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The integration of religion and spirituality in group therapy: Practitioners' perceptions and practices

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The integration of religion and spirituality in group therapy:

Practitioners' perceptions and practices

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ABSTRACT

The current study examined practitioners' perceptions and practices regarding the integration of religion and spirituality in group therapy. Results indicate that therapists' degree of spirituality positively predicts their perceived appropriateness of religious and spiritual interventions. This perceived appropriateness, as well as therapists' spirituality and religious commitment, influenced practitioners' use of the same religious and spiritual interventions. Therapists in the study reported low levels of perceived barriers to addressing spirituality in group therapy, yet largely did not practice religious or spiritual integration. In addition, participants viewed spirituality and religion to be different constructs. Participants reported spiritual interventions to be more appropriate than religious interventions and reported more frequent use of spiritual interventions than they did use of religious interventions. Finally, practitioners in this study reported more openness to addressing spirituality in group therapy than they did openness to addressing religion in group therapy.

CHAPTER 1: OVERVIEW

The field of psychology has increasingly viewed religion and spirituality as important components of human diversity that can and should be addressed in mental health treatment (Brawer, Handal, Fabricatore, Roberts, & Wajda-Johnston, 2002). With this changing perception has come a growing amount of research on religion and spirituality in therapy. Within individual therapy, efforts have been made to research various aspects of religion and spirituality, including client preferences for addressing religion and spirituality, practitioner perceptions about addressing religion and spirituality, practitioner use of religious and spiritual interventions, and the effectiveness of spiritually-integrated treatments. Although it is encouraging to see that research has come this far within individual therapy, this research has been conducted while neglecting other forms of treatment, such as group therapy. Because group therapy is an effective and growing mode of treatment (Corey, 2008), it is unfortunate that so little research has been conducted on group therapy in general and the integration of religion and spirituality in group therapy in particular.

For individual therapy, research has demonstrated that many religious and spiritual interventions are perceived as appropriate by therapists (e.g., Shafranske & Malony, 1990; Wade, Worthington, & Vogel, 2007; Weinstein, Parker, & Archer, 2002), but that actual use of the interventions is lower than would be expected based on those perceptions (e.g., Hathaway, Scott, & Garver, 2004; Shafranske & Malony, 1990). However, many clients have concerns related to religion or spirituality (Hathaway et al., 2004; Johnson & Hayes, 2003) and most are open to and have a preference for addressing religion or spirituality in individual therapy (Rose, Westefeld, & Ansley, 2001). In addition, religiously-integrated

treatments have been found to be as effective as secular treatments (e.g., Richards, Berrett, Hardman, & Eggett, 2006).

Despite this rationale for attending to clients' religion and spirituality in therapy, it is not frequently done. This may be because practitioners perceive barriers to incorporating religion and spirituality in therapy. For example, practitioners may believe they do not have adequate training to effectively address religious or spiritual issues, they may be uncomfortable with the topic, or they may not think it is beneficial to attend to these issues.

In terms of individual counseling, research has developed to the point in which these barriers can be examined more systematically and methods of training therapists in religious and spiritual integration can be more thoroughly developed. For group counseling, however, research on religion and spirituality is still in its early stages. In fact, the only areas that appear to have been covered in the group therapy literature are the development of spiritually-based group treatments for specific concerns (e.g., Cole & Pargament, 1999; Tarakeshwar, Pearce, & Sikkema, 2005) and guidelines for religious or spiritual integration with specific populations (e.g., Dufrene & Coleman, 1992; Sweifach & Heft-LaPorte, 2007). Although these treatments and guidelines provide an important contribution to the literature, most of those treatments and guidelines were designed for a very specific concern and/or a very specific population. This greatly limits the utility of the treatments and guidelines because many groups consist of a heterogeneous set of clients with a diverse range of concerns. In addition, some clients in these heterogeneous groups may not be expecting religious or spiritual discussions, whereas clients in the spiritually-based treatments self-select into a group that will focus on or include spirituality.

The development of specific treatments and guidelines does provide an important contribution to the group therapy literature, but one could argue that researchers should take a step back and attempt to answer some of the more basic questions that have greater relevance to the general group practitioner. The degree to which practitioners find it appropriate to address religious and spiritual issues in group therapy is still unknown. Perceived appropriateness likely varies according to certain characteristics of the practitioner. In addition, there may be some methods of addressing religious and spiritual issues that are perceived as more appropriate than others. Finally, some practitioners may find it appropriate to address spiritual, but not religious, issues.

Related to, but distinct from, practitioners' perceptions of appropriateness is the extent to which practitioners actually attend to religion and spirituality in group therapy. This is another area that has not yet been examined by researchers. It is possible that some practitioners generally avoid discussions of religion or spirituality in group therapy. In contrast, some practitioners may actively work to make discussions of religion and spirituality part of the normal group process. There may be specific religious and spiritual interventions that are used frequently, whereas others may be rarely, if ever, used.

In addition, it is likely that some practitioners who find it appropriate to address religious and spiritual issues in group therapy do not regularly do so. There may be various reasons for this, but they have yet to be studied empirically. For example, practitioners may be concerned about group members' reactions to discussions about religion and spirituality or they may worry that some members would feel left out if religious or spiritual issues were discussed. Until it is determined to what extent practitioners experience these or other barriers, little can be done to address them.

These are important questions that should have been among the first addressed in research on religion and spirituality in group therapy. Without first understanding these more fundamental elements of religious and spiritual integration, there is no solid empirical foundation from which to conduct additional, more specific research on attending to religion and spirituality in group therapy.

This gap in the literature is what led to the development of the current research study. In this study, experienced group practitioners were surveyed about their perceptions of the appropriateness of various religious and spiritual interventions, actual use of those interventions, perceptions about addressing religion and spirituality, perceived barriers to addressing spirituality, and self-reported reactions to discussions of spirituality, all within the context of group therapy.

Examining perceived appropriateness of religious and spiritual interventions, actual use of those interventions, perceived barriers to addressing spirituality, and practitioners' reactions to discussions of spirituality could each constitute individual research endeavors, but the current study examined them together in order to better determine the extent to which they are related. Gaining an understanding of the interrelationships among these factors will be important for moving the field forward. As these more fundamental questions begin to be answered about group therapists' perceptions of appropriateness and barriers, as well as how those perceptions influence actual practices, the field can then begin to develop guidelines and best practices to assist therapists in attending to clients' religion and spirituality within the group therapy process.

CHAPTER 2: LITERATURE REVIEW

After a history of general neglect of religion and spirituality in the practice of psychology, recent decades have seen a growing interest in this topic. Practitioners are increasingly viewing religion and spirituality as important components of the human experience that can be successfully incorporated into mental health treatment (Brawer et al., 2002). The increasing interest and changing perceptions have stimulated a growth in research addressing the integration of religion and spirituality in therapy. Much has been learned about client preferences for addressing religion and spirituality in therapy, practitioner perceptions about doing so, the use of religion and spirituality in therapy, and the effectiveness of religious and spiritual interventions. However, this research has focused almost exclusively on individual therapy. Although knowledge continues to grow about the use of religion and spirituality in individual therapy, relatively little is known about the use of religion and spirituality in group therapy. Group therapy is an effective method of treatment and can provide a viable, cost-effective alternative to individual therapy. In addition, the structure of group therapy can actually provide additional benefits not easily achieved in individual therapy (Corey, 2008). It is unfortunate then, that so little attention has been paid to group therapy in general and the incorporation of religion and spirituality in group therapy in particular.

This literature review will explore the issue of religious and spiritual integration in therapy, with specific attention given to the integration of religion and spirituality in group therapy. However, because of the lack of research in the area of religion and spirituality in group therapy, much of the background literature will necessarily come from research on individual therapy. When available, research on group treatment will also be incorporated.

This literature review will first define and distinguish between *spirituality* and *religion*. Then, rationale for the integration of religion and spirituality in therapy will be provided. Third, practitioner views about and actual use of religious and spiritual interventions will be examined. Fourth, possible barriers to addressing religion and spirituality will be explored, including characteristics specific to group therapy that may increase practitioners' hesitancy. Finally, the current study will be explained within the context of the existing literature.

Definitions

Defining *spirituality* and *religion*, as well as differentiating between the two concepts, is a difficult task. Although the concepts of *spirituality* and *religion* are distinct in some regards, they also share characteristics that make it difficult to separate the two (Zinnbauer, Pargament, & Scott, 1999). *Spirituality* can be defined as "the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred" (Hill et al., 2000, p. 66). Here, *sacred* refers to "a divine being, divine object, Ultimate Reality, or Ultimate Truth as perceived by the individual" (Hill et al., 2000, p. 66). Spirituality may or may not occur within the context of religion.

To paraphrase Hill et al. (2000), *religion* can be defined as "the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred" (p. 66) that may also include a search for nonsacred goals (e.g., identity, belongingness, or wellness). The sacred search process receives validation and support from an identifiable group of people (Hill et al., 2000).

Thus, both constructs have a sacred core and involve a search process. However, religion can (but need not) involve a search for non-sacred goals in addition to a search for the sacred. This could occur when an individual seeks external ends such as safety, personal

comfort, or affiliation in a religious setting. Another criterion present in religion but not in spirituality is the legitimization by an identifiable group of both the means and the methods of searching for the sacred. Because of these distinctions, religion is often seen as occurring within a formally structured religious institution, whereas spirituality is often perceived to be based on personal experiences and meaning making. However, most people consider themselves to be both religious and spiritual, in which their search for the sacred includes institutional beliefs and practices. Other people may consider themselves to be spiritual but not religious or religious but not spiritual. Of course, some people consider themselves to be neither spiritual nor religious (Hill et al., 2000).

Rationale for the Integration of Religion and Spirituality in Therapy

The growing focus on religion and spirituality in therapy is evidenced by the increasing number of journals with a focus on psychology and religion or spirituality (e.g., *Journal of Psychology and Theology*, *Counseling and Values*), increased research attention (for the most recent major review article, see Worthington, Kurusu, McCullough, & Sandage, 1996), the 1994 addition of a V-code for spiritual problems in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994), and books dedicated to the integration of religion and spirituality in clinical practice (e.g., W. R. Miller, 1999; Pargament, 2007; Richards & Bergin, 2005; Shafranske, 1996). In addition, during the 1990s, religion was added as an element of diversity in the ethics codes of both the American Psychological Association (APA, 1992) and the American Counseling Association (ACA, 1995). Religion and spirituality have also been included as important components of diversity in APA's Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (APA, 1993). Guideline five states, "Psychologists

respect clients' religious and/or spiritual beliefs and values, including attributions and taboos since they affect worldview, psychosocial functions and expressions of distress" (p. 46).

Prevalence of religious beliefs. The recognition of religion and spirituality as components of diversity was an important shift for the psychological community, considering the high rates of religious beliefs in the United States. According to a large-scale national survey, a large majority of Americans report believing in God or a universal spirit (92%) and state an allegiance to a specific religious faith (83.1%; Pew Forum, 2008). Some would argue that simple allegiance to a religion does not necessarily translate into religion being an important component of an individual's life. This does appear to be true, in that 56 percent of respondents in the national survey reported their religion to be very important in their lives. Although there was a notable discrepancy between allegiance and personal importance (83.1% vs. 56%), this poll did demonstrate that the majority of Americans sampled find religion to be very important to them (Pew Forum, 2008). Therefore, many clients who enter therapy are likely to have significant religious or spiritual commitments. For these clients, religion or spirituality is an integral part of their being that cannot be ignored during treatment. These clients will often view problems and potential solutions through a religious or spiritual lens, regardless of whether they came into treatment for issues related to their religion or spirituality (Pargament, 2007).

Prevalence of religious and spiritual issues among clients. In addition to encountering religious or spiritual clients whose issues do not directly relate to their beliefs, it is likely that clinicians will at times encounter clients whose issues are of a religious or spiritual nature. Johnson and Hayes (2003) reported prevalence rates of religious or spiritual concerns among 5,472 university students, some of whom were receiving counseling from

their university counseling center and some of whom were not. Twenty-six percent of the overall sample reported at least moderate distress related to religious or spiritual concerns. Among the subsample of students seeking help from university counseling centers (*n* = 2,754), the prevalence of moderate or higher levels of distress related to religious or spiritual concerns was still considerable (19%).

Thus, it appears that a sizable minority of clients experience issues related to religion or spirituality. This finding is supported by clinicians' reports about their clients. Hathaway and colleagues (2004) conducted a national survey of 1000 clinical psychologists, of whom 332 responded. Over half of the respondents reported never or rarely examining the impact of clients' disorders on their religious or spiritual functioning, yet approximately 91 percent acknowledged that clients spontaneously report such changes. Twenty-two percent indicated these spontaneous reports occur from at least half of their clients. Thus, most clinicians can expect, at least at some point, to encounter clients who are concerned about their religious or spiritual functioning as it relates to the issues that brought them to therapy.

