analyses, using a direct entry method. It must be noted again that although ethnicity was originally intended to be a predictor variable, almost the entire sample represented a single ethnicity (White). This variable, therefore, was

dropped from all inferential analyses. The final two null hypotheses were tested using repeated measures one-way ANOVA.

The first null hypothesis to be tested was there is no relationship between counselors' age, gender, and years in counseling delivery, level of spiritual well-being and their attitudes toward the importance of spiritual issues in the treatment process when working with clients with serious and persistent mental illness. Prior to performing the multiple regressions, preliminary analysis indicated that gender was not related to the outcome measure, general attitude about using spirituality in the treatment process. This predictor variable was, therefore, dropped from this specific analysis. Remaining predictor variables consisted of age, years in counseling delivery, and level of spiritual well being. Table 18 presents a summary of the final multiple regression analysis.

Table 18

Multiple regression results for null hypothesis 1

Model

$R^2 = .05$ Adjusted $R^2 = .03$ Standard Error of the Estimate = 3.17

ANOVA

Model	SS	Df	Mean Sq	<i>f</i>	p
Regression	92.08	3	30.70	3.05	.03*
Residual	1963.65	195	10.07		
Total	2055.74	198			

*p<.05

Coefficients

Model	Unstandardized		Standardized		t	p
	Coefficients		Coefficients			
	B	Std. Error	β			
(Constant)	18.08	1.56			11.56	.000
AGE	.048	.02	.18		1.99	.048*
# yrs in counseling delivery	-.039	.03	-.18		-.14	.12
SWBS	.028	.01	.16		2.24	.03*

*p<.05

As Table 18 shows, the adjusted $R^2 = .03$, $p = .03$, indicating that there is a significant relationship between the set of predictor variables and counselors' general attitude about the importance of spirituality in the treatment process, as measured by the total score derived from items 1- 4 on the GAS. Approximately three percent of the variance in the GAS scores was explained by counselors' age, years in counseling delivery, and their level of spiritual well being. An examination of the beta weights shows that two predictors, age and SWBS contributed significantly to the equation, with level of spiritual well being accounting for the largest part of the variance. Specifically, older counselors who had higher levels of spiritual well-being tended to have more positive general attitudes about the importance of using spirituality in the treatment process with clients diagnosed with serious and persistent mental illness.

The second null hypothesis stated that there is no relationship between counselors' age, gender, years in counseling delivery, level of spiritual well-being and

their comfort with addressing spiritual issues in the treatment process when working with clients with serious and persistent mental illness. Results of the multiple regression analysis computed to test this hypothesis are found in Table 19.

Table 19

Multiple regression results for null hypothesis 2.

Model					
$R^2 = .07$ Adjusted $R^2 = .05$ Standard Error of the Estimate = 4.93					
ANOVA					
Model	SS	Df	Mean Sq	<i>f</i>	p
Regression	328.68	4	82.17	3.38	.01*
Residual	4716.62	194	24.31		
Total	5045.30	198			
*p<.05					
Coefficients					
Model	Unstandardized		Standardized		p
	Coefficients		Coefficients		
	B	Std. Error	β	t	
(Constant)	20.43	2.54		8.04	.000
AGE	.065	.04	.16	1.74	.08
# yrs in counseling delivery	-.069	.04	-.16	-1.72	.09
SWBS	.059	.02	.21	3.04	.003**

Score

GENDER	3.44	.81	.03	.42	.67
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**p<.01 *p<.05

The adjusted $R^2 = .05$, $p < .01$, indicating that the null hypothesis is rejected and there is a significant relationship between counselors' age, gender, years in counseling delivery, and their level of spiritual well being and counselors' comfort with addressing spiritual issues, as measured by the total score derived from items 5-9 on the GAS. The predictors explain approximately 5% of the variance in the GAS scores. Only the SWBS scores contributed significantly to the equation. With regard to the direction of the relationship of the predictors, counselors with higher levels of spiritual well-being tend to be more comfortable with addressing spiritual issues in the treatment process. It should be noted, however, that age and number of years in counseling delivery both made important, if not significant contributions to the equation, as evidenced by the fact that both beta weights associated with these variables had alpha values under .10. Specifically, older counselors with less experience tended to be more comfortable with addressing spiritual issues.

The third null hypothesis states that there is no relationship between counselors' age, gender, years in counseling delivery, level of spiritual well-being and their frequency of use of spiritual interventions in the treatment process when working with clients with serious and persistent mental illness as measured the Intervention Scale. Results of the multiple regression analysis computed to test this hypothesis are found in Table 20.

Table 20

Multiple regression results for null hypothesis 3.

Model					
$R^2 = .18$ Adjusted $R^2 = .16$ Standard Error of the Estimate = 14.41					
ANOVA					
Model	SS	df	Mean Sq	<i>f</i>	p
Regression	8732.82	4	2183.21	10.51	.000***
Residual	40288.98	194	207.68		
Total	49021.80	198			
***p<.001					
Coefficients					
Model	Unstandardized		Standardized		p
	Coefficients		Coefficients		
	B	Std. Error	β	t	
(Constant)	-3.82	8.44		-.45	.651
AGE	.50	.11	.39	4.51	.000***
# yrs in counseling delivery	-.28	.12	-.21	-2.38	.018*
SWB Scale Total Score	.26	.06	.30	4.53	.000***
GENDER	1.56	2.37	.05	.66	.511
*** p<.001 *p<.05					

As Table 20 shows, once again the multiple regression analysis resulted in a significant finding. The adjusted $R^2 = .16$, $p < .01$, indicating that approximately 16 % of the variance in counselors' frequency of use of spiritual interventions is explained by the predictor variables. Consistent with the findings for null hypothesis 1 and 2, years in counseling delivery, age, and level of spiritual well being all had coefficients that contribute significantly to the prediction equation. Contrary to the findings for null hypothesis 2, however, the coefficient for gender was not significant. Age had the largest beta weight followed by level of spiritual well being, and years in the counseling delivery. Specifically, older counselors with higher levels of spiritual well-being and fewer years in counseling delivery have higher frequencies of using spirituality in the treatment process.

The fourth null hypothesis stated that there is no difference between the importance counselors attach to the use of spiritual interventions in the treatment process for clients with the following diagnoses: Alcohol and Substance Abuse, Schizophrenia and other psychotic disorders, Minor Depression, Mood Disorders (including Major Depression, Bipolar, and Dysthymia), Anxiety Disorders (including Phobia, Panic Disorder, and Obsessive Compulsive Disorder), Personality Disorders (Borderline Personality Disorder and Antisocial Personality Disorder), and Disassociated Disorders (Multiple Personality Disorder) as measured by the SISS scale. Since only one sample was involved in this hypothesis, a one-way ANOVA with repeated measures was utilized to test it. This resulted in a Wilks' Lambda = .42 ($f = 44.52$, hypothesis $df = 6.00$, error $df = 194.00$, $p < .01$), indicating that the null hypothesis is rejected and that counselors attach varying levels of importance to using spirituality when treating clients with the

diagnoses cited above. The tests of within-subjects effects and the specific mean scores on Part I of the SISS for each diagnosis are summarized in Table 21.