Client preferences for addressing religious and spiritual issues in therapy. Although it has been demonstrated that a sizable number of clients who enter treatment are experiencing concerns related to religion or spirituality (Hathaway et al., 2004; Johnson & Hayes, 2003), that does not necessarily mean clients are open to addressing these issues in therapy. The question of whether clients find it appropriate to discuss religious and spiritual issues in individual therapy and whether they desire to do so was examined in a study of 74 clients from various types of counseling sites (Rose et al., 2001). Although the sample had low levels of problems related to religion (*M* = 2.04 on a 5-point scale), over half found it appropriate to and actually had a preference for discussing religion or spirituality during

counseling. Specifically, 55 percent of respondents expressed a desire to discuss religion or spirituality. Some reasons offered included: religion and spirituality are essential for healing and growth; religious and spiritual issues are personally important; and religion and spirituality are central to human personality, behavior, and worldview. Twenty-two percent of the sample indicated that their preference for discussing religious or spiritual issues was dependent on other factors, including the relevance of spirituality to their problems and qualities of the therapist; approximately 8 percent of clients expressed a willingness to discuss spiritual, but not religious, issues. Finally, 18 percent expressed a desire not to discuss religion or spirituality in treatment for various reasons, including: religious or spiritual issues not being relevant to the current problem, a preference for discussing such concerns with clergy, and being unsure of their own beliefs (Rose et al., 2001).

This research demonstrated that some clients prefer not to discuss religion or spirituality with mental health professionals, and these preferences should be respected. The majority of clients, however, found it appropriate to discuss religious or spiritual issues in therapy and expressed a personal preference for doing so (Rose et al., 2001). Practitioners would be well advised to be sensitive to the fact that many clients may desire to discuss religious or spiritual issues as a part of their treatment.

Wade and colleagues (2007) assessed current clients receiving individual therapy on their comfort with specific religious interventions, drawing clients from Christian counseling centers, Christian private practices, and a secular counseling center. Clients were asked to rate on a 1 (*very uncomfortable*) to 5 (*very comfortable*) scale how comfortable they were with five different religious interventions, but only if the specific intervention had been used in their most recent treatment session. The interventions examined were: praying with/for the

client, quoting/referring to scripture, forgiveness by God, discussing religious faith, and assigning a religious task. Clients in the Christian settings reported higher comfort levels with each intervention than did clients in the secular setting. Responses did not differ between the two types of Christian settings, with a mean comfort rating of at least 4.0 out of 5 for all interventions.

Mean comfort ratings of clients in the secular setting were all around 3.0. The lowest mean rating was 2.1, which was for the intervention of praying with/for the client. It should be noted, however, that the standard deviations were larger (at times twice as large) for clients in the secular setting than they were for clients in the Christian settings (Wade et al., 2007). This is partially due to smaller numbers of secular clients experiencing religious interventions in the previous session. However, it is also likely to be due to greater variability in responses; some clients in the secular setting were quite comfortable with the religious interventions, whereas others felt uncomfortable with them. Thus, simple questions during intake could be asked to assess which clients would be comfortable with, and possibly even desire, religious or spiritual interventions (Leach, Aten, Wade, & Hernandez, 2009).

Client preferences for the integration of religion and spirituality in group therapy have yet to be directly assessed. However, some authors writing about spiritually-oriented group therapy have noted clients' appreciation for the addition of spiritual elements in their group therapy. For example, members of a spirituality group for individuals with severe mental illness reported gratitude for the opportunity to explore a topic of such importance and meaning to them (Lindgren & Coursey, 1995). All the group members were also receiving individual treatment from a mental heath professional. One-third of the participants were currently discussing spiritual concerns with their mental health professional, with an

additional one-third indicating a desire to do so. Had these latter clients been given an invitation from their individual therapist to address spiritual issues, it could have potentially benefited their treatment. Members of a similar group appreciated the unique format that allowed them to explore the topic of spirituality, which the group members felt was often neglected in mental health treatment (Phillips, Lakin, & Pargament, 2002). These findings were only anecdotal, but nevertheless provide some evidence that spiritual clients may be open to, and even desire, spiritual issues to be discussed in group therapy.

Beneficial elements of religion and spirituality. In addition to client preferences for the integration of religion and spirituality in therapy, there are other reasons for practitioners to consider adding spiritual, and possibly religious, elements to treatment. For example, the benefits of religion and spirituality for mental and physical well-being have been increasingly documented. One set of studies examined the role of gratitude on well-being (Emmons & McCullough, 2003). Individuals randomly assigned to keep a weekly (Study 1) or daily (Studies 2 and 3) log of blessings reported significantly higher ratings of well-being and relief of physical symptoms compared to individuals instructed to keep a log of burdens or neutral events. In another study (Wachholtz & Pargament, 2005), individuals who performed a spiritual meditation for 20 minutes a day for 2 weeks reported greater reductions in anxiety, as well as more positive mood, spiritual health, and spiritual experiences compared to individuals who performed secular meditation or relaxation exercises.

An intervention designed to cultivate sacred moments in daily life produced significant increases in subjective and psychological well-being, as well as decreases in stress. These were changes similar to those linked to an empirically established therapeutic writing exercise (Goldstein, 2007). Religious beliefs and participation in religion have also

been correlated with various physical health benefits, including lower rates of hypertension, heart disease, stroke, and disability (for an extensive review, see Koening, McCullough, & Larson, 2001).

Effectiveness of religiously- and spiritually-integrated treatments. A growing number of studies have examined the effect of integrating religion or spirituality into psychological treatments, and these studies have found the religious and spiritual treatments to be effective. Unlike for other areas within the topic of religion and spirituality in therapy, the development and examination of religiously- and spiritually-integrated treatments within group therapy has actually outpaced that of individual therapy.

Rye and colleagues have conducted two randomized clinical trials to examine the role of religion in facilitating forgiveness of romantic partners by female college students (Rye & Pargament, 2002) and ex-spouses by divorced men and women (Rye et al., 2005). In both studies, participants were assigned to one of three conditions: a secular group intervention, a religiously-integrated group intervention from a Christian perspective, and a no-intervention comparison condition. The interventions loosely followed Worthington's (1998) REACH model of forgiveness: (R)ecall the hurt, (E)mpathy, (A)ltruistic gift, (C)ommitment to forgive, and (H)old on to forgiveness. The active interventions were the same except that in the secular intervention, leaders did not refer to religion or spirituality, whereas leaders in the religiously-integrated intervention actively encouraged participants to utilize their religious and spiritual resources to help them forgive. The use of prayer and scripture readings were also explored in the religiously-integrated intervention.

In both studies, participants in the active intervention groups improved significantly more on a variety of forgiveness and mental health measures than did the comparison groups.

Contrary to the hypothesis, however, those in the religiously-integrated intervention did not improve more than did those in the secular intervention. Interestingly, participants in the secular and religiously-integrated interventions were equally likely to report that they drew upon religious or spiritual resources to promote forgiveness, which may explain the lack of outcome differences between the two active conditions (Rye & Pargament, 2002; Rye et al., 2005). Some individuals, with or without help from a facilitator, might use religion or spirituality in the process of forgiveness, an observation clinicians should be aware of when working with clients wanting to forgive. Forgiveness may be one area in which religious or spiritual integration could be especially useful for some clients.

A controlled trial has also been conducted to examine the effectiveness of a spiritual group intervention for eating disorders (Richards et al., 2006). Women receiving inpatient treatment for eating disorders were randomly assigned to one of three groups: spiritual group, cognitive group, and emotional support group. The spiritual intervention included the use of a book with non-denominational spiritual readings and educational materials from a Judeo-Christian perspective about topics such as spiritual identity, grace, forgiveness, repentance, faith, prayer, and meditation. Group members were encouraged to discuss their experiences related to spirituality during group sessions. The spiritual and cognitive groups met weekly for one hour and were structured around self-help workbooks read by participants. Members of the emotional support group did not read a book, but attended a weekly one hour "open-topic" support group. These interventions were in addition to an already rigorous inpatient treatment program for individuals with eating disorders.

Results indicated that those in the spiritual group improved significantly more on several measures than did those in the cognitive group, including eating attitudes, existential

well-being, and social role conflict. Those in the spiritual group did not differ significantly from those in the emotional support group on these measures. However, those in the spiritual group improved significantly more on the following measures than did those in either of the other groups: religious well-being, symptom distress, and relationship distress. Effect sizes for the significant differences ranged from small to moderately large. The researchers considered these differences as theoretically and clinically meaningful given that the effects were observed even within the context of an already intensive and effective program. Thus, adding spiritual components to eating disorder treatment may increase its overall efficacy (Richards et al., 2006).

In addition to these controlled clinical trials, the use of religiously- and spiritually-integrated group treatments have also been examined using non-controlled designs. Several spiritually-integrated group treatment protocols have been created for individuals with severe mental illness (e.g., Kehoe, 1998; Lingdren & Coursey, 1995; O'Rourke, 1997; Phillips et al., 2002; Sageman, 2004). Using a pre-test post-test design, Lindgren and Coursey (1995) found that participants in the treatment program increased in perceived spiritual support following treatment. The authors also found several interesting correlations. For example, greater reductions in depression from pre- to post-intervention were correlated with more frequent thoughts about God (r = .42). In addition, greater increases in hopefulness from pre- to post-intervention were correlated with stronger beliefs that religion has a positive effect when ill (r = .41).

Spiritually-integrated groups have also been developed to help individuals cope with the psychological ramifications of potentially terminal physical illnesses. For example, a spiritual coping group for adults with HIV/AIDS was created and pilot tested (Tarakeshwar

et al., 2005). Much of the intervention focused on coping methods. Members shared their own experiences with coping, and facilitators provided information about more healthy coping strategies and the potential benefits of using spiritual coping strategies. In spite of the small number of participants, significant changes from pre- to post-intervention were found. Group members reported an increase in self-rated religiosity and in positive spiritual coping (e.g., looking to a higher power for strength), as well as a decrease in negative spiritual coping (e.g., feeling angry at a higher power, feeling punished by a higher power) and depression. Post intervention evaluations demonstrated that all members agreed that focusing on spirituality often helped them "let go" and find "peace" in the face of uncontrollable events (Tarakeshwar et al., 2005, p. 187).

As another spiritual group for those with potentially terminal illnesses, a psychotherapeutic group was created for people diagnosed with cancer (Cole & Pargament, 1999; Cole, 2005). The goals of this intervention were to enhance overall adjustment, enhance spiritual support, and identify and resolve spiritual struggles and strain. Participants self-selected into a control group or a spiritually-focused group therapy (SFT). At post-intervention, participants in the SFT group remained stable on measures of pain severity and depression, whereas participants in the control group increased on both measures. Positive religious coping was associated with less depression, anxiety, and pain severity and greater physical well-being. It appears that facilitating a spiritual connection with the transcendent may act as a buffer against increased pain and depression. Participants in the treatment group did not demonstrate decreases in pain severity or depression, but given the tremendous threat imposed by a cancer diagnosis, as well as the difficulties associated with treatment, the author of the study considered the stabilization of pain severity and depression to be a

clinically significant achievement (Cole, 2005). The results of the study, however, should be interpreted with caution. This was a small pilot study and random assignment was not used to assign participants to conditions. Thus, differences between the two groups could have been due to factors other than the effects of the intervention.

A religiously-integrated group intervention has also been developed for Mormon college students struggling with perfectionism, the effects of which were tested in a pilot study (Richards, Owen, & Stein, 1993). The treatment incorporated a religious emphasis in several ways. The relationship between religion and perfectionism was explored, several religious articles were assigned and discussed, and religious imagery was used in relaxation exercises. Pretest measures indicated the participants were, on average, very perfectionistic, quite depressed, and rather low in self-esteem. They also scored low on both religious and existential well-being, which indicated they did not feel very positive about their relationship with God and did not feel very satisfied with the purpose or direction of their lives. At posttest, group members had significantly lower scores on perfectionism and depression and significantly higher scores on self-esteem and existential well-being. No significant change, statistically or clinically, was found on the measure of religious well-being. Overall, it appears the participants improved not only on their issues with perfectionism, but also on other measures of psychological well-being. In addition, informal evaluations by the group indicated they felt very positive about the group and especially found the religious bibliotherapy to be helpful (Richards et al., 1993).

The use of group therapy with a spiritual emphasis has also been examined to determine if enhancing perceptions of the sacred dimension can decrease social anxiety (McCorkle, Bohn, Hughes, & Kim, 2005). The effects of this intervention were tested in two

pilot studies. Individuals who had completed a cognitive-behavioral group therapy treatment for social anxiety in the previous two years were invited to participate. On average, religion was not particularly important to participants, but they were interested in spirituality. The intervention was psychoeducational in nature, but also included a portion of time for unscripted discussion of the topics. Sessions were designed to increase clients' awareness of the sacred, defined by the authors as "the holy, those things that are 'set apart' from the ordinary and deserving of veneration and respect" (p. 228). Group members rated their anxiety and perceptions of sacredness before and after each session. In all but the final session (which was devoted to termination and celebration), perceptions of sacredness increased from pre- to post-session. In addition, anxiety ratings decreased during all sessions except session five, with a falling trend line over the course of the intervention. Participants indicated that "thinking bigger" (p. 237) helped them to offset their anxiety. Focusing on external, sacred elements took the focus off internal reactions to anxiety-provoking stimuli.