Table 21

Within subjects effects and means for null hypothesis 4

Within-Subjects Effects

Source	Type III Sum of Squares	df	MS	<i>f</i>	<i>p</i>
Diagnosis	183.51	6	30.59	48.17	.000**
Error	758.20	1194	.64		

Means on SISS, Part I, by Diagnosis

Diagnosis	M	SD
Alcohol / substance abuse	3.95	.97
Schizophrenia /psychotic	2.87	.97
Mood disorders	3.45	.93
Anxiety disorders	3.36	.96
Personality disorders	3.07	1.68
Disassociated disorders	2.85	.98
Minor depression	3.46	.91

***p*<.01

As stated above, the repeated measures analysis indicates that significant differences exist among the mean SISS scores by diagnostic categories. Further testing was necessary to distinguish exactly which means differed significantly from the others. The multiple comparison procedure employed was Fisher's LSD test, resulting in LSD =

.15. Thus, only 4 of the possible 21 mean contrasts did not significantly differ. These were: schizophrenia/psychotic disorders and disassociated disorders; mood disorders and anxiety disorders; mood disorders and minor depression; anxiety disorders and minor depression. All other contrasts were significant. Specifically, counselors rated spiritual interventions to be more important when working with alcohol/substance abusers than all other diagnostic categories; to be more important to treat minor depression, mood disorders or anxiety disorders than personality, schizophrenia/psychotic disorders, or disassociated disorders; and to be more important to treat personality disorders than schizophrenia/psychotic disorders or disassociated disorders.

The last hypothesis to be tested, null hypothesis five, stated that there is no difference in the importance counselors attach to the use of spiritual interventions in the treatment process for clients with serious and persistent mental illness from the following ethnic categories: Caucasians, African Americans, Asians, Hispanics, Native Americans, and other. Once again, only one sample was involved and a one-way ANOVA with repeated measures was utilized. The resulting Wilks' Lambda = .60 ($f = 32.10$, hypothesis $df = 4.00$, error $df = 196.00$, $p < .01$), was significant, and it can be concluded that counselors attach varying levels of importance to using spirituality when treating clients from the ethnic categories cited above. The tests of within-subjects effects and the specific mean scores on Part II of the SISS for each ethnic category are summarized in Table 22

Within subjects effects and means for null hypothesis 5

Within-Subjects Effects

Source	Type III Sum of Squares	df	MS	<i>f</i>	<i>p</i>
Ethnicity	66.71	4	16.68	52.75	.000**
Error	251.68	796	.32		

Means on SISS, Part II, by Ethnicity

Ethnicity	Mean	Standard Deviation
Caucasians	3.11	.90
African Americans	3.61	.95
Hispanics	3.70	.98
Native Americans	3.82	1.05
Asians	3.33	.96

***p*<.01

Fisher's LSD was once again used as a multiple comparison procedure to pinpoint which means differed from each other. Results indicated that $LSD = .08$. An inspection of the means in Table 24 reveals, therefore, that all contrasts were significant. Specifically, counselors rated the use of spiritual interventions for clients with serious and persistent mental illness to be most important for their Native American clients, with Hispanic clients next in importance, followed by African Americans and Asians, with Whites receiving the lowest importance rating.

Audio Taped Interviews

Five phone numbers were randomly selected from the phone numbers of all volunteers who indicated their willingness to be interviewed by phone. These volunteers were contacted at the time slot they indicated as convenient, and were asked once again for their permission to be audio taped.

The audio taped interviews supported the findings of the quantitative analyses. During the interview process this researcher discovered that all interviewees were of the Caucasian race, had been in private practice for at least five years, and had successful practices. They also all professed spiritual issues as important to them. Interviewees' ages ranged between 40 and 70 years of age. They all indicated they worked with individuals with severe and persistent mental illness diagnoses.

The three female interviewees and one male interviewee shared excitement about the research and were glad to be asked to take part in the interview process. These four shared they felt spirituality to be important, yet they struggled to define it. They also shared that they felt their clients positively benefited from having the opportunity to discuss spiritual issues in the treatment process. All four shared that they considered their clients' religious practices to be part of their expression of spirituality. It appeared that they did not separate religious practices from spirituality. The remaining male interviewee's responses were impassively given. Each interview took about 10 minutes, with the interviewee answering 24 questions.

Table 23 is a summarization of the data collected from the interviewees' responses to 24 questions.

Qualitative Analyses

Table 23

Summarization of interview data

1. What is your definition of spirituality?

Interviewee 1 (male)

Higher being

Interviewee 2 (female)

Internal force related to religion and morals

and how those affect our functioning and perceptions.

Interviewee 3 (female)

Experiential and how you identify it.

Person's identification of spirituality.

Interviewee 4 (female)

Not completely related to religion, not so much a philosophy as the understanding of the essence of life.

Interviewee 5 (male)

Personal feeling, connection person would have with own conscious self / universe.

2. Discuss your opinion of whether spirituality would be useful during the treatment process when working with individuals with different mental illness diagnoses.

Interviewee 1 (male)

It would depend on individual and diagnosis.

Interviewee 2 (female)

Yes, through our own spirituality we have a larger acceptance of others.

Interviewee 3 (female)

Yes, for some spirituality does enter into it and for others it is a great part of who they are, feeling they are not alone.

Interviewee 4 (female)

Yes, especially with those with Bi-Polar disorder, and substance abuse.

Interviewee 5 (male)

Try not to connect spiritual realm with the psychological.

3. Respond to the following statement based on how intensely agreement or disagreement is with the statement: A client's spiritual beliefs can have a significant impact on the course of treatment.

Interviewee 1 (male) Strongly agree.

Interviewee 2 (female) Strongly Agree.

Interviewee 3 (female) Agree.

Interviewee 4 (female) Agree.

Interviewee 5 (male) Possibly.

4. Respond to the following statement based on how intensely agreement or disagreement is with the statement: A client's spiritual background may be a social or cultural variable that you should be aware of.

Interviewee 1 (male) Strongly agree.

Interviewee 2 (female) Agree.

Interviewee 3 (female) Agree.

Interviewee 4 (female) Agree.

Interviewee 5 (male) Agree.

5. Respond to the following statement based on how intensely agreement or disagreement is with the statement: You do not feel comfortable talking with clients about their spiritual beliefs.

Interviewee 1 (male) Disagree.

Interviewee 2 (female) Disagree.

Interviewee 3 (female)	Strongly disagree.
Interviewee 4 (female)	Disagree.
Interviewee 5 (male)	Disagree, not a primary focus of therapy, unless they see it that way.

6. Respond to the following statement based on how intensely agreement or disagreement is with the statement: Only members of the clergy are qualified to talk with people about their problems in spiritual terms.

Interviewee 1 (male)	Disagree.
Interviewee 2 (female)	Strongly disagree.
Interviewee 3 (female)	Disagree.
Interviewee 4 (female)	Disagree.
Interviewee 5 (male)	Disagree.

7. Respond to the following statement based on how intensely agreement or disagreement is with the statement: It is appropriate to discuss spiritual issues with clients.

Interviewee 1 (male)	Agree.
Interviewee 2 (female)	Agree.
Interviewee 3 (female)	Agree, if it is okay with the client.
Interviewee 4 (female)	With some, agree
Interviewee 5 (male)	Not inappropriate to use with the client; only if the client raises the subject.