The results of these non-controlled studies provide some evidence for the utility of incorporating spirituality into group therapy. However, the results of these studies need to be interpreted with caution. Some studies experienced attrition of members, who were not evaluated at posttest (e.g., Cole, 2005; Richards et al., 1993). It is highly possible that individuals not benefitting from the intervention dropped out, thus biasing results. In addition, in these studies, the religious or spiritual groups were not compared against control or alternate treatment groups or, when comparisons were made, random assignment was not used. Therefore, the positive changes may have been a result of time or the general effects of psychological treatment, rather than the specific religious or spiritual ingredients.

The results of the controlled trials, however, indicate that religiously- and spiritually-integrated treatments are more effective than no treatment and are at least as effective as traditional treatments. Evidence of the effectiveness of spiritually-integrated treatments, coupled with the desire of many clients to address religion and spirituality in therapy, provides strong support for attending to religion and spirituality in treatment. However, practitioners' perceptions of religion and spirituality will likely play a role in determining whether the topic is actually addressed in therapy.

Practitioners' Perceptions and Use of Religion and Spirituality in Therapy

Research on practitioners' perceptions and use of religion and spirituality in treatment were only found for individual therapy, with the exception of one study that examined the perceptions of marriage and family therapists (Carlson, Kirkpatrick, Hecker, & Killmer, 2002). Thus, the following literature refers almost exclusively to individual therapy. Although this can help provide a barometer for group practitioners' perceptions and use of religion and spirituality in group therapy, there will likely be differences between the two modes of treatment, which will be discussed later.

Perceptions of the relevancy of religion and spirituality. Practitioners' perceived relevancy of religion and spirituality in treatment will likely affect whether they attend to the religious and spiritual issues of their clients. Shafranske and Malony (1990) randomly sampled 1000 clinical psychologists who were members of APA Division 12, Division of Clinical Psychology (409 individuals responded for a return rate of 41%). In general, these clinical psychologists viewed religious and spiritual issues to be relevant to treatment. Seventy-four percent disagreed with the statement "religious or spiritual issues are outside the scope of psychology," with 15 percent agreeing and 11 percent with a neutral position.

Sixty-four percent indicated that client religious background influences the course and outcome of treatment. Among a more recent national sample of clinical psychologists (*N* = 332), approximately half strongly believed that "religious/spiritual functioning is a significant and important domain of human adjustment" (Hathaway et al., 2004, p. 101).

In addition, Carlson and colleagues (2002) surveyed 400 members of the American Association for Marriage and Family Therapy (AAMFT). Among the 153 respondents (response rate 38%), 96 percent agreed or strongly agreed that there is a relationship between spiritual and mental health and 88 percent agreed or strongly agreed that there is a relationship between spiritual and physical health. Almost half (48%) of the respondents agreed or strongly agreed with the statement, "It is usually necessary to work with a client's spirituality if you expect to help them [*sic*]" and 68 percent believed that "every person has a spiritual dimension that should be considered in clinical practice" (Carlson et al., 2002, p. 162).

Perceptions of the appropriateness of addressing religion and spirituality. The three previous studies lend evidence that most mental health practitioners find religious and spiritual functioning to be important and believe that religious and spiritual issues can be addressed within the scope of psychology. However, to what extent do practitioners find it appropriate to do so? Several researchers have attempted to answer this question by asking practitioners to rate the appropriateness of various interventions deemed to be religious or spiritual in nature. Among Shafranske and Malony's (1990) sample of clinical psychologists, 87 percent found it appropriate to know the religious background of their clients (7% inappropriate, 9% neutral) and 59 percent found it appropriate to use religious language, metaphors, and concepts during psychotherapy (26% inappropriate, 15% neutral). However,

59 percent found it inappropriate to utilize religious scripture or texts during psychotherapy (19% appropriate, 13% neutral) and 68 percent found it inappropriate to pray with a client (19% appropriate, 13% neutral). Thus, it appears that as interventions become more explicitly religious and require more clinician involvement, the perceptions of appropriateness decrease.

Jones, Watson, and Wolfram (1992) surveyed practitioners who graduated from Christian training programs (N = 640) to assess how appropriate they found various religious interventions to be for religious clients and for general practice. Appropriateness ratings were measured on a 1 (*never appropriate*) to 5 (*always appropriate*) scale. The mean appropriateness rating for religious clients was at least 3.0 for 9 of the 11 interventions. The two interventions rated lower were claiming or praying for direct divine healing (M = 2.5) and deliverance or exorcism from the demonic (M = 1.8). On the other hand, only 3 of the 11 interventions received a mean appropriateness rating of at least 3.0 for general practice. The highly rated interventions were praying for clients outside of sessions (M = 4.6), implicitly teaching biblical concepts (M = 4.0), and instructing in forgiveness (M = 3.4). Thus, although most of these interventions were rated as appropriate for religious clients, the practitioners recognized that many of the interventions were not as appropriate for the average client.

Wade and colleagues (2007) also assessed the perceived appropriateness of various religious interventions by comparing therapists at Christian counseling centers, Christian private practices, and a secular counseling center. Therapists could rate each intervention as *appropriate*, *inappropriate*, or *neutral*. Therapists in the Christian settings did not differ in their ratings on the appropriateness of any of the interventions. However, as was expected, therapists in the Christian settings found most of the interventions to be more appropriate

than did therapists in the secular setting. The only intervention that did not differ among the settings was knowing the client's religious background, with 88.9 percent of secular therapists, 95.7 percent Christian counseling center therapists, and 100 percent of Christian private practice therapists rating it as appropriate. The majority of therapists at the secular center found it appropriate to pray privately for a client (55.6%; 11.1% inappropriate) and use religious language or concepts (50%; 11.1% inappropriate). At least 90 percent of therapists in the Christian settings found these interventions to be appropriate.

The remaining interventions investigated in the study were rated as appropriate by less than half of the secular therapists: recommending religious or spiritual books, 38.9 percent (22.2% inappropriate); recommending participation in religion, 16.7 percent (44.4% inappropriate); and praying with a client, 11.2 percent (44.4% inappropriate). All of these interventions were rated as appropriate by at least three-fourths of therapists in the Christian settings. The only intervention rated as inappropriate by some therapists in the Christian settings was recommending participation in religion (therapists at Christian counseling centers, 4.3%; therapists at Christian private practices, 10%). Results from this study indicated that therapists in secular settings find some types of spiritual interventions to be appropriate (Wade et al., 2007). However, as in Shafranske and Malony's (1990) study, as the interventions became more explicitly religious, ratings of appropriateness tended to decrease. In the Christian settings, however, all the interventions were rated as appropriate by a large majority of therapists (Wade et al., 2007). This is not surprising because clients who come to these settings typically expect the treatment to be explicitly Christian in orientation. In secular settings, there is more ambiguity about the appropriateness of spiritual interventions. Some clients may desire religious or spiritual integration, while others may be

offended, and possibly even harmed, by religious or spiritual interventions. Thus, in secular settings, it becomes even more important for practitioners to work collaboratively with clients to determine if religious or spiritual integration should be used.

Another study was conducted to assess therapists' attitudes toward religious and spiritual discussions and practices in individual counseling at university counseling centers (Weinstein et al., 2002). Thirty practices and topics of discussion were categorized as either primarily religious or primarily spiritual by the authors. As a measure of perceived appropriateness, therapists were asked to rate how likely they would be to use each practice or discuss each topic. In general, therapists were more likely to favor the religious and spiritual topics of discussion (e.g., forgiveness, meaning/purpose in life, faith, and relationship with a higher power) than they were to favor suggesting that clients engage in religious or spiritual practices (e.g., prayer, therapist and client sharing religious views, reading religious/spiritual texts; Weinstein et al., 2002).

All of the studies described thus far refer to therapists' perceptions of the appropriateness of various spiritual interventions in individual therapy. No studies were found addressing the perceived appropriateness of spiritual interventions in group therapy. However, one study was found that examined marriage and family therapists' perceptions of the appropriateness of several religious and spiritual interventions (Carlson et al., 2002). In the study, 153 marriage and family therapists completed questionnaires asking about their views of the appropriateness of five spiritual interventions (e.g., recommend spiritual books) and five corresponding religious interventions (e.g., recommend religious books). Participants responded on a 1 (*strongly disagree*) to 5 (*strongly agree*) scale to each of 10

questions starting with the phrase, “It is appropriate for a family therapist to:” (Carlson et al., 2002, p. 163).

Participants found it significantly more appropriate for a family therapist to discuss their own spirituality (M = 2.85) compared to religion (M = 2.52), recommend spiritual books (M = 3.33) compared to religious books (M = 2.87), use spiritual language (M = 3.37) compared to religious language (M = 3.05), and recommend a spiritual program (M = 3.15) compared to a religious program (M = 2.64). The only intervention in which significant differences were not found was asking clients about their spirituality (M = 3.73) compared to asking them about their religion (M = 4.05). Interestingly, there was actually a trend toward participants finding it more appropriate to ask about religion than spirituality (Carlson et al., 2002). Because participants rated the religious interventions as less appropriate than the spiritual interventions in four of the five cases, it appears that marriage and family therapists view spirituality and religion as different constructs (Carlson et al., 2002). This should be further examined in research addressing practitioners’ perceptions of the appropriateness of religious and spiritual interventions.

Use of religious and spiritual interventions. In addition to examining practitioners’ perceptions of the appropriateness of various religious and spiritual interventions, researchers have also examined the frequency of use of the interventions. As evidenced in the previous section, knowing about a client’s religious or spiritual background is seen as the most appropriate use of religion and spirituality in treatment, but how many practitioners actually ask about clients’ religious and spiritual backgrounds? This question has been addressed by several researchers. Shafranske and Malony (1990) found that 91 percent of clinical psychologists in their sample have asked about their clients’ religious background. However,

respondents only indicated whether or not they had ever asked a client about his or her religious background, not how frequently they do so. Hathaway and colleagues (2004) found that 88 percent of the clinical psychologists sampled asked clients about religious beliefs, experiences, practices, or involvements during assessment at least some of the time, with 82 percent asking about spirituality. Still, only about one-fourth asked about religion and/or spirituality at least 75 percent of the time (Hathaway et al., 2004). Among a random sample of Mormon psychotherapists (N = 215, response rate = 72%), the mean usage rate of spiritual assessment was 1.66 out of 5, with a rank of 2 indicating the therapist occasionally used the intervention (Richards & Potts, 1995). These studies indicate that, although most practitioners reported asking at least some clients about their religious or spiritual history, it does not appear to be a standard part of the assessment or therapy process for the large majority of practitioners.

In addition to knowing a client's religious or spiritual background, there are many religious and spiritual interventions that have been identified and researched. For example, Worthington, Dupont, Berry, and Duncan (1988) identified 20 religious interventions; Ball and Goodyear (1991) identified 15; Jones and colleagues (1992), 11; Moon, Willis, Bailey, and Kwasny (1993), 20; and Richards and Potts (1995), 18. From these studies, it appears that the most frequently used interventions are praying silently for clients, teaching religious or spiritual concepts, encouraging forgiveness, and referencing scripture. Interventions used less frequently include religious relaxation and imagery, spiritual meditation, and therapist/client in-session prayer. Interventions rarely used include blessings (e.g., laying on of hands, anointing with oil), asking clients to memorize scripture, and praying for direct divine healing.

As evidenced here, some practitioners do appear to address religion and spirituality in treatment. However, given that most practitioners do not even assess for clients' religion and spirituality on a regular basis, one can assume there are clients who would benefit from the integration of religion or spirituality in treatment who are not receiving it. Because of the personal nature of religion and spirituality, some clients may not be forthcoming about religious or spiritual issues unless the therapist asks about them. Although religion and spirituality are generally seen by practitioners as important in human functioning (Hathaway et al., 2004), therapists may still be hesitant to address religion and spirituality in therapy for several reasons.

Possible Barriers to Addressing Religion and Spirituality in Therapy

Lack of training. In spite of increased acceptance of religion and spirituality as important components of client diversity, training programs have been slow to incorporate teaching and supervision in this area. In the past, there appears to have been little systematic incorporation of religious and spiritual issues in training programs. In Shafranske and Malony's (1990) survey of clinical psychologists, the average psychologist was 48 years old (range: 29-88). The training these psychologists received in the area of psychology and religion was very limited, with 85 percent reporting they rarely or never had discussions on the topic during training. Among this sample, 68 percent agreed with the statement, "Psychologists, in general, do not possess the knowledge or skills to assist individuals in their religious or spiritual development" (p. 75). Only approximately one-third of the sample indicated personal competence in therapy clients regarding religious and spiritual issues.