8. Respond to the following statement based on how intensely agreement or disagreement is with the statement: Counselors should discourage clients from talking about their spiritual beliefs.

Interviewee 1 (male)	Disagree.
Interviewee 2 (female)	Strongly Disagree.
Interviewee 3 (female)	Strongly disagree.
Interviewee 4 (female)	Disagree.
Interviewee 5 (male)	Disagree.

9. Respond to the following statement based on how intensely agreement or disagreement is with the statement: You encourage clients to talk about their spiritual beliefs.

Interviewee 1 (male)	Agree if the dialogue in the session is moving in the direction of speaking about spiritual beliefs.
Interviewee 2 (female)	Disagree.
Interviewee 3 (female)	Agree.
Interviewee 4 (female)	Don't encourage it, if it comes up in the sessions, will allow clients to talk.
Interviewee 5 (male)	Don't encourage, nor discourage.

10. Respond to the following statement in terms of whether you do the following in the treatment process with your clients, and if so, how often: Discuss the spiritual implications of choices that clients make.

Interviewee 1 (male)	Yes, 50% of the time
Interviewee 2 (female)	No.

Interviewee 3 (female)	Yes, 5%.
Interviewee 4 (female)	Yes, 25%.
Interviewee 5 (male)	Do not.

11. Respond to the following statement in terms of whether you do the following in the treatment process with your clients, and if so, how often: Quote spiritual texts to establish a point.

Interviewee 1 (male)	Never.
Interviewee 2 (female)	No.
Interviewee 3 (female)	Yes, 50-60% of the time.
Interviewee 4 (female)	50-75%
Interviewee 5 (male)	Quote writers who can be considered as spiritual (Martin Luther King). Rarely.

12. Respond to the following statement in terms of whether you do the following in the treatment process with your clients, and if so, how often: Challenge client's spiritual beliefs.

Interviewee 1 (male)	Seldom, 10% of the time.
Interviewee 2 (female)	No.
Interviewee 3 (female)	No.
Interviewee 4 (female)	No.

Interviewee 5 (male) Never.

13. Respond to the following statement in terms of whether you do the following in the treatment process with your clients, and if so, how often: Teach clients about spiritual issues and concepts.

Interviewee 1 (male) About 10% of the time.

Interviewee 2 (female) No.

Interviewee 3 (female) No.

Interviewee 4 (female) When asked, 50%.

Interviewee 5 (male) If clients express desire to investigate spirituality.

14. Respond to the following statement in terms of whether you do the following in the treatment process with your clients, and if so, how often: Engage in prayer (without a client's knowledge) to ask for guidance or assistance in providing treatment.

Interviewee 1 (male) Never.

Interviewee 2 (female) Yes, up to a third of the time.

Interviewee 3 (female) Yes, 25%.

Interviewee 4 (female) 45%.

Interviewee 5 (male) Never.

15. Respond to the following statement in terms of whether you do the following in the treatment process with your clients, and if so, how often: Engage in vocal or silent prayer with the client during the treatment session.

Interviewee 1 (male)	Never.
Interviewee 2 (female)	No.
Interviewee 3 (female)	Rare.
Interviewee 4 (female)	When asked, 50%.
Interviewee 5 (male)	Never.

16. Respond to the following statement in terms of whether you do the following in the treatment process with your clients, and if so, how often: Engage in the practice of meditation with the client during the session.

Interviewee 1 (male)	20% of the time.
Interviewee 2 (female)	No.
Interviewee 3 (female)	Yes, 30-40%.
Interviewee 4 (female)	When they want to be taught meditation, 100%.
Interviewee 5 (male)	Never.

17. Respond to the following statement in terms of whether you do the following in the treatment process with your clients, and if so, how often: Encourage the client to pray outside the treatment process.

Interviewee 1 (male)	Never.
Interviewee 2 (female)	No.
Interviewee 3 (female)	Less than 10%.

Interviewee 4 (female) 45-50%.

Interviewee 5 (male) Never.

18. Respond to the following statement in terms of whether you do the following in the treatment process with your clients, and if so, how often: Use, with the client, guided imagery or relaxation containing religious or spiritual imagery.

Interviewee 1 (male) Never.

Interviewee 2 (female) No.

Interviewee 3 (female) 40%.

Interviewee 4 (female) Accommodate person based upon religion or spirituality base.

Interviewee 5 (male) Never.

19. Respond to the following statement in terms of whether you do the following in the treatment process with your clients, and if so, how often: Engage in the laying on of hands, priesthood blessings, or some conscious use of healing energy.

Interviewee 1 (male) Never.

Interviewee 2 (female) No.

Interviewee 3 (female) 10%.

Interviewee 4 (female) 50%

Interviewee 5 (male) Never.

20. Respond to the following statement in terms of whether you do the following in the treatment process with your clients, and if so, how often: Read, with clients, relevant religious/biblical texts during the session.

Interviewee 1 (male) Never.

Interviewee 2 (female) No.

Interviewee 3 (female) No.

Interviewee 4 (female) 25%.

Interviewee 5 (male) Never.

21. Respond to the following statement in terms of whether you do the following in the treatment process with your clients, and if so, how often: Encourage the clients to read relevant religious/biblical texts on their own.

Interviewee 1 (male) Never.

Interviewee 2 (female) No.

Interviewee 3 (female) No.

Interviewee 4 (female) 25%.

Interviewee 5 (male) Never.

22. Respond to the following statement in terms of whether you do the following in the treatment process with your clients, and if so, how often: Employ therapeutic interventions using spiritual language or symbolism.

Interviewee 1 (male) No.

Interviewee 2 (female)	No.
Interviewee 3 (female)	75-80%
Interviewee 4 (female)	20%
Interviewee 5 (male)	Never.

23. Respond to the following statement in terms of whether you do the following in the treatment process with your clients, and if so, how often: Encourage clients to spend more time in their life on spiritual activities.

Interviewee 1 (male)	10% of the time
Interviewee 2 (female)	No.
Interviewee 3 (female)	40-50%.
Interviewee 4 (female)	45%.
Interviewee 5 (male)	Never.

24. Respond to the following statement in terms of whether you do the following in the treatment process with your clients, and if so, how often: Give or suggest to the client religious or spiritual material to read.

Interviewee 1 (male)	No.
Interviewee 2 (female)	No.
Interviewee 3 (female)	10%
Interviewee 4 (female)	50%
Interviewee 5 (male)	Very rare.

Summary

The first null hypothesis tested whether there would be a significant relationship between counselors' age, gender, and years in counseling delivery, level of spiritual well-being and their attitude toward the importance of spiritual issues in the treatment process when working with clients with serious and persistent mental illness. In the quantitative analysis a significant relationship was found between counselors' age, years in counseling delivery, their level of spiritual well-being, and their attitude about the importance of spiritual issues in the treatment process. Interview questions 2, 3, 4 and 7 asked questions relative to the importance of the usefulness of spirituality, impact of use in treatment process, knowledge of clients' spirituality, and appropriateness of spiritual issues in the treatment process. The three female interviewees' responses supported the qualitative findings, while both male responses varied on the strength of their agreement with the statements.

A significant relationship was found between the predictor variables of counselors' age, years in counseling delivery, their level of spiritual well-being, and their comfort in addressing spiritual issues. Interview statement 5 supported the quantitative finding because all interviewees disagreed with the statement that they did not feel comfortable discussing spiritual issues with their clients.