More recent studies have collected data from actual training programs to better understand how religion and spirituality are currently being presented to students. Young,

Cashwell, Wiggins-Frame, and Belaire (2002) surveyed liaisons of therapist education programs accredited by the Counsel for Accreditation of Counseling and Related Educational Programs (CACREP). Programs include master's, educational specialist, and doctoral degree-granting programs. A questionnaire was constructed using 26 therapist competencies for spirituality in counseling created during a Summit on Spirituality in 1995. These competencies address four main knowledge domains and there are multiple competencies listed under each domain. The main areas are: (a) general knowledge of spiritual phenomena, (b) awareness of one's own spiritual perspective, (c) understanding of clients' spiritual perspective, and (d) spiritually related interventions and strategies. The authors asked the liaisons to rate the importance of each of the 26 competencies for therapist training (1 = *very unimportant*, 5 = *very important*). In addition, liaisons were asked to rate how well prepared they and others in their program were to incorporate these competencies into their teaching and supervision (1 = *very unprepared*, 5 = *very prepared*).

The authors sent questionnaire packets to the CACREP liaison of each accredited program (136 at time of data collection in 1999) and received 94 back, for a 69 percent return rate. There was moderately strong agreement among the respondents that the competencies were important for therapist training, with an overall mean importance rating of 3.83 out of 5. In fact, only one competency ("Assist therapists in training in conceptualizing themselves from two different models of spiritual development across the lifespan") received a mean rating below the midpoint of the scale (M = 2.92), whereas 10 of the 26 competencies received a mean rating higher than 4.0. In spite of general agreement that these competencies are important, less than half of the respondents (46%) rated themselves as prepared or very prepared to incorporate the competencies into their teaching or supervision. In addition, the

respondents rated themselves as more prepared than other faculty members in their program. The average rating for colleagues' preparation was 2.92 out of 5, compared to 3.3 for themselves. Respondents rating themselves as unprepared cited the need for additional training and curriculum guidelines for direction in incorporating the spiritual competencies in therapist education (Young et al., 2002).

APA-accredited clinical psychology programs have also been evaluated for inclusion of religion and spirituality in training (Brawer et al., 2002). In 1998, training directors at 197 programs were sent questionnaire packets. The packets included a 10-item questionnaire to assess if and how issues of religion and spirituality were covered in various training areas, including classes, supervision, and research activities. Approximately half (51%) of the surveys were returned. Most training directors indicated their programs included issues of religion or spirituality in at least some aspect of their training. Surprisingly, 16 percent indicated their programs do not cover issues of religion or spirituality at all. Clinical supervision was the area of training for the incorporation of religion or spirituality in therapy most frequently endorsed by the directors (77%). However, the authors noted this statistic may be misleading because 20 of the individuals who endorsed supervision as a mode of training added comments suggesting that coverage was inconsistent and not part of the usual supervisory process. Because of the high frequency of these unsolicited comments, it is unlikely that most programs incorporate religious or spiritual issues in supervision in a systematic fashion. Only 13 percent of programs offered a specific course on religion/spirituality and psychology. However, 61 percent of the programs indicated that religion or spirituality was incorporated into another course (cultural diversity/cross-cultural psychology 51%, psychopathology 19%, history of psychology 15%, assessment 13%, and

family 10%). Interestingly, 20 percent of the training directors reported that students had approached faculty members requesting a course on religion and spirituality (Brawer et al., 2002).

Results of these studies indicated that most training programs do include issues of religion and spirituality to some extent. However, inclusion does not appear to be done in a systematic way at most institutions, likely leaving many therapists feeling unprepared to address religion and spirituality with their clients. In fact, given that many faculty members feel unprepared to train students in the inclusion of religion and spirituality (Young et al., 2002), it is unlikely that most training programs produce practitioners who feel competent and confident in addressing religion and spirituality in therapy.

Practitioners are less religious than their clients. Another possible barrier to incorporating spirituality in treatment is that the average therapist is less religious than his or her clients (Hill et al., 2000). Delaney, Miller, and Bisonó (2007) sent questionnaires to 489 clinician members of APA to compare their religiosity to a sample of the general population, as well as an earlier sample of psychotherapists (Bergin & Jensen, 1990). They had 258 members respond, for a response rate of 53 percent. Results indicated that, although psychologists today are no less religious than they were in Bergin and Jensen's (1990) sample, they remain far less religious than the general American population. For example, 21 percent of psychologists rated religion as "very important" in their lives and 55 percent rated it as "not very important," whereas ratings from the general population were 55 and 15 percent, respectively. In addition, only 45 percent of psychologists agreed with the statement, "my whole approach to life is based on my religion," compared to 72 percent of the general public (Delaney et al., 2007).

Although non-religious clinicians can effectively incorporate spiritual interventions into therapy (Propst, Ostrom, Watkins, Dean, & Mashburn, 1992), they may be less likely to do so than religious clinicians. If religion and/or spirituality are not important components of a clinician's worldview, he or she may be less likely to incorporate religion and spirituality, even with clients who indicate religion or spirituality is important to them. There is some evidence for this, in that Shafranske and Malony (1990) found a positive correlation between religious affiliation and use of religious interventions, as well as participation in organized religion and use of religious interventions. Practitioner religiosity, of course, is not a desirable or ethical factor to change. However, given the current lack of training provided on religion and spirituality, increased education may give non-religious clinicians the tools to effectively incorporate religion and spirituality when appropriate. In addition, education for religious clinicians should also be a priority to ensure their attention to religion and spirituality is competent and ethical.

Religious and spiritual discussions are not viewed as appropriate for therapy. Another possible barrier to incorporating religion and spirituality in therapy is that some clinicians do not view religious or spiritual discussions as appropriate for therapy. Shafranske and Malony (1990) found that 15 percent of psychologists agreed with the statement, "Religious or spiritual issues are outside the scope of psychology (p. 75)." An additional 11 percent responded neutrally to this statement. Although this means the majority of psychologists believed religious or spiritual issues can be covered within the scope of psychology, approximately one-fourth were at best ambivalent as to whether those topics can or should be covered. Clinicians with this view would not likely assess for religion and

spirituality and some may be openly opposed to discussions of religion and spirituality in treatment.

In addition, some clinicians who would like to practice religious or spiritual integration believe they cannot because of their work setting. One therapist said, "I personally believe that the use of spiritual and religious techniques in therapy depends on the nature of the work place. I work for the state…and am not at liberty to use spiritual or religious techniques I would like" (Richards & Potts, 1995, p. 167). While there are no ethical guidelines that prohibit clinicians in civic settings from discussing religious and spiritual issues or using religious and spiritual interventions, clinicians are ethically obligated to obey the law (APA, 2002). The religious clauses in the First Amendment of the Constitution have created controversy about what civic employees can and cannot do in terms of religion. Regarding religion and spirituality in therapy, Richards and Bergin (2005) have concluded that clinicians working in civic settings do have the right to explore religious and spiritual issues and concerns when the discussions are initiated by the client or when clinicians believe religious or spiritual issues are pertinent to their clients' concerns and the clients agree. Therapists are also allowed to disclose their own religious or spiritual beliefs to clients if their clients ask them to do so. However, for therapists in civic settings, it is illegal (and unethical) to "promote, proselytize, or attempt to persuade clients, covertly or overtly, to their religious viewpoint or tradition" (Richards & Bergin, 2005, p. 201). Of course, ethical clinicians should not do this in any setting, even if there are not laws preventing it.

Richards and Bergin (2005) and Chappelle (2000) do provide some notes of caution for the use of religious and spiritual interventions in therapy. First, they advise caution when considering praying with clients, referencing scripture, and assigning religious bibliotherapy.

Before using these interventions, therapists should give clients and supervisors a written document explaining the rationale for using the intervention and obtain written consent to do so. Second, Richards and Bergin advise therapists to take the age of the client into account when determining the appropriateness of a religious or spiritual intervention. When working with children and adolescents, the use of religious and spiritual interventions may be more likely to be construed as an abuse of governmental influence. Therefore, Richards and Bergin recommend that clinicians working with minors in civic settings do not pray with clients, read scriptures to them, or distribute religious literature to them. Any other explicitly religious interventions (e.g., discussing religious concepts, religious relaxation or imagery) should only be used with written client, parental, and supervisor consent. These notes of caution do not mean that clinicians working in civic settings can never discuss religion and spirituality in therapy, but they do provide some important caveats clinicians should be aware of. The recommendations, although essential in civic settings, are important points for clinicians in all settings to take into consideration.

Fear of imposing values. Another potential barrier is a fear of imposing one's own values on clients (Mack, 1994). This was a concern cited by some Mormon psychologists in Richards and Potts' (1995) research. Clinicians should not use treatment as a way of promoting their own religious or spiritual views (Richards & Bergin, 2005). However, discussions of religion or spirituality and even the use of religious or spiritual interventions with willing clients does not equate with imposing ones own values. Clinicians are able to navigate many topics, about which they may have very strong opinions, without imposing their own values on clients. This should also be able to be done with the topic of religion and spirituality. Mack (1994) writes, "Because spirituality is a unique experience for each

individual, psychotherapy can only aid growth in this area through an exploration, versus explanation, of meanings and blocks in a client's spiritual life" (p. 28).

Souza (2002) reported that in seminars on spiritual integration, some students have expressed the view that the therapist should never be the one to initiate a discussion on spirituality, believing the topic should be avoided unless the client brings it up first. Of course, the clinician should not force the subject on unwilling clients. However, especially during the assessment process, clinicians ask about many sensitive topics with the assumption that clients might not otherwise share the information. Clients may not know whether it is appropriate to discuss spirituality in therapy unless the clinician makes an effort to inform them it is appropriate to do so. This is why several authors have suggested clinicians ask about religion and spirituality during assessment (e.g., Brabender, Fallon, & Smolar, 2004; Leach et al., 2009; Tisdale, 2003). It opens the door for clients to explore the area if desired, but in no way forces clients to do so.

Potential barriers specific to group therapy. The potential barriers discussed above can apply to all clinicians, whether they practice in the individual or group format. The nature of group treatment, however, makes it likely that group practitioners perceive additional barriers about addressing religion and spirituality in group therapy. No literature was found that directly addressed factors of group therapy that may increase hesitancy. Therefore, general literature on group therapy was utilized to elucidate this assumption. First, in individual therapy, the only person there to potentially judge the client is the clinician, but the ethical clinician is to respect the rights and dignity of the client (APA, 2002), not judge him or her. However, in group therapy, there are other clients present and the group facilitator cannot guarantee that members will always follow the basic guideline of respect

(Corey, 2008). If a group discusses a religious or spiritual topic, members with opposing viewpoints may come at odds with one another, a situation facilitators may wish to avoid. However, groups often discuss topics about which members have differing views, and facilitators are able to effectively navigate the resulting group dynamics (Corey, 2008). In addition, Pargament (2007) notes that group therapy can be an appropriate context for facilitating spiritual tolerance. Group members can learn to respect the beliefs of others without sacrificing their own beliefs.

Group facilitators may also worry that discussions of religion and spirituality will leave some group members feeling left out because they are not religious or spiritual. This is a possibility, but an effective group leader will be aware of changing dynamics and use that as a source of discussion (Corey, 2008). In addition, if some members do not view themselves as religious or spiritual, this can open a discussion on the various ways in which the group members view the world. Personal definitions of religion and spirituality can be discussed and challenged. Through this, some members may realize they have a personal spirituality but had not previously defined it as such, or they may find support and acceptance from others for their lack of spiritual beliefs that they may not have experienced before.

Guidelines for the Use of Religion and Spirituality in Group Therapy

In spite of these possible barriers to incorporating religion and spirituality in group therapy, a fair number of religious or spiritual group interventions have been created for people with various mental and physical health conditions, as outlined earlier in this paper. The creation of these religiously- and spiritually-integrated group interventions for specific concerns has been an important step in the effort to address the spiritual needs of clients. However, most groups conducted by mental health practitioners are not as tailored to a

specific concern as the interventions outlined earlier. Still lacking in the literature are guidelines for practitioners to address religion and spirituality in general group treatments.

Getting one step closer to those general guidelines is a group program called Winding Road (Gear et al., 2008; Gear, Krumrei, & Pargament, 2009). Winding Road was developed as an experiential group for college students experiencing spiritual struggles, defined as "questions, doubts, and uncertainties regarding one's spiritual and religious beliefs and practices" (Gear et al., 2009, pp. 1-2). Thus, rather than using spiritually-sensitive interventions to work on other concerns (such as coping with cancer, overcoming perfectionism, or working on forgiveness), this model was developed specifically to focus on spiritual issues. Although it could be a promising program when working with a group consisting solely of individuals experiencing spiritual struggles, it still does not provide guidelines for the group practitioner wanting to address spirituality in general group therapy.

In addition to the creation of spiritual interventions for various concerns, there have been quite a few articles written with guidelines for the use of religion and spirituality in group therapy for various populations, including Native Americans (Dufrene & Coleman, 1992), HIV-infected gay and bisexual men (Norsworthy & Horne, 1994), African Americans (Williams, Frame, & Green, 1999), Latina women (Rodriguez, 2001), male batterers (Ronel & Tim, 2003), and Orthodox Jewish victims of domestic violence (Sweifach & Heft-LaPorte, 2007). However, these guidelines are presented for the practitioner who is working with a group consisting solely of the population of interest. Once again, although this information is useful, most of it will not be directly applicable for the average group facilitator. There has not been a set of suggestions or guidelines created for addressing religion and spirituality in groups without a specifically religious or spiritual focus or with a diverse set of clients.

However, groups with a heterogeneous client population and no specific focus on religious or spiritual issues are the type of group many practitioners most commonly utilize. In these groups, it is likely that some religious or spiritual members would want to incorporate their beliefs into treatment. Others may have specific concerns related to religion or spirituality that they would like to discuss. Yet, practitioners have little to no guidance about how to approach religious and spiritual issues when they arise in these groups.

In searching the literature, one can find many books on effective group therapy, as well as a sizable number of books on effectively incorporating religion and/or spirituality in therapy. It is interesting to note, however, that most books of both types do not include the other topic, and those that do generally only mention it in passing. For example, Corey's (2008) newest edition of *Theory and Practice of Group Therapy* is over 500 pages, but the three mentions of spirituality (spirituality is a central value of many African Americans; existential exploration may sometimes take a spiritual direction; and, ironically, group workers need more education to effectively incorporate exploration of spiritual issues) take up less than one page. *Essentials of Group Therapy* (Bradender et al., 2004), meant as a practical guide to effective group therapy, made an effort to discuss religion. In discussing the need for multicultural competency in group therapy, the authors made a telling statement: "…there are certain areas of diversity such as religion that have still been only scantily explored" (p. 14). The authors discussed how to deal with a client who uses religion defensively, outlined the challenge of leading groups for a church that one holds discordant values to, and briefly mentioned that asking clients about their religion and spirituality during intake can open the door to discussions during treatment. Once again, all this material could

fit on approximately one page. Yet, this small listing of topics was the most comprehensive coverage of religion and spirituality found in the group therapy texts examined.

Handbook of Group Counseling and Psychotherapy (DeLucia-Waack, Gerrity, Kalodner, & Riva, 2004), another well-known reference book for group practitioners, provided a brief discussion about spirituality as an important value of many African Americans and also presented a short overview of how individuals with GLBT identities may work to reconcile their spirituality with their sexual orientation. Yalom (2005) and Shapiro, Peltz, and Bernadett-Shapiro (1998) made no mention of religion or spirituality in their books on group therapy.

A final book on group therapy that was examined is *The Practice of Multicultural Group Work* (DeLucia-Waack & Donigian, 2004). One would expect that a book on multicultural issues would address religion and spirituality. However, this topic was largely overlooked. The book is unique in that it included contributing experts who provided autobiographical sketches, as well as responses to various case vignettes. Several of the contributing experts discussed how their spiritual or religious beliefs influence their responses to various issues that come up in group therapy. Despite the attention some contributing experts paid to their own religious or spiritual beliefs, the remainder of the book was mostly silent on the topic. The book included sections on how group workers can examine their own values, beliefs, and assumptions, but religion and spirituality were oddly left from the list of factors that may influence one's values, beliefs, and assumptions. In addition, no attention was paid to clients' religion and spirituality and how that area of multiculturalism may influence the group therapy process.

On the other hand, books on religious and spiritual integration devote little discussion to integration in the context of group therapy. Most books on religious or spiritual integration do not even mention group therapy (e.g., Richards & Bergin, 2000; Sperry, 2001; Sperry & Shafranske, 2005). Others discuss Alcoholics Anonymous (Frame, 2003; Griffith & Griffith, 2002; G. Miller 2003; W. R. Miller, 1999; Shafranske, 1996), but do not address religious or spiritual integration in groups led by trained facilitators. However, Richards and Bergin (2005) devoted some attention to the topic of group therapy. They reviewed some of the attempts to add religious or spiritual elements to group therapy, most of which are cited earlier in this paper as well. In addition, the authors offered some cautions when working with groups. Therapists were advised to be sensitive to differences in client comfort with theistic therapy, and they noted that not all group members may be receptive to adding spiritual components. They reported, however, that some approaches can be tailored to fit the needs of individual clients without compromising treatment for other members of the group, although they do not offer any guidelines for doing so. Thus, although group therapy is mentioned in this book, it offers little to the practitioner wanting to address religious and spiritual issues in group therapy.

Of course, this short review does not include all of the books available on group therapy or religious and spiritual integration. However, these books represent some of those most frequently referenced for the topics of group therapy and religious and spiritual integration. The fact that these books offer little, if any, information on the other topic demonstrates the lack of guidance in the field for attending to religious and spiritual issues in group therapy.

Current Study

Because of the general dearth of literature on religion and spirituality in group therapy, there are many questions still to be addressed. The one area related to religion and spirituality in group therapy in which research has actually been conducted is religiously- and spiritually-integrated treatment programs. Although the development of these treatment programs does provide an important contribution to the literature, one could argue that researchers should take a step back and attempt to answer some of the more basic questions that have greater relevance to the general group practitioner. The degree to which practitioners find it appropriate to address religious and spiritual issues in group counseling is still unknown. Perceived appropriateness likely varies according to certain characteristics of practitioners, such as their own degree of spirituality and religious commitment. In addition, there may be some methods of addressing religious and spiritual issues that are perceived as more appropriate than others. Finally, some practitioners may find it appropriate to address spiritual, but not religious, issues.

Related to, but distinct from, practitioners' perceptions of appropriateness is the extent to which practitioners actually address religion and spirituality in group therapy. This is another area that has not yet been examined by researchers. It is possible that some practitioners generally avoid discussions of religion and spirituality in group therapy. In contrast, some practitioners may actively work to make discussions of religion and spirituality part of the normal group process and may even utilize various religious and spiritual interventions.

In addition, it is likely that some practitioners may perceive barriers to addressing spirituality in group therapy. For example, practitioners may believe they do not have

adequate training to effectively address spiritual issues, they may be uncomfortable with the topic, or they may not think it is beneficial to address spiritual issues. Until it is determined to what extent practitioners experience these barriers, little can be done to address them.

Although these three areas—perceptions, practices, and barriers—could each constitute individual research endeavors, the current study examined them together in order to better determine the extent to which they are related. Gaining an understanding of the interrelationships among therapists' perceptions of appropriateness, their actual practices, and perceived barriers will be important for moving the field forward. As the more fundamental questions begin to be answered about group therapists' perceptions of appropriateness and barriers, as well as how those perceptions influence actual practices, the field can then begin to develop guidelines and best practices to assist therapists in attending to clients' religion and spirituality within the group therapy process.

CHAPTER 3: METHOD

Participants

Members of the American Group Psychotherapy Association (AGPA) who belonged to the membership categories of clinical member, associate clinical member, and adjunct member were invited to participate in this study. These membership categories were selected because they required members to have a mental health degree and have some level of experience working with groups. The other membership categories of new professional, student member, academic member, and research professional did not require experience working with groups. Members in these categories were excluded because, although they all likely have an interest in group therapy, there was the potential that many members would have minimal experience in the practice of group therapy.

There were 251 AGPA members who initiated participation in this study. After data cleaning, the sample size was 242 participants (134 female, 95 male, 13 no response). The average participant was 57.8 years old (*SD* = 11.25; range = 31-86) and had been working as a mental health professional for 25.12 years (*SD* = 11.16; range = 2-50). Four participants did not indicate race or ethnicity; of those who did indicate, 88.7 percent were White/Caucasian American, 2.1 percent were Latino/a, 1.7 percent were Black/African American, and 0.8 percent were Asian American/Pacific Islander. In addition, 4.5 percent indicated “other” for their race and 2.1 percent selected more than one race or ethnicity.

Procedures

This study was approved by the Internal Review Board at Iowa State University. Because AGPA did not allow distribution of members’ e-mail addresses, an employee of AGPA sent an invitation e-mail to potential participants that explained the nature of the study

and invited them to participate. Individuals interested in participating clicked on a link in the e-mail, which took them to an informed consent page for the study. Those agreeing to participate after reading the informed consent were directed to complete an online version of the questionnaire. As an incentive, participants could enter their e-mail address into a drawing for one of two $100 Amazon.com gift certificates. The e-mail address was entered in a separate questionnaire not attached to their responses to ensure confidentiality. In addition, Internet protocol addresses were not recorded to maintain confidentiality.

Two reminder e-mails were planned to be sent to those originally invited in order to increase the response rate. Prior to sending the reminder e-mails, the AGPA staff member removed the e-mail addresses of those who signed up for the prize drawing to prevent duplicate participation. After the initial e-mail 108 questionnaires were completed. A reminder e-mailed was scheduled to be sent 7 days after the invitation e-mail. However, the AGPA staff member mistakenly sent the invitation e-mail again. This second invitation resulted in 64 additional responses. The first reminder e-mail was then sent 12 days following the second invitation e-mail, and 51 additional people participated. The final reminder e-mail was sent 16 days later and resulted in 28 additional participants. This was a total of 251 participants. At the time the initial e-mail was sent, there were 1462 members in the selected membership categories. Assuming all members actually received the e-mail, the response rate was 17.2 percent.

Measures

At the beginning of the questionnaire, participants were supplied with definitions of group therapy, spirituality, and religion. Participants were instructed to use these definitions when answering items on the questionnaire. *Group therapy* was defined as “a therapeutic

group (themed or open-ended) comprised of a potentially heterogeneous clientele led/facilitated by at least one professional therapist/counselor, without a specifically religious or spiritual theme." *Spirituality* was defined as "the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred (i.e., a divine being, divine object, Ultimate Reality, or Ultimate Truth as perceived by the individual). Spirituality may or may not occur within the context of religion." Finally, *religion* was defined as "the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred that may also include a search for non-sacred goals (e.g., identity, belongingness, or wellness). The means and methods (e.g., rituals or prescribed behaviors) of the search receive validation and support from within an identifiable group of people."

Perceived appropriateness of religious and spiritual interventions. A measure containing 14 religious and spiritual interventions was created (see the Appendix for all study measures). Most of the interventions were adapted from previous research on religious and spiritual interventions in individual and family therapy (e.g., Carlson et al., 2002; Shafranske & Malony, 1990; Wade et al., 2007). Five of the items referred to spirituality (e.g., using spiritual language and concepts; self-disclosing one's own spiritual beliefs). Five additional items were the same as the previous five except for the substitution of the term "religion/religious" for "spirituality/spiritual." Four other religious interventions were included that did not have a spiritual counterpart (e.g., reading/reciting religious scripture; allowing a group member to lead in-session vocal prayer). Participants indicated their perceptions of the appropriateness of each intervention on a 1 (*completely inappropriate*) to 6 (*completely appropriate*) scale.

A principal components analysis (PCA) was conducted on the 14 appropriateness of religious and spiritual interventions items. Results of this PCA indicated that all 14 items loaded on one component. However, two items had factor loadings under .5 and also loaded heavily on a second component. As a result of the cross-loading, these items were dropped from the measure. The two items were "facilitating discussion about spirituality after a group member brings it up" and the corresponding religious item. These two items could best be seen as reactive steps taken by group leaders when a group member first initiates a discussion about spirituality or religion. Thus, they do not fully capture the construct of religious and spiritual interventions as measured by the other items. The resulting 12-item measure had a Cronbach's alpha of .91, indicating good internal consistency. Scale scores can range from 12 to 72, with higher scores indicating higher perceived appropriateness of the interventions. The measure is referred to as the Perceived Appropriateness of Religious and Spiritual Interventions Scale (PARSIS).

Use of religious and spiritual interventions. The same 14 interventions were used in a measure of self-reported use of religious and spiritual interventions. Participants indicated how frequently they used each intervention in their group therapy work on a 1 (*never*) to 6 (*almost always*) scale.

A PCA was conducted on the 14 items. All of the items loaded heavily (the lowest loading was .546) on the first component, although some items also loaded on a second or third component. The two items about facilitating discussion loaded heavily on another component, as they did for the appropriateness items. Thus, they were removed from the measure for consistency. Rerunning the PCA with those items removed resulted in all items loading on the first factor at .624 or higher. The 3 items regarding prayer also loaded on a

second factor, but they were retained in order to keep the appropriateness and use measures consistent. The 12 items were summed to create a use measure that is referred to as the Use of Religious and Spiritual Interventions Scale (URSIS). Cronbach's alpha for this measure was .91. Scale scores can range from 12 to 72, with higher scores indicating more frequent use of the interventions.

Barriers to addressing spirituality. Participants indicated how true they believed 12 statements regarding spirituality in group therapy to be (1 = *completely untrue*, 6 = *completely true*). These statements included general perceptions about the appropriateness of addressing spirituality in group therapy (e.g., "Spiritual concerns are better dealt with in individual therapy"), participants' perceived competence in addressing spirituality (e.g., "I have enough training to effectively address spirituality in group therapy"), and potential hesitations about addressing spirituality (e.g., "I worry that conflict among group members might arise if spiritual issues were discussed in group therapy"). Statements were constructed to capture all the potential barriers to addressing spirituality in group therapy discussed in the literature review.