A significant relationship was found between age, years in counseling delivery, counselors' level of spiritual well-being, and their frequency of use of spiritual interventions in the treatment process when working with clients with serious and persistent mental illness. Interview statements 10 through 24 addressed the interviewees' feelings about the use of spiritual interventions. Responses varied on how often a spiritual

intervention was used based upon the particular spiritual intervention. However, the female interviewees used spiritual interventions more often than the male interviewees. Gender was found to be significant for this null hypothesis, while responses did not differ according to gender in the qualitative analysis. Fourteen of the fifteen statements had at least one or more affirmative responses to the use of spiritual interventions in the treatment process.

The fourth null hypothesis was not thoroughly addressed during the taped interviews. All interviewees stated that they were not inclined to use spiritual interventions for clients with psychotic disorders. One interviewee felt that spiritual interventions were helpful for individuals with substance abuse issues and bipolar disorders.

The fifth null hypothesis was not addressed at all during the taped interviews. The taped interviews contained information that confirmed the findings from the quantitative portion of this study, as well as brought up the concern about the ease and frequency of use of spiritual interventions in the treatment process, that may be occurring without formal classroom training.

This chapter contained the results of the statistical analysis for this study. The summary, conclusion, and recommendations will be discussed in Chapter Five.

CHAPTER 5

Discussion

The purpose of this study was to examine whether a significant relationship exists between selected demographic variables of rehabilitation and mental health counselors and their attitudes about the importance of spiritual issues, comfort with addressing spiritual issues, and their frequency of use of spiritual interventions when working with clients with serious and persistent mental illness. The researcher sought to explore the effect of counselors' age, gender, years in counseling delivery, and level of spiritual well-being on their (1) attitude about the importance of spiritual issues, (2) comfort with addressing spiritual issues, and (3) frequency of use of spiritual interventions in the treatment process. This research focused on rehabilitation and mental health counselors' perceptions of spirituality in order to better understand the impact of their spiritual beliefs in the treatment process. An examination was also conducted on the attitudes of rehabilitation and mental health counselors toward the use of spiritual interventions in the treatment process with individuals of different ethnicities and different serious and persistent mental illness diagnoses.

This chapter will review a) major findings, b) general conclusions, c) limitations of the study, and 4) implications for practice, training, and future research.

Major Findings

The four scales used for the research, the General Attitude Scale (GAS), the Intervention Scale (IS), the Spiritual Well Being Scale (SWBS), and the Smith's Importance of Spirituality Scale (SISS) were used to generate the major findings of this study. A short qualitative section was incorporated into the study consisting of open-

ended phone interviews conducted with five counselors asking them to speak about their feelings regarding the use of spirituality in the therapeutic process. This data was gathered in order to enrich the quantitative findings and possibly detect areas of concern for future research.

Quantitative Findings

The Spiritual Well-Being Scale measured spiritual well-being, which is an aspect of spirituality, and it also measured religious well-being. The discussions of the findings in this paper, therefore may include reference to both religious and spiritual findings, as they relate to the variables in this study.

The findings in this study indicated that there was a significant relationship between rehabilitation and mental health counselors' age, years in counseling delivery, and their level of spiritual well being. Specifically, older counselors, with higher levels of spiritual well being tended to have more positive general attitudes about the importance of using spirituality in the treatment process. This is consistent, in part with Shafransky and Gorsuch's (1984) study, which found that the perceived relevance of spirituality in psychologists' clinical practices was related to spirituality's relevance for their personal life and experience. In searching for comparative studies that examined age with perceptions of spirituality or spiritual well being, this researcher looked at a study that studied Christian adults and found age to be positively related to several religious indications, including reading the Bible, attending church, participating in Bible studies or church related classes, and volunteering at church in a study of Christian adults (Seifert, 2002). A possibility exists that individuals with a history of mainstream denomination affiliation may have developed religious indications, which carry over into

later life; therefore they may have a greater propensity to have a heightened perception of spirituality. Since the majority of the participants in this current study professed childhood and adult mainstream denomination affiliation, this factor may account for the finding that older counselors have a positive attitude about the importance of spiritual issues in the treatment process.

Findings in this study indicated that older counselors with higher levels of spiritual well being was significantly related to their tendency to be more comfortable addressing spiritual issues in the treatment process. The tendency for older counselors to be more comfortable with bringing up topics relating to spirituality in the treatment process may be related to a traditional premise that older individuals have wisdom or heightened sense of self confidence that may come with the aging process. Due to this heightened sense of self confidence, along with having higher levels of spirituality, they may feel more inclined to be at ease talking about spiritual issues with their clients.

Regression analyses findings in this study indicated that older counselors with higher levels of spiritual well-being and fewer years in counseling delivery have higher frequencies of using spirituality in the treatment process. This finding may also be related to the aging process, which indicates that as individuals mature, the more existential they may become. An additional possibility is that older counselors, new to the field of counseling may be more willing to use less traditional practices, and less inclined to adhere to traditional practices and protocol.

Goncalves' (2000) research found that the more counselors believed spirituality was relevant to their work and their personal lives they seemed to be more favorably disposed to utilize interventions in the treatment process. Thus, a suggestion is being

made for greater confidence in the idea that the personal spirituality of mental health professionals is related to their attitudes towards spirituality in clinical practice and to their use of spiritual interventions in clinical practice. Shafranske and Maloney (1990) also found that psychologists who reported positive experiences with religion or spirituality were more likely to use religious interventions.

There has been a surprising lack of research investigating demographic characteristics of counselors and clinicians and the relationships of those demographic variables to treatment outcomes. Research is lacking that specifically examines mental health professionals' age, gender, years of counseling delivery, and spiritual well-being to determine if any significant relationship exists between these variables and their comfort level in addressing spiritual issues in the treatment process.

There are a few studies that examined gender differences in levels of spirituality and how they express spirituality. Findings from Hickson, Housley, and Wages's (2000) study indicated the counselors perceive that women and men express their spirituality differently. Goncalves's (2000) study concluded that female counselors are more likely to have higher levels of spirituality, while the current study did not indicate that gender was significant. The authors of the SWBS summarized the findings from other studies and concluded it was unnecessary to report on norms for males and females since the scores on the SWBS do not seem to be appreciably affected by the sex of the subject (Bufford, Palouzian & Ellison, 1991). Hathaway, Scott, and Garver's (2004) national survey of 1,000 clinical psychologists also found that gender was not significantly related to overall tendencies of clinicians to address client religiousness / spirituality. These studies support the findings in this study that gender was not significant to counselors'

attitude about the importance of spiritual issues, comfort with addressing spiritual issues, and their frequency of use of spiritual interventions when working with clients with serious and persistent mental illness.

The repeated measures analysis of this study indicated that significant differences exist among the mean SISS scores by diagnostic categories. Results indicated counselors rated spiritual interventions to be more important when working with alcohol/substance abusers than all other diagnostic categories, with minor depression next in importance.

This result is consistent with previous research that indicated that spirituality is perceived as a treatment for chemical dependency (Piedmont, 2004). Counselors may have rated spiritual interventions to be more important when working with alcohol/substance abusers due to the possible high profile of organizations, such as Alcohol Anonymous (AA). According to Sheridan and Bullis (1992), counselors have found AA's spiritually based programs to be associated with effective treatment outcomes for alcoholism.