A PCA was conducted on these 12 items. Items with an absolute value over .5 were retained on the first component. This resulted in the first item, "spirituality is an important component of diversity," being eliminated. No items loaded highly on other components. Because 4 items loaded negatively, scale scores were reversed for those 4 items. The resulting 11-item scale consisted of aspects that could be considered barriers to addressing spirituality in group therapy. The measure is referred to as the Barriers to Addressing Spirituality Scale (BASS). Cronbach's alpha for this measure was .85. Scale scores can range from 11 to 66, with higher scores indicating greater perceived barriers.

Reactions to spiritual discussions. Participants were asked to indicate their reactions if/when clients bring up issues related to spirituality. Twelve polarities were given, to which participants were asked to indicate where they fell on a 7-point spectrum ranging from one reaction to its polar opposite reaction. This measure was constructed to represent two factors. The first factor was general comfort and consisted of 6 polarities (e.g., relaxed—tense; open—guarded). The second factor was perceived competence and also consisted of 6 polarities (e.g., skilled—unskilled; qualified—unqualified). In half of the polarities, the descriptor that indicated more comfort or competence was anchored at "7." In the remaining polarities, those descriptors were anchored at "1."

A PCA was conducted on these 12 items after 6 of the items were reversed so all items reflected more comfort or competence. All 12 items loaded on the first component (the lowest loading was .568). However, one item (qualified – unqualified) also had a high loading on a second component. Thus, this item was dropped. After the item was dropped, the remaining 11 items loaded cleanly on one component, indicating the comfort and competence items did not produce separate factors as intended. The resulting measure is referred to as the Reactions to Spiritual Discussions Scale (RSDS). Cronbach's alpha for this measure was .90. Scale scores can range from 11 to 77, with higher scores indicating more positive reactions to spiritual discussions.

Openness to addressing spirituality and religion. As a general measure of participants' openness to addressing spirituality and religion in group therapy, participants were asked two questions: "To what extent are you open to addressing spirituality in group therapy?" and "To what extent are you open to addressing religion in group therapy?" Participants responded on a 1 (*not at all open*) to 5 (*extremely open*) scale for both questions. After each of the questions, participants

were given the chance to make comments regarding their openness by responding to the follow-up question "For what reason(s) did you select this rating?"

Therapist spirituality. The Spiritual Transcendence Index (STI; Seidlitz et al., 2002) was used to assess participants' spirituality or "spiritual transcendence," defined as "a subjective experience of the sacred that affects one's self-perception, feelings, goals, and ability to transcend difficulties" (p. 441). The STI is an 8-item questionnaire with response options ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). Scale scores can range from 8 to 48, with higher scores indicating greater spirituality. The STI has two subscales with four questions each. The God subscale consists of items referring specifically to God (e.g., "I maintain an inner awareness of God's presence in my life"), whereas the Spirit subscale has questions referring more generally to spirituality without reference to God (e.g., "Maintaining my spirituality is a priority to me"). The STI has adequate internal consistency, with a Cronbach's alpha of .96 for the Spirit subscale and .97 for both the God subscale and total scale (Seidlitz et al., 2002). In the current study, only the total scale was utilized. Cronbach's alpha for the current sample was .95.

Therapist religious commitment. The Religious Commitment Inventory—10 (RCI—10; Worthington et al., 2003) was used to assess participants' religious commitment, defined as "the degree to which a person adheres to his or her religious values, beliefs, and practices and uses them in daily living" (p. 85). The RCI—10 is a 10-item questionnaire with response options ranging from 1 (*not at all true of me*) to 5 (*totally true of me*). Questions include "My religious beliefs lie behind my whole approach to life" and "I enjoy working in activities of my religious organization." Scale scores can range from 10 to 50, with higher scores indicating greater religious commitment. The authors suggested the RCI—10 has a normative

mean of 26 for a general sample of U.S. adults and that a score of 38 or higher would justify the labeling a person as highly religious. The RCI—10 has been found to have adequate internal consistency, with an average Cronbach's alpha of .95 and a range of .92 to .98 for specific religious groups (Worthington et al., 2003). In the current sample, the Cronbach's alpha was .95.

Demographic information. Participants were asked to provide general demographic information including sex, age, race and ethnicity, religion or spiritual worldview, and region of the U.S. in which they lived. Participants were also asked several questions about their education and clinical experience, including degree area, highest degree achieved, years of clinical experience, percentage of clinical work devoted to group therapy, types of groups facilitated, clinical setting, whether they had conducted spiritual issues groups, and amount of training and experiences related to religion and spirituality in therapy. The question about training included 12 training activities and other experiences related to the topic of spirituality and religion in therapy (e.g., reading book(s), attending a conference or seminar, receiving supervision). An "other" category was also included. The number of activities each participant selected was used as a measure of training, referred to as "training in religion/spirituality (R/S)." Finally, participants were asked to specify on a 1 (*not at all interested*) to 5 (*extremely interested*) scale the extent to which they were interested in the topic of spirituality/religion and therapy. This question was included as a sample representativeness check in the event that the response rate was low.

Hypotheses and Rationale

Due to the dearth of research on practitioners' perceptions of attending to spirituality in group therapy, the current study was exploratory and descriptive in nature. However,

based on previous research on individual and family therapy, several hypotheses were also tested. First, it was expected that most of the measures would be correlated with one another. Perceived appropriateness of religious and spiritual interventions, self-reported use of religious and spiritual interventions, self-reported in-session reactions to spiritual discussions, therapists' spirituality, and therapists' religious commitment were hypothesized to be positively correlated with one another. These measures were expected to be negatively correlated with perceived barriers to addressing spirituality in group therapy.

The second set of hypotheses involved therapists' religious commitment and spirituality in relation to perceived appropriateness of religious and spiritual interventions and use of those interventions. It was expected that participants scoring higher on the RCI (i.e., those demonstrating higher religious commitment) would perceive the religious and spiritual interventions to be more appropriate and would be more likely to use them than would participants scoring lower on the RCI. This was also expected for those scoring higher on the STI (i.e., those high in spirituality) compared to those scoring lower. These hypotheses were based largely on Shafranske and Malony's (1990) study, which found religious affiliation and participation in organized religion to be positively correlated with views on the appropriateness of religious interventions, as well as actual use of the interventions.

The third hypothesis was that participants scoring lower on the STI would indicate greater barriers to addressing spirituality in group therapy than would those scoring higher on the STI, even after controlling for participants' amount of training in spirituality and religion. This hypothesis was drawn from the finding that clinical psychologists with religiousness high in ends orientation (i.e., viewing religion as providing an answer to existential questions) expressed higher degrees of competence in knowledge and skills about religious

integration than did other clinical psychologists, regardless of breadth of training in the area of religion (Shafranske & Malony, 1990). There was not expected to be a significant difference in perceived barriers between those scoring high on the STI but low on the RCI (i.e., those who are spiritual but not religious) and those scoring high on both measures (i.e., those who are spiritual and religious) because the questions pertinent to barriers referred to spirituality without specific mention of religion.

Fourth, it was hypothesized that participants scoring higher on the STI would report in-session reactions to spiritual discussions that indicated greater comfort and competence with the subject compared to participants scoring lower on the STI. As above, there was not expected to be a significant difference in reactions between those scoring high on the STI but low on the RCI (i.e., those who are spiritual but not religious) and those scoring high on both measures (i.e., those who are spiritual and religious) because the reactions measure referred to spirituality without specific mention of religion.

Finally, it was hypothesized that participants would find it more appropriate and would be more open to addressing spirituality than religion in group therapy. This hypothesis was based on research that found that family therapists believed it was more appropriate to discuss their own spirituality, recommend spiritual books, use spiritual language, and recommend a spiritual program compared to the corresponding religious interventions (Carlson et al., 2002).

CHAPTER 4: RESULTS

Data Cleaning

Data cleaning was conducted prior to performing any statistical analyses. First, participants were removed if they did not complete any items on the second half of the questionnaire. It was assumed that these individuals decided to end their participation in the study early. Eight participants were removed in this procedure. Next, the necessary scale items were reverse scored. The data set was then examined for missing data points. If a value was missing for an item that was part of a larger scale, a value was created for that missing item by calculating the mean of the remaining scale items. Missing values for stand-alone items were simply coded as missing. There was generally no identifiable pattern for the missing data points. The one exception, however, was for items measuring the use of religious and spiritual interventions. Seven participants chose not to answer any items on that scale. This could potentially be because some participants were not currently facilitating groups (in fact, some participants mentioned this in an open-response answer). The participants who left the use scale blank were not utilized in the regression analysis examining use of spiritual and religious interventions.

The scales were examined for both univariate and multivariate outliers. Univariate outliers were detected by examining box plots for each scale. Outliers were detected on the PARSIS, URSIS, BASS, and RSDS scales. However, examining the 5 percent trimmed mean of each scale revealed the outliers had little effect on the mean. Each 5 percent trimmed mean was within 1 point of the observed mean. Still, one outlier was altered on the URSIS scale because it was flagged as a severe outlier (i.e., it was more than three box lengths from the

mean). For the regression analysis in which URSIS was the criterion variable, that score was changed from 61 to 55, which was one point higher than the next highest score.

Multivariate outliers were detected through examination of Mahalanobis distance (Tabachnick & Fidell, 2001). One participant was found to be a severe multivariate outlier on STI and RCI. Because the STI and RCI were used in all regression analyses, this participant was dropped from the data set.

Tests of Normality

Prior to examining the research questions, the data was tested to determine whether it met the regression assumptions of normality (Cohen & Cohen, 1983). Each of the regression analyses below was conducted and the regression residuals were examined for skewness and kurtosis. Skewness was examined by dividing the residual skewness statistic by the residual skewness standard error and comparing the resulting *z*-score to a critical value of 1.96. Kurtosis was examined by dividing the residual kurtosis statistic by the residual kurtosis standard error and comparing the resulting *z*-score to a critical value of 1.96. Any values greater than 1.96 significantly differ from normal at a *p*-value of .05 using a two-tailed significance test (Tabachnick & Fidell, 2001).

Residuals for the regressions predicting the PARSIS and BASS met the assumptions for normality. Residuals for the regression predicting URSIS score were in the normal range for skewness (*z*-score = 1.80), but not for kurtosis (*z*-score = 4.72). Because this regression did not meet all assumptions for normality, logarithmic, square root, and inverse transformations were conducted on URSIS and regressions were re-run for each transformed criterion variable. The square root transformation resulted in the greatest reduction in residual kurtosis (*z*-score = 2.86), although it was still outside of normality. The conclusions

of the transformed regression did not differ from those of the untransformed regression. Because the conclusions did not differ and the untransformed regression had residuals that were not significantly skewed, the original untransformed regression was utilized below.

Residuals for the regression predicting RSDS score were found to significantly differ from normality on skewness (*z*-score = -3.48), but not kurtosis (*z*-score = .15). Therefore, a square root reflected transformation of RSDS score was conducted and the regression was re-run using the transformed criterion variable. This transformation resulted in the regression residuals meeting the normality assumption on both skewness (*z*-score = -1.58) and kurtosis (*z*-score = 1.64). The conclusions of the regression analysis did not change. Because the conclusions did not differ between the regressions using transformed and untransformed RSDS scores, the untransformed regression was utilized below to allow for clearer and more meaningful interpretation of the results.

Therapy- and Spirituality-Related Participant Demographics

The highest percentage of participants were trained in social work (31.2%), followed by clinical psychology (28.7%), counseling psychology (15.2%), psychiatry (5.8%), marriage and family therapy (5.0%), counselor education (2.5%), and pastoral counseling (.8%). An additional 10.3 percent of participants indicated a training type (e.g., theology, psychiatric nursing) not included on the questionnaire. There was an even split between individuals with a master's degree (48.9%) and a doctoral degree (48.1%), with 3.0 percent indicating another degree type (e.g., a medical degree). Almost all participants were currently licensed as mental health practitioners (97.5%) and the average participant had been working in the field for 25.1 years (*SD* = 11.16; range = 2-50). Participants could indicate multiple work settings; the most frequent settings were private practice (*n* = 169), community mental health center (*n*

= 27), outpatient hospital (*n* = 26), and group practice (*n* = 22). For most participants, less than half of their clinical work was devoted to group therapy (82.2%). Participants could indicate multiple types of groups that they conduct; the most common type of group was process-oriented (*n* = 204). Support groups (*n* = 81) and psychoeducational groups (*n* = 77) were also frequently used. In addition, 23 participants reported they conducted another type of group, such as training groups or themed groups.

Most participants (79.6%) indicated they had never conducted a group in which the main focus was the discussion of spiritual or religious issues. A fair number had conducted such groups in the past (16.3%) and a few were conducting a group at the time of the questionnaire (4.2%). For correlation and regression analyses, this variable ("spiritual group") was collapsed into two levels, those who had never conducted a spiritual issues group (coded as 0) and those who had conducted a spiritual issues group (either currently or in the past; coded as 1).

For the question about training in religion and spirituality, the most common types of training and experiences endorsed were reading journal article(s) on the topic (56.6%), reading book(s) on the topic (56.2%), and attending a conference or seminar on the topic (47.9%). About a tenth of the participants (9.9%) indicated having no training or experiences in this area. In this sample, the number of training experiences ranged from 0 to 13, with a mean of 3.16.

Because the response rate was low, the question "To what extent are you interested in the topic of spirituality/religion and therapy?" was used to check the representativeness of this sample. The mean response was 3.22 (*SD* = 1.24) on a 5-point scale. The sample was

normally distributed according to interest in the subject, which provides evidence that individuals did not self-select into this study simply out of interest.

Eleven participants did not answer the question about their current religion or spiritual worldview. Of those who did answer, the most frequent responses were Judaism (21.6%), Protestant Christianity (16.0%), Catholicism (12.1%), Buddhism (12.1%), and agnosticism (9.1%). Less frequent worldviews were Unitarianism/Universalism (3.0%), atheism (3.0%), Mormonism (1.7%), and Taoism (.9%). In addition, 20.3 percent of participants chose to write in their own religion or worldview (e.g., non-theist, Quakerism, a mix of several traditions) rather than select one of the options provided.

The mean STI score in this sample was 32.56 (*SD* = 11.29), which denotes an average response of "slightly agree" on the items assessing one's level of spirituality. These results are very similar to those of a community sample utilized to validate the STI, in which the mean was 33.30 (*SD* = 10.74; Seidlitz et al., 2002). The mean RCI score in this sample was 22.09 (*SD* = 11.42), which denotes an average response of "somewhat true of me" on the items assessing one's level of religious commitment. After validating the RCI on several different populations, its developers concluded that the normative mean of the general U.S. population was approximately 26 with a standard deviation of 12 (Worthington et al., 2003). This suggests that participants in this sample had somewhat less religious commitment than the general population. This is not surprising, given that others have demonstrated lower levels of religiosity among therapists (Delaney et al., 2007).

Descriptive Analyses

Appropriateness of religious and spiritual interventions. Because this study was largely exploratory in nature, descriptive statistics were conducted on many of the measures

and individual measure items. First, the means and standard deviations of the individual items assessing appropriateness of religious and spiritual interventions were examined. As can be seen in Table 1, perceived appropriateness varied among the different types of interventions. The intervention with the highest perceived appropriateness was "facilitating discussion about spirituality after a group member brings it up" (*M* = 5.45 out of 6; *SD* = .84). The intervention with the lowest perceived appropriateness was "leading in-session vocal prayer" (*M* = 1.46; *SD* = .92). Examining Table 1, it appears that as the interventions became more overtly spiritual or religious in nature, participants viewed them as less appropriate. In addition, although participants rated the paired religious and spiritual interventions relatively equally, each spiritual intervention was always rated as more appropriate on average than was its corresponding religious intervention. Whether or not these differences were significant is explored later.

Use of religious and spiritual interventions. Next, the means and standard deviations of the individual items assessing the self-reported use of religious and spiritual interventions were examined. As can be seen in Table 2, all of the items had means below 4, which indicates "fairly often" use of the interventions. Use of all but one of the interventions was ranked within one ranking of its appropriateness score, indicating that participants used the interventions to the degree to which they found them appropriate. The one exception was "bringing up the topic of religion," which ranked 5th in perceived appropriateness but 8th in use, indicating that participants did not use that intervention as often relative to its appropriateness ranking. Examination of Table 2 demonstrates that the average practitioner in this sample uses religious and spiritual interventions infrequently.

Table 1

Descriptive Statistics for Appropriateness of Religious and Spiritual Interventions Items.

Item	*M* (*SD*)	% Selecting Each Rating					
		6	5	4	3	2	1
3. Facilitating discussion about spirituality after a group member brings it up	5.45 (.84)	62.2	24.9	10.0	1.7	1.2	0
4. Facilitating discussion about religion after a group member brings it up	5.07 (1.12)	47.9	26.3	17.5	5.0	2.5	0.8
1. Bringing up the topic of spirituality	4.35 (1.56)	28.9	26.9	18.6	8.3	10.7	6.6
9. Using spiritual language or concepts	3.93 (1.43)	13.6	23.1	33.5	8.3	14.9	6.6
2. Bringing up the topic of religion	3.75 (1.58)	14.5	22.7	23.6	13.6	14.0	11.6
5. Asking group members about their spiritual beliefs	3.74 (1.61)	16.5	19.8	24.0	12.4	15.7	11.6
6. Asking group members about their religious beliefs	3.33 (1.63)	11.6	14.5	23.2	14.9	17.0	18.7
10. Using religious language or concepts	3.17 (1.43)	5.5	12.6	25.6	21.0	19.3	16.0
7. Self-disclosing one's own spiritual beliefs	3.01 (1.46)	6.3	7.5	28.5	14.9	23.4	19.2
8. Self-disclosing one's own religious beliefs	2.68 (1.43)	4.1	6.2	20.7	16.6	26.6	25.7
12. Having a moment of silence for personal prayer	2.09 (1.44)	2.9	5.0	12.8	10.7	14.9	53.7
11. Reading/reciting religious scripture	1.86 (1.18)	1.2	2.5	8.7	10.3	23.6	53.7
13. Allowing a group member to lead in-session vocal prayer	1.72 (1.12)	1.7	2.1	5.0	9.1	22.3	59.9
14. Leading in-session vocal prayer	1.46 (.92)	0.8	.04	4.1	7.0	14.0	73.6

Note: N = 242. Items ranked from most to least appropriate. Item numbers refer to the order they were presented to participants. 6 = *completely appropriate*, 5 = *mostly appropriate*, 4 = *somewhat appropriate*, 3 = *somewhat inappropriate*, 2 = *mostly inappropriate*, 1 = *completely inappropriate.*

Table 2

Descriptive Statistics for Use of Religious and Spiritual Interventions Items.

Item	*M* (*SD*)	% Selecting Each Rating					
		6	5	4	3	2	1
3. Facilitating discussion about spirituality after a group member brings it up	3.92 (1.35)	16.7	16.7	24.9	29.6	7.7	4.3
4. Facilitating discussion about religion after a group member brings it up	3.54 (1.42)	12.0	13.7	22.2	28.6	16.2	7.3
9. Using spiritual language or concepts	2.80 (1.23)	3.4	7.7	9.8	38.3	26.0	14.9
1. Bringing up the topic of spirituality	2.70 (1.26)	3.8	7.2	7.7	33.6	31.9	15.7
5. Asking group members about their spiritual beliefs	2.59 (1.23)	2.1	8.1	6.0	35.0	27.8	20.9
6. Asking group members about their religious beliefs	2.23 (1.09)	0.9	3.8	5.5	26.0	35.3	28.5
10. Using religious language or concepts	2.22 (1.07)	1.3	2.6	4.7	28.5	34.0	28.9
2. Bringing up the topic of religion	2.15 (.98)	0.4	2.1	5.5	22.6	42.6	26.8
7. Self-disclosing one's own spiritual beliefs	2.00 (1.02)	1.3	1.7	3.4	18.3	40.0	35.3
8. Self-disclosing one's own religious beliefs	1.74 (.87)	0.4	0.8	2.1	11.5	38.5	46.6
12. Having a moment of silence for personal prayer	1.39 (.91)	0.9	1.3	2.1	7.2	8.5	80.0
11. Reading/reciting religious scripture	1.31 (.71)	0.4	0.9	0.4	3.8	17.0	77.4
13. Allowing a group member to lead in-session vocal prayer	1.26 (.74)	0.4	1.3	1.3	1.7	11.5	83.8
14. Leading in-session vocal prayer	1.12 (.47)	0	0.4	0.9	0.9	6.0	91.9

Note: *N* = 235. Items ranked from most to least frequently used. Item numbers refer to the order they were presented to participants. 6 = *almost always*, 5 = *very often*, 4 = *fairly often*, 3 = *occasionally*, 2 = *rarely*, 1 = *never*.

Barriers to addressing spirituality in group therapy. The means and standard deviations of the items assessing perceived barriers to addressing spirituality in group therapy were also calculated and reported in Table 3. There was high agreement with the statement, "Spirituality is an important component of diversity" (M = 5.05; SD = 1.14). From the ratings on the items that could be viewed as measuring worries about attending to spirituality in group therapy (i.e., items # 3, 7, 8, 10, 11), it appears that on average group therapists do not experience these types of uncertainties (e.g., "I worry that conflict among group members might arise if spiritual issues were discussed in group therapy"). The two items that assessed confidence in attending to spirituality (i.e., "I have enough training to effectively address spirituality in group therapy" and "I feel confident in my ability to address spirituality in group therapy") had mean scores of 4.56 (SD = 1.27) and 4.89 (SD = 1.15), respectively. This indicates that, on average, participants found these statements to be somewhat to mostly true for them.

Main Analyses

Descriptive statistics for the STI, RCI, and all the measures created for this study are presented in Table 4.

Hypothesis 1: The measures will be correlated. Perceived appropriateness of religious and spiritual interventions, self-reported use of religious and spiritual interventions, self-reported in-session reactions to spiritual discussions, therapists' spirituality, and therapists' religious commitment were hypothesized to be positively correlated with one another. These measures were expected to be negatively correlated with perceived barriers to addressing spirituality in group therapy. Pearson correlations were conducted to examine this set of hypotheses. Because 15 hypotheses were tested, a Bonferroni adjustment was utilized with an

Table 3

Descriptive Statistics for Barriers to Addressing Spirituality Items.

Item	*M* (*SD*)	% Selecting Each Rating					
		6	5	4	3	2	1
1. Spirituality is an important component of diversity.	5.05 (1.14)	45.0	28.8	20.0	1.7	2.1	2.5
12. I feel confident in my ability to address spirituality in group therapy.	4.89 (1.15)	33.5	40.2	15.9	5.0	3.3	2.1
9. I believe clients can benefit from the discussion of spirituality in group therapy.	4.57 (1.17)	25.0	28.3	32.9	7.5	4.6	1.7
6. I have enough training to effectively address spirituality in group therapy.	4.56 (1.27)	23.8	38.1	20.1	9.2	5.9	2.9
4. Group therapy can be an effective place for a client to work on issues related to spirituality.	4.50 (1.17)	21.3	31.7	31.3	8.3	6.3	1.3
7. I worry that some group members might feel left out if spirituality were discussed in group therapy.	2.98 (1.38)	5.0	9.1	23.2	18.7	29.9	14.1
3. I worry about how other group members might react to discussions related to spirituality.	2.96 (1.31)	3.3	6.7	29.2	20.0	25.4	15.4
5. Spiritual concerns are better dealt with in individual therapy.	2.69 (1.30)	1.7	10.4	13.3	24.1	31.5	19.1
2. I prefer NOT to address issues related to spirituality in group therapy.	2.53 (1.38)	1.7	9.7	14.8	17.3	26.6	29.6
8. I fear I might impose my own values on clients if I addressed spirituality in group therapy.	2.47 (1.34)	1.7	6.6	17.8	13.7	31.5	28.6
11. I worry that conflict among group members might arise if spiritual issues were discussed in group therapy.	2.27 (1.19)	1.2	3.3	12.9	16.6	35.7	30.3
10. I feel uncertain about what to do when spirituality is brought up in group therapy.	2.05 (1.08)	0.4	1.7	10.0	15.8	33.3	38.3

Note: *N* = 241. Items ranked from most to least true. Item numbers refer to the order they were presented to participants. 6 = *completely true*, 5 = *mostly true*, 4 = *somewhat true*, 3 = *somewhat untrue*, 2 = *mostly untrue*, 1 = *completely untrue.*

Table 4

Descriptive Data of Continuous Study Variables.

Variable	*n*	*M*	*SD*	*Median*	*Range*
Appropriateness (PARSIS)	242	35.10	12.01	35	13-72
Use (URSIS)	235	23.51	8.42	23	12-61
Barriers (BASS)	241	27.45	8.79	28	11-54
Reactions (RSDS)	242	62.40	10.72	64	26-77
Spirituality (STI)	241	32.56	11.29	34	8-48
Religiosity (RCI)	241	22.09	11.42	18	10-50
Training in R/S	239	3.16	2.38	3	0-13

Note: PARSIS = Perceived Appropriateness of Religious and Spiritual Interventions Scale. URSIS = Use of Religious and Spiritual Interventions Scale. BASS = Barriers to Addressing Spirituality Scale. RSDS = Reactions to Spiritual Discussions Scale. STI = Spiritual Transcendence Index. RCI = Religious Commitment Inventory.

adjusted alpha level of .003 (.05/15). Results of the Pearson correlations are presented in Table 5. First, it is important to note that therapists' spirituality and religious commitment were moderately correlated (r = .61), as was expected. The correlation was not so high, however, as to indicate a singular construct. Examining a scatter plot of the two measures demonstrated that participants could largely be categorized into three groups. First, there were participants who scored low on both measures (i.e., they were neither spiritual nor religious). Second, there were participants who scored high on the STI but low on the RCI (i.e., they were spiritual but not religious). Third, there were participants who scored high on

Table 5

Correlations among Study Measures and Selected Demographic Variables.