Again, a repeated measures analysis discovered that significant differences exist among the mean SISS scores by different ethnicities. Counselors rated the use of religious and spiritual interventions for clients with serious and persistent mental illness to be most important for their Native American clients.

This finding is consistent with research that indicates spirituality is a part of the way of life for Native Americans. Research conducted by Locust (1985) concluded that spirituality is integral to all life activities. Native Americans have a tendency to seek out a healer before going to a doctor. According to Vash (1995), a medicine man may be consulted who aids healing by restoring harmony between the body, mind, and spirit. For

the Native American, treating the spirit is a process of finding out why illness has occurred. Counselors may perceive, therefore, that as assistive devices help the body, so do ceremonies, songs, herbs, prayers, and rituals help the mind and spirit to heal, in the Native American culture.

Demographic data from this study also had some interesting highlights. Females represented 70% of the respondents, and almost all respondents were white (91.0%). Both of these factors may be due to the demographics of the population of the two branches of the ACA, used for the participants for this study. These demographic findings were similar to other research studies that also had a participant population heavily represented by females and individuals from the white race (Goncalves, 2000; Hickson, Housley, & Wages, 2000; Sheridan & Bullis, 1992). Future research should use a more ethnically represented sampling of counselors so as to improve the generalizability of the results.

Forty nine percent of the participants were in solo practice. This pattern of respondents is consistent with literature, which indicates that in research conducted with counseling professionals, those in private practice responded to surveys more than those working in other settings (Goncalves, 2000; Hickson, Housley, & Wages, 2000; Shafranke, 2000; Shafranke & Maloney, 1990; Sheridan & Bullis, 1992). Future research should be conducted with rehabilitation and mental health counselors who work in public and non-profit agencies to determine the outcome results of surveying a population of counselors who work under established protocols and procedures of bureaucratic organizations.

Qualitative Findings

The adjectives female and male were used in this section to distinguish the gender of the interviewee in this study. The five interviewees reported statements that indicated they all had a belief in the construct of spirituality, and felt it was important if the client thought it was important. Each person struggled with defining spirituality. This is consistent with research that states that attempts at defining spirituality have often been confusing and ambiguous, with some individuals viewing spirituality in the context of religious practices (Stroll, 1989).

Interview questions 2, 3, 4 and 7 asked questions about the importance of the usefulness of spirituality, impact of use in treatment process, knowledge of clients' spirituality, and appropriateness of spiritual issues in the treatment process. The three female interviewees' responses strongly supported the quantitative findings that spirituality was important in the treatment process, while both male responses varied on the strength of their agreement with the statements. This is consistent with Hickson, Housley, and Wages's (2000) research that indicated that women and men express their spirituality differently. This may be based upon society's view that women have a greater sensitivity to religious / spiritual issues, which may be related to their greater attendance and participation in church and community activities.

The taped interviews indicated the female interviewees and one male interviewee tended to be comfortable using spiritual interventions in the treatment process. Interview statements 10 through 24 addressed how interviewees felt about the use of spiritual interventions. Responses varied on how often a spiritual intervention was used based upon the particular spiritual intervention. Fourteen of the fifteen statements had at least

one or more affirmative responses to the use of spiritual interventions in the treatment process. This information was consistent with results in the research literature that suggests older counselors with high levels of spirituality think spirituality is important to the therapeutic process and willing to use spiritual interventions. Information was inconsistent with research that suggests that females are more likely to be comfortable with using spiritual interventions (Goncalves, 2000, Hickson, Housley, & Wages, 2000, Sheridan & Bullis, 1992).

The fourth null hypothesis was not thoroughly addressed during the taped interviews. All interviewees stated that they were not inclined to use spiritual interventions for clients with psychotic disorders. One interviewee felt that spiritual interventions were helpful for individuals with substance abuse issues and bipolar disorders. Interviewees were not asked which ethnic groups they worked with.

The findings of this research study described above have broadened the understanding of the perceptions of rehabilitation and mental health counselors concerning spirituality.

Limitations of the Study

There are several limitations to this study that must be noted. The most important is the self-report measurement instrument. In this type of study, there is always the possibility of bias caused by participants wanting to appear socially desirable in their responses. This study was also limited to the description of counselors who are predominately white and did not attempt to infer descriptions of the independent variables to other cultural orientations.

Another limitation of the study was that circumstances did not allow for probability sampling, using a random process to select a subset of cases from a larger population, and the use of probability theory. However, the respondents to the survey constitute a voluntary random sample from which, using inferential statistical analysis, references to the larger population might be made. A further limitation was that the population was predominately Judeo-Christian in its religious and spiritual orientation and structure of beliefs and practices. Finally, it is important to note that since the participants were members of professional rehabilitation and mental health counseling associations, their views may not have been representative of the general population of rehabilitation and mental health counselors. Future research should use a more nationally representative sample so as to improve the generalizability of the results.

This study attempted to operationalize spirituality or spiritual well-being with the Spiritual Well-Being Scale (SWBS). It assumed that spiritual well-being or spirituality is a multidimensional phenomenon with many components. Many of the dimensions of spirituality are possibly unrecognized at present, and some, such as those that pertain to a person's private, concealed relationship with God, are beyond the boundaries of that which can be seen (Moberg, 1984).

Implications of the Study

Implications for Training

Level of spiritual well-being was significantly related to the perceptions of spirituality in the treatment process. It is possible that as counselors become more spiritually aware they may be more inclined to be sensitive to the spiritual needs of their clients. Counselors could possibly benefit from exposure to training programs that

develop their spiritual awareness in order to facilitate a holistic and standardized approach in the treatment process, especially since some counselors think spirituality is important.

It is clear from the literature cited in this study and especially in the work of Miller (1999) and Shafranske (1996) that rehabilitation and mental health counselors are utilizing some types of spiritual interventions. There is also a growing awareness of an interest in religious and spiritual issues in mental health and in the counseling practice. Miller (1999) states that based upon research there is a heightened awareness and search for what is transcendent in and beyond us as individuals. He also remarks that patients want clinicians and counselors to consider spiritual issues in the treatment process. Shafranske's (2000) study of psychiatrists and other mental health professions discovered that religious or spiritual issues were involved in psychiatric treatment often or a great deal of the time. He also proposed that the provision of religious and spiritual resources was integral to a holistic model of patient care. This information might well be used to train new professionals and to provide continuing education.

The repeated measures analyses indicated that rehabilitation and mental health counselors felt that individuals diagnosed with minor depression, mood disorders, as well as Hispanics may benefit from spiritual interventions. These groups are mentioned because there is limited research literature that has been conducted that focuses on counselors' perceptions of spirituality with these groups, or the use of spiritual interventions with these groups. This may be due to rehabilitation and mental health counselors' perception of their training that does not include consideration of their clients' spiritual issues.

The research literature has recommendations that have been made about how to teach counselors to deal with spiritual issues in the treatment process. Miller (1999) recommends an approach in which diversity issues are addressed throughout the training curriculum instead of adding specialty coursework. His emphasis is on teaching students to openly discuss spiritual issues. He also believes that instructors should help students overcome biases and prejudices by modeling professional respect for differences. (Goncalves, 2000).

Another significant finding in this study was that older counselors with fewer years of counseling delivery had a tendency to use spiritual interventions. Demographic data from this study indicated that 33.5% of the counselors received training regarding spirituality in connection with cultural issues, while 30% received training in religious / spiritual interventions. This training took place outside of a graduate program; therefore young graduate students are not receiving training on spiritual issues. Miller (1999) believes that psychology faculty (which can also apply to counseling faculty), should have personal awareness and knowledge regarding spiritual issues to guide the learning experience of their students and supervisors. A recommendation is for counseling supervisors to integrate spirituality with clinical practice. This would necessitate that they be skilled in facilitating the exploration of supervisees' own spiritual beliefs and the ways in which these beliefs affect their work with their clients. One recommendation is for supervisors to prepare supervisees to assess religion and spirituality in clinical practice by using assessments. Supervisors can also help supervisees to approach religious and spiritual issues and clients with multicultural sensitivity. They can do this by encouraging supervisees to (a) examine their own beliefs and values, (b) explore different

religious issues and traditions, (c) reflect on their experiences with religion, and (d) recognize the unique assumptions of their clients' religious / spiritual system. Since there is a current lack of graduate training in this area, it seems unlikely that a significant portion of current faculty have the necessary skills to implement Miller's ideas.

Another strategy for improving spiritual aspects of counseling training would be for counseling programs to begin to recruit faculty with specific expertise who can integrate the training of spiritual concepts into counseling programs.

Implications for Research

There is a need for the development of instruments that clearly measure spirituality as an independent construct. The Spiritual Well-Being Scale (SWBS) used in this study is an instrument to measure spirituality or spiritual well-being. There are several questions that still need to be addressed. Is it possible for the SWBS to be refined to overcome its conservative evangelical religious bias? The taped interviews indicated that the interviewees had trouble defining spirituality.

To date, there is not much information that is found in research about the formation of counselors' attitudes towards spirituality and mental health services. In addition, information is lacking as to how counselors choose their spiritual interventions. This research, as well as research conducted by Goncalves (2000), indicates there are likely to be factors other than the spirituality of the counselor that play a role in choice of spiritual interventions, as indicated by the fact that a large portion of the variance in both the attitude and intervention scales remain unaccounted for. The regression models only accounted for 3% of the attitude scale variance and 16% of the intervention scale.

Research still needs to be conducted to determine what interventions to use and what issues to address. Gorsuch and Miller (1999) discussed the importance of assessment in terms of spirituality prognostic value, the context it provides for understanding clients' lives, changes in spirituality as being indicators of therapeutic change, and spirituality as a source of interventions (e.g., prayer and meditation). It seems that greater strides are needed to develop theoretical models that consider spirituality as a major component of an individual. This consideration would be a major asset in developing instruments that assess spirituality.

This author engaged in this research from a perspective that arose from personal life experiences and from experience in counseling sessions with people struggling with a variety of issues and concerns. This author's perspective views the search for significance and the struggle to understand each individual's place in the universe as fundamental human endeavors. Spirituality is an important aspect of the human experience as it relates to the search for individual purpose and destiny. Assisting the client in discovery of purpose and destiny is important to counseling, and the expertise of the counselor is well suited to exploring these issues. Due to the expert training of counselors in facilitating behavioral, cognitive, and emotion change, counselors can facilitate a relationship that can provide a safe context in which a client is able to explore questions about purpose and destiny. This research does not imply that all problems that clients bring to the treatment process need to be addressed from a spiritual perspective. However, greater awareness of spirituality as it relates to individuals from different ethnicities and mental illness diagnoses would enhance counselors' ability to provide comprehensive and appropriate services to their clients.

This study examined counselors' age, gender, years of training, and level of spiritual well-being) and their (1) attitude about the importance of spiritual issues, (2) comfort with addressing spiritual issues, (3) frequency of use of spiritual interventions in the treatment process, and (4) attitude toward the use of spiritual interventions in the treatment process with individuals from different ethnicities and serious and persistent mental illness diagnoses.

Findings indicated that older counselors who had higher levels of spiritual well-being tended to have more positive general attitudes about the importance of using spirituality in the treatment process with clients diagnosed with serious and persistent mental illness. Older counselors with higher levels of spiritual well-being and less experience in counseling delivery tended to be more comfortable with addressing spiritual issues, as well as had a higher frequency of use of religious and spiritual interventions in the treatment process. In this study a difference was found in the importance counselors attached to the use of spiritual interventions in the treatment process with clients from different ethnicities and severe and persistent mental illness diagnoses.

Appendix A

Dear Counseling Professional,

Recently the general media and scholarly publications have reflected a growing interest in religious and spiritual beliefs and values as they pertain to physical and mental health. This research paper is an effort to meet the need to determine where we are as a profession in this process. As a doctoral candidate from the University of Maryland, College Park, I am writing to ask you to participate in my dissertation research that examines the relationship between counselors' spiritual beliefs and the way they address the spiritual issues of the clients they work with while providing treatment services.

You are one of many individuals from a variety of professional backgrounds who have been randomly selected to receive this packet. Whether you have an interest in spirituality, you are deeply religious, or have no interest; your participation is critical to the success of this research endeavor.

Your participation in this project is very much needed. Furthermore, I will place your name in the drawing to receive \$300.00, \$200.00, or \$100.00, if I receive your completed packet. You can also refuse to participate or can drop out at any time without penalty. Thank you very much for your time and consideration.

Sincerely,

Rita P. Smith, M. A., C.R.C., L.C.P.C.
Doctoral Candidate

Appendix B

Informed Consent

As indicated in the cover letter, the study attempts to gain more information about mental health and rehabilitation counselors' spiritual beliefs and the way they address the spiritual issues of the clients they work with while providing treatment services. In addition to the cover letter and this informed consent / instruction sheet this packet should contain the following materials:

- Spiritual Well Being Scale (SWBS). A measure of spiritual attitudes and values
- Participant Survey, a measure requesting demographic data and information about attitudes and behaviors related to addressing religious / spiritual issues in clinical practice
- The General Attitude Scale, a measure of degree of comfort with addressing spiritual issues in counseling.
- The Intervention Scale, a measure of frequency of use of spiritual interventions.
- Smith's Importance of Spirituality Scale, a measure of importance of using spiritual interventions among clients from different ethnic groups and with different diagnoses.
- Postage-paid return envelope
- Postcard with return address

Please fill out the Spiritual Well-Being Scale, The General Attitude Scale, The Intervention Scale, and the Smith's Importance of Spirituality Scale. To maintain anonymity, do not write your name or other identifying information on the surveys or the return envelope. The surveys should take about 45 minutes or less to complete.

When the surveys have been completed, place them in the return envelope and mail them. In addition, write your name on the back of the postcard and mail the post card. Do not place the postcard in the envelope. It must be mailed separately to protect anonymity. The returned postcard will allow for follow-up without linking specific surveys with specific participants.

This study is not expected to yield specific benefits or pose any risk for participants. None of the research materials are coded in any way and cannot be identified as being filled out by you. Thus, your survey responses will be anonymous. The fact that you have been mailed surveys at all will be kept confidential to the extent permitted by law.