	Variable	1	2	3	4	5	6	7	8	9
1	Appropriateness (PARSIS)	--								
2	Use (URSIS)	.78**	--							
3	Barriers (BASS)	-.31**	-.25**	--						
4	Reactions (RSDS)	.18*	.20**	-.53**	--					
5	Spirituality (STI)	.47**	.48**	-.35**	.23**	--				
6	Religiosity (RCI)	.29**	.35**	-.05	.13*	.61**	--			
7	Age	-.23**	-.06	.02	.07	-.09	.00	--		
8	Sex	-.04	-.04	.08	-.17*	.14*	.02	-.06	--	
9	Training in R/S	.36**	.38**	-.27**	.20**	.35**	.31**	-.11	.00	--
10	Spiritual group	.22**	.35**	-.19**	.19**	.48**	.25**	.04	.04	.33**

Note: *$p < .05$ **$p < .003$ PARSIS = Perceived Appropriateness of Religious and Spiritual Interventions Scale. URSIS = Use of Religious and Spiritual Interventions Scale. BASS = Barriers to Addressing Spirituality Scale. RSDS = Reactions to Spiritual Discussions Scale. STI = Spiritual Transcendence Index. RCI = Religious Commitment Inventory. Sex: 0 = male, 1 = female. Spiritual group: 0 = have not led a spiritual issues group, 1 = have led a spiritual issues group.

both measures (i.e., they were both spiritual and religious). Of course, there were also some participants who fell in the midrange of both scales.

As expected, most of the remaining measures also significantly correlated with one another. There was a strong positive correlation (.78) between perceived appropriateness of religious and spiritual interventions and self-reported use of those interventions, which was evidenced in the examination of the individual items above. The more appropriate participants found the religious and spiritual interventions to be, the more frequently they reported using them. Contrary to expectation, there was only a minimal relationship between therapists' religious commitment and their reactions to in-session discussions of spirituality (.13), which did not reach significance after the Bonferroni correction. There was also no relationship between therapists' religious commitment and perceived barriers to addressing spirituality. In addition, the correlation between perceived appropriateness of religious and spiritual interventions and reactions to in-session discussions of spirituality was not significant at the .003 level.

In addition to the hypothesized correlations, Table 5 also includes demographic variables that were correlated with at least one of the study measures. Multiple demographic variables were included in bivariate correlation analyses with the main study variables. Only those that were significantly correlated with at least one dependent variable at an alpha level of .05 were included in the correlation matrix. These demographic variables were included in regression analyses if they correlated with the criterion variable for that analysis.

Standardizing variables for regression analyses. Following the procedures recommended by Aiken and West (1991) and Frazier, Tix, and Barron (2004), the continuous predictor variables were standardized. This reduces the multicollinearity when creating

interaction terms. In addition, standardizing the remaining continuous predictor variables not associated with the interaction allows for more meaningful analysis of a significant interaction effect because setting the other predictor variables to zero is the same as setting them to their mean. The interaction term for these regression analyses was calculated by multiplying the standardized STI scores by the standardized RCI scores. The two categorical predictor variables (sex and experience conducting a spiritual group) were dummy coded.

Hypothesis 2: Predictors of appropriateness and use of interventions. To examine whether therapists' spirituality and religious commitment predicted their perceived appropriateness of religious and spiritual interventions, a hierarchical linear regression was conducted with PARSIS score as the criterion variable. Because PARSIS was found to be significantly correlated with training in religion/spirituality (R/S), whether participants had conducted a spiritual issues group, and age, these variables were entered in Step 1 as control variables. STI and RCI scores were entered in Step 2. Finally, the interaction between STI and RCI was entered in Step 3. The model at Step 1 was significant, $R^2 = .205$, F (3, 227) = 19.53, $p < .001$ (see Table 6). The more training in religion/spirituality participants had, the more appropriate they found the interventions to be ($B = 4.05$, $SE = .75$). The older participants were, the less appropriate they found the interventions to be ($B = -2.48$, $SE = .70$). Having led a spiritual issues group was not a significant predictor of perceived appropriateness.

The model at Step 2 was significant, $R^2 = .320$, F (5, 225) = 21.21, $p < .001$, as was the change in R^2, $\Delta R^2 = .115$, F (2, 225) = 19.06, $p < .001$. Amount of training in R/S and age remained significant predictors. STI was also a significant predictor of perceived appropriateness ($B = 4.39$, $SE = .86$), but RCI was not.

Table 6

Results of Hierarchical Linear Regression Predicting Perceived Appropriateness of Religious and Spiritual Interventions (PARSIS).

Predictor	R^2	ΔR^2	*B*	*B* 95% CI	*SE*	β	*t*
Step 1	.205**	.205**					
Training in R/S			4.05	[2.58, 5.53]	.75	.34	5.42**
Spiritual Group			2.49	[-1.18, 6.16]	1.86	.09	1.34
Age			-2.48	[-3.86, -1.10]	.70	-.21	-3.53**
Step 2	.320**	.115**					
Training in R/S			2.69	[1.25, 4.13]	.73	.23	3.68**
Spiritual Group			.55	[-2.93, 4.03]	1.77	.02	.31
Age			-2.14	[-3.43, -.84]	.66	-.18	-3.26**
STI			4.39	[2.69, 6.09]	.86	.37	5.09**
RCI			.05	[-1.59, 1.69]	.83	.004	.06
Step 3							
Training in R/S	.306**	.004	2.72	[1.28, 4.16]	.73	.23	3.72**
Spiritual Group			.54	[-2.94, 4.02]	1.77	.02	.30
Age			-2.18	[-3.47, -.88]	.66	-.19	-3.31**
STI			4.83	[2.96, 6.70]	.95	.41	5.09**
RCI			-.61	[-2.63, 1.41]	1.03	-.05	-.60
STI x RCI			.97	[-.75, 2.70]	.88	.08	1.11

Note: $N = 231$. $^{**}p < .001$ STI = Spiritual Transcendence Index. RCI = Religious Commitment Inventory. Spiritual Group: 0 = have not led a spiritual issues group, 1 = have led a spiritual issues group.

Finally, the overall model in Step 3 was also significant, $R^2 = .324$, F (6, 224) = 17.90, $p < .001$, but the change in R^2 was not, $\Delta R^2 = .004$, F (1, 224) = 1.233, $p = .268$. Amount of training in R/S, age, and STI remained significant predictors, but the STI x RCI interaction was not a significant predictor. Thus, it appears there is not an interaction between

STI and RCI and that only STI, and not RCI, scores uniquely predict perceived appropriateness of these interventions after controlling for the effects of training in R/S, whether participants had led a spiritual issues group, and age.

STI and RCI were also hypothesized to predict participants' use of the religious and spiritual interventions, as measured by the URSIS. A hierarchical linear regression was conducted to test these hypothesized predictors. Perceived appropriateness of the interventions was included in Step 1 in order to control for the variance in use accounted for by how appropriate participants found the interventions to be. This provided for a more focused examination of the extent to which therapists' spirituality and religious commitment predicted use of interventions that is above and beyond the relationships spirituality and religious commitment have with perceived appropriateness of those interventions. Amount of training in R/S and whether participants had led a spiritual issues group were also entered in Step 1 because they were correlated with URSIS. STI and RCI scores were entered in Step 2, and the interaction between STI and RCI was entered in Step 3.

The model for Step 1 was significant, $R^2 = .664$, F (3, 226) = 148.57, $p < .001$ (see Table 7). Having led a spiritual issues group ($B = 3.74$, $SE = .85$) and perceived appropriateness of the interventions ($B = 6.15$, $SE = .35$) were both significant predictors of use, but training in R/S was not. The overall model in Step 2 was significant, $R^2 = .671$, F (5, 224) = 91.39, $p < .001$, but the change in R^2 was not, $\Delta R^2 = .007$, F (2, 224) = 2.552, $p = .080$. Having led a spiritual issues group and perceived appropriateness of the interventions remained significant predictors, but the new variables (STI and RCI) did not account for any unique variance.

Table 7

Results of Hierarchical Linear Regression Predicting Use of Religious and Spiritual Interventions (URSIS).

Predictor	R^2	ΔR^2	*B*	*B* 95% CI	*SE*	β	*t*
Step 1	.664**	.664**					
Training in R/S			.46	[-.25, 1.17]	.36	.06	1.27
Spiritual Group			3.74	[2.07, 5.42]	.85	.18	4.41**
PARSIS			6.15	[5.46, 6.83]	.35	.73	17.63**
Step 2	.671**	.007					
Training in R/S			.30	[-.43, 1.01]	.37	.04	.79
Spiritual Group			3.43	[1.75, 5.12]	.85	.17	4.02**
PARSIS			5.87	[5.13, 6.62]	.38	.70	15.55**
STI			.46	[-.43, 1.34]	.45	.05	1.02
RCI			.48	[-.33, 1.29]	.41	.06	1.18
Step 3	.682**	.011*					
Training in R/S			.34	[-.38, 1.05]	.36	.04	.93
Spiritual Group			3.39	[1.73, 5.05]	.84	.16	4.03**
PARSIS			5.83	[5.10, 6.56]	.37	.70	15.64**
STI			1.02	[.06, 1.98]	.49	.12	2.10*
RCI			-.31	[-1.29, .67]	.50	-.04	-.63
STI x RCI			1.17	[.33, 2.01]	.43	.13	2.74*

Note: $N = 230$. $^*p < .05$ $^{**}p < .001$
PARSIS = Perceived Appropriateness of Religious and Spiritual Interventions Scale. STI = Spiritual Transcendence Index. RCI = Religious Commitment Inventory. Spiritual Group: 0 = have not led a spiritual issues group, 1 = have led a spiritual issues group

The overall model at Step 3 was significant, $R^2 = .682$, F (6, 223) = 79.63, $p < .001$, as was the change in R^2, $\Delta R^2 = .011$, F (1, 223) = 7.52, $p = .007$. Having led a spiritual issues group and perceived appropriateness of the interventions remained significant predictors. In

this model, STI (*B* = 1.02, *SE* = .49) was also a significant unique predictor. The interaction between STI and RCI was also significant (*B* = 1.17, *SE* = .43).

In order to demonstrate how this interaction works, RCI was selected as the moderator variable. From between STI and RCI was also significant (*B* = 1.17, *SE* = .43). In order to demonstrate how this interaction works, RCI was selected as the moderator variable. From Step 3 of the regression model, the portion of the unstandardized regression equation pertinent to the interaction is (training in R/S, whether participants had led a spiritual issues group, and perceived appropriateness were set to zero):

URSIS = 21.98 - .31(RCI) + 1.02(STI) + 1.17(Interaction).

This equation can be algebraically rearranged as:

URSIS = (1.02 + 1.17[RCI])(STI) + (-.312[RCI] + 21.98)

With this rearranged equation, specific RCI values can be inserted to determine the slope of STI and the y-intercept at varying levels of religious commitment (Cohen & Cohen, 1983). Because the predictor variables were standardized, RCI values of -1, 0, and 1 are 1 standard deviation below the mean, the mean, and 1 standard deviation above the mean in this sample. When RCI equals -1, the slope of STI is -.15 with a y-intercept of 22.29. When RCI equals 0, the slope of STI is 1.02 with a y-intercept of 21.98. When RCI equals 1, the slope of STI is 2.19 with a y-intercept of 21.67. Thus, the interaction suggests that for individuals with low religious commitment, there is not a relationship between spirituality and use of religious and spiritual interventions. For individuals with medium to high religious commitment, there is a positive relationship between spirituality and use of the interventions, with a stronger relationship at higher levels of religious commitment.

Hypothesis 3: Predictors of barriers to addressing spirituality. To examine the third hypothesis, that those with less spirituality would perceive greater barriers regardless of training, a hierarchical linear regression was conducted with BASS score as the criterion variable. Training in R/S and whether participants had led a spiritual issues group were entered in Step 1 because they correlated with BASS. STI and RCI scores were entered in Step 2, and the interaction between STI and RCI was entered in Step 3. The model at Step 1 was significant, $R^2 = .085$, F (2, 233) = 10.79, $p < .001$ (see Table 8). More training in R/S (B = -1.99, SE = .58) and having led a spiritual issues group (B = -2.72, SE = 1.45) significantly predicted lower perceived barriers to addressing spirituality in group therapy.

At step 2, the overall model was significant, $R^2 = .221$, F (4, 231) = 16.35, $p < .001$, as was the change in R^2, $\Delta R^2 = .136$, F (2, 231) = 20.14, $p < .001$. Amount of training in R/S remained a significant predictor, but experience leading spiritual issues