Your participation is completely voluntary and at any time you may choose to withdraw simply by not mailing the inventories. Choosing not to participate or discontinuing your participation will not have any adverse consequences. Please keep this letter for your records because it serves as your consent form. You demonstrate your consent to participate in this study simply by mailing back the inventories. If you have any questions about your rights as a research participant you may contact the Institutional Review Board Director at the University of Maryland, College Park, Maryland.

If you have any questions or concerns, or if you wish to have more details about the study upon completion, please do not hesitate to contact Rita Smith, M.A. at the following address:

11012 Mill Centre Drive
Owings Mills, Maryland 21117
410-356-4933
rsmith@jhu.edu

Thank you for your participation.

Appendix C

The General Attitude Scale

Please read the following statements and circle the number that best represents how intensely you agree or disagree with the statement. Remember to circle only one number. Respond considering clients diagnosed with the following mental illness diagnoses: Minor Depression, Alcohol and Substance Abuse, Schizophrenia and other psychotic disorders, Mood Disorders (including Major Depression, Bipolar, and Dysthymia), Anxiety Disorders (including Phobia, Panic Disorder, and Obsessive Compulsive Disorder), Personality Disorders (Borderline Personality Disorder and Antisocial Personality Disorder), and Disassociated Disorders (Multiple Personality Disorder).

		Intensely Disagree						Intensely Agree
1	The problem that some clients bring to treatment can be viewed as spiritual problems.	1	2	3	4	5	6	7
2	A client's spiritual or religious beliefs can have a significant impact on the course of treatment.	1	2	3	4	5	6	7
3	Religious or spiritual conflicts may lead to emotional distress or other psychological problems.	1	2	3	4	5	6	7
4	A client's spiritual or religious background may be a social or cultural variable that the clinician should be aware of.	1	2	3	4	5	6	7
5	I do not feel comfortable talking with clients about their spiritual beliefs.	1	2	3	4	5	6	7
6	Only members of the clergy are qualified to talk with people about their problems in religious or spiritual terms.	1	2	3	4	5	6	7
7	It is appropriate to discuss spiritual issues with clients.	1	2	3	4	5	6	7
8	Counselors should discourage clients from talking about their religious or spiritual beliefs.	1	2	3	4	5	6	7
9	I encourage clients to talk about their spiritual beliefs.	1	2	3	4	5	6	7

Appendix D

The Intervention Scale

Please read the following items and circle the one number that best represents how frequently you do the following in the treatment process:

		Never						Very Frequently
		1	2	3	4	5	6	7
10	Use your knowledge about a client's religious affiliation to better understand cultural and or situational variables affecting his/her circumstances.	1	2	3	4	5	6	7
11	Discuss the religious/spiritual implications of choices that clients make.	1	2	3	4	5	6	7
12	Use your own spiritual beliefs to guide your work.	1	2	3	4	5	6	7
13	Quote religious/spiritual texts to establish a point.	1	2	3	4	5	6	7
14	Challenge client's spiritual beliefs.	1	2	3	4	5	6	7
15	Teach clients about spiritual issues and concepts.	1	2	3	4	5	6	7
16	Engage in prayer (without a client's knowledge) to ask for guidance or assistance in providing treatment.	1	2	3	4	5	6	7
17	Engage in vocal or silent prayer with the client during the treatment session.	1	2	3	4	5	6	7
18	Encourage the client to pray outside the treatment session.	1	2	3	4	5	6	7
19	Engage in the practice of meditation with the client during the session.	1	2	3	4	5	6	7
20	Use, with the client, guided imagery or relaxation containing religious or spiritual imagery.	1	2	3	4	5	6	7
21	Engage in the laying on of hands, priesthood blessings, or some conscious use of healing energy.	1	2	3	4	5	6	7
22	Read. with clients. relevant	1	2	3	4	5	6	7

religious/biblical texts during the session.

23	Encourage the clients to read relevant religious/biblical texts on their own.	1	2	3	4	5	6	7
24	Employ therapeutic interventions using spiritual language or symbolism.	1	2	3	4	5	6	7
25	Encourage clients to spend more time in their life on spiritual activities.	1	2	3	4	5	6	7
26	Give or suggest to the client religious or spiritual material to read.	1	2	3	4	5	6	7

Appendix E

Smith's Importance of Spirituality Scale

Please read the following statements and circle the number that best represents the level of importance you might place upon the statement when working with those within the categories listed. You may still answer even if you have not worked with someone in each category.

1. On a scale of 1-5, how would you rate the importance of using spirituality in the treatment process of individuals who are mentally ill and from the following ethnic categories:

	Don't know	Unimportant	2	Somewhat important	3	4	Most important
Caucasians	0	1	2	3	4	5	
African Americans	0	1	2	3	4	5	
Hispanics	0	1	2	3	4	5	
Native Americans	0	1	2	3	4	5	
Asians	0	1	2	3	4	5	
Other (specify) _____	0	1	2	3	4	5	

2. On a scale of 1-5, how would you rate the importance of using spirituality in the treatment process of individuals who are mentally ill and have the following diagnoses:

	Don't know	Unimportant	2	Somewhat important	3	4	Most important
Alcohol and Substance abuse	0	1	2	3	4	5	
Schizophrenia and other psychotic disorders	0	1	2	3	4	5	
Mood disorders (including Major Depression, Bipolar,	0	1	2	3	4	5	

and Dysthymia)						
Anxiety disorders (including Phobia, Panic Disorder, and Obsessive Compulsive Disorder)	0	1	2	3	4	5
Personality Disorders (including Borderline Personality Disorder and Antisocial Personality Disorder)	0	1	2	3	4	5
Disassociated Disorders (Multiple Personality Disorder)	0	1	2	3	4	5
Minor Depression	0	1	2	3	4	5

Appendix F

Spiritual Well Being Scale

For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience.

SA = Strongly Agree
 MA = Moderately Agree
 A = Agree

D = Disagree
 MD = Moderately Disagree
 SD = Strongly Disagree

- | | | | | | | |
|--|----|----|---|---|----|----|
| 1. I don't find much satisfaction in private prayer with God. | SA | MA | A | D | MD | SD |
| 2. I don't know who I am, where I came from, or where I'm going. | SA | MA | A | D | MD | SD |
| 3. I believe that God loves me and cares about me. | SA | MA | A | D | MD | SD |
| 4. I feel that life is a positive experience. | SA | MA | A | D | MD | SD |
| 5. I believe that God is impersonal and not interested in my daily situations. | SA | MA | A | D | MD | SD |
| 6. I feel unsettled about my future. | SA | MA | A | D | MD | SD |
| 7. I have a personally meaningful relationship with God. | SA | MA | A | D | MD | SD |
| 8. I feel very fulfilled and satisfied with life. | SA | MA | A | D | MD | SD |
| 9. I don't get much personal strength and support from my God. | SA | MA | A | D | MD | SD |
| 10. I feel a sense of well-being about the direction my life is headed in. | SA | MA | A | D | MD | SD |
| 11. I believe that God is concerned about my problems. | SA | MA | A | D | MD | SD |
| 12. I don't enjoy much about life. | SA | MA | A | D | MD | SD |
| 13. I don't have a personally satisfying relationship with God. | SA | MA | A | D | MD | SD |
| 14. I feel good about my future. | SA | MA | A | D | MD | SD |
| 15. My relationship with God helps me not to feel lonely. | SA | MA | A | D | MD | SD |
| 16. I feel that life is full of conflict and unhappiness. | SA | MA | A | D | MD | SD |
| 17. I feel most fulfilled when I'm in close communion with God. | SA | MA | A | D | MD | SD |
| 18. Life doesn't have much meaning. | SA | MA | A | D | MD | SD |
| 19. My relationship with God contributes to my sense of well-being. | SA | MA | A | D | MD | SD |
| 20. I believe there is some real purpose for my life. | SA | MA | A | D | MD | SD |

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^aItems are scored from 1 to 6, with higher number representing more well-being.

Reverse scoring for negatively worded items. Odd-numbered items assess religious well being; even numbered items assess existential well-being.

Appendix G

Interview Questions

1. What is your definition of spirituality?
2. Discuss your opinion of whether spirituality would be useful during the treatment process when working with individuals with different mental illness diagnoses.

Please respond to the following statements based upon how intensely you agree or disagree with the statement.

3. A client's spiritual beliefs can have a significant impact on the course of treatment.
4. A client's spiritual background may be a social or cultural variable that you should be aware of.
5. You do not feel comfortable talking with clients about their spiritual beliefs.
6. Only members of the clergy are qualified to talk with people about their problems in spiritual terms.
7. It is appropriate to discuss spiritual issues with clients.
8. Counselors should discourage clients from talking about their spiritual beliefs.
9. You encourage clients to talk about their spiritual beliefs.

Please respond to the following statements in terms of whether you do the following in the treatment process with your clients, and if so, how often?

10. Discuss the spiritual implications of choices that clients make.
11. Quote spiritual texts to establish a point.

12. Challenge client's spiritual beliefs.
13. Teach clients about spiritual issues and concepts.
14. Engage in prayer (without a client's knowledge) to ask for guidance or assistance in providing treatment.
15. Engage in vocal or silent prayer with the client during the treatment session.
16. Engage in the practice of meditation with the client during the session.
17. Encourage the client to pray outside the treatment process.
18. Use, with the client, guided imagery or relaxation containing religious or spiritual imagery.
19. Engage in the laying on of hands, priesthood blessings, or some conscious use of healing energy.
20. Read, with clients, relevant religious/biblical texts during the session.
21. Encourage the clients to read relevant religious/biblical texts on their own.
22. Employ therapeutic interventions using spiritual language or symbolism.
23. Encourage clients to spend more time in their life on spiritual activities.
24. Give or suggest to the client religious or spiritual material to read.

Appendix H

PARTICIPANT SURVEY

This survey is used in a research study that Rita Smith, doctoral candidate in the Department of Counseling and Personnel at the University of Maryland, College Park is conducting to examine counselors' spiritual beliefs and their use of interventions addressing spiritual issues with clients diagnosed with mental illness. Your honesty in completing the following items will ensure that this study provides meaningful and useful information. This survey asks only demographic information. It should only take about 10 minutes of your time to complete. This survey is anonymous. Please do not sign your name. I would like to thank you for your participation.

- 1 Age: _____
- 2 Gender: Male Female
- 3 Race/Ethnicity
 Native Americans Asian Hispanic or Latino Black or African American White
 Other (specify) _____
- 4 Professional degree (s):
 M. D. D.O. Ph.D. Psy.D. Ed.D. LSW
 L.C.S.W. M.S.W. M.S. M.A. M.Ed. MFT
 D. Min. M.Div. M.S.N. M.S.S. Other (specify) _____
- 5 Field of Training (specify) _____
- 6 License Status Licensed Non-Licensed
- 7 Certification Status Certified Non-Certified
- 8 Number of years in the counseling field _____
- 9 Number of years in counseling delivery _____
- 10 Type of work setting (select all that apply)

- Solo private practice
- Public rehabilitation facility
- Hospital outpatient department
- Public mental health clinic
- For profit psychiatric facility
- Nonprofit psychiatric facility
- Hospital inpatient unit
- Other (specify) _____

11 From the list below, rank three influences to your counseling orientation in order of importance. Write the number on the line to the left of the item.

- | | | |
|---|---------------------|-----|
| ___ Psychodynamic | ___ Behavioral | ___ |
| ___ Counseling | ___ Family Systems | ___ |
| ___ Existential/Humanistic | ___ Biomedical | ___ |
| ___ Cognitive | ___ Other (specify) | ___ |
| ___ Transpersonal (I.e., body, mind & spiritual emphasis) | | |

12 Please indicate the types of problems you typically help clients with in your clinical work (check all that apply)

- Alcohol, drug, and other addictions
- Schizophrenia and other psychotic disorders
- Anxiety disorders
- Posttraumatic Stress Disorder
- Mood disorders
- Impulse control disorders

13 Please indicate the type of populations you typically work with (check all that apply).

- Children
- Adolescents
- Adults
- Families
- Highly religious clients
- Geriatric adults
- Patients on general medical units
- Offenders and clients referred by judicial systems

14 Please fill in the percentage of your professional time in the following activities:

- ___ Treatment ___ Assessment ___ Administration

Teaching Consulting Other
 Receiving supervision Providing supervision

15 Current religious identification

Protestant Catholic Jewish Unitarian Buddhist Islamic
 Hindu Agnostic Atheist Other

16 Childhood religious background

Protestant Catholic Jewish Unitarian Buddhist Islamic
 Hindu Agnostic Atheist Other

Please read the following items and circle one number which best represents how frequently you do the following:

	Never							Daily
17 Attend religious services	1	2	3	4	5	6	7	
18 Participate in religious/spiritual activities other than services	1	2	3	4	5	6	7	

Please read the following questions and select the one answer that best applies.

19 How much formal training have you received about religious and or spirituality as a cultural factor in clinical practice?

None
 One or more workshops or conferences outside of a graduate program
 A portion of one or more courses in a graduate program
 One or more entire courses devoted to the subject in my graduate program
 A major focus of my graduate training

20 How much formal training have you received about using religious or spiritual interventions in treatment?

None
 One or more workshops or conferences outside of a graduate program
 A portion of one or more courses in a graduate program
 One or more entire courses devoted to the subject in my graduate program
 A major focus of my graduate training

Please indicate your willingness to be interviewed and tape-recorded by phone, with reference to your feelings about using spirituality in the treatment process by listing your phone number and a preferred time to call (mornings, afternoons, evenings).

_____The interview will take about 15 minutes.

Appendix I

DRAWING ENTRY FORM

FOR YOUR PARTICIPATION IN THIS STUDY TITLED:

**“Counselor’s Perceptions of Spirituality: Implications of Spirituality
for the Treatment of individuals From Different ethnicities and
serious and persistent mental illness Diagnosis”**

FIRST PRIZE

\$300.00

SECOND PRIZE

\$200.00

THIRD PRIZE

\$100.00

*Please return this flyer under separate cover within
10 DAYS
IN ORDER TO BE ELIGIBLE FOR THE DRAWING!*

BE SURE TO INCLUDE YOUR NAME AND MAILING ADDRESS

THE DRAWING WILL BE SUPERVISED BY AT LEAST TWO
FACULTY MEMBERS SERVING ON THE DISSERTATION
COMMITTEE

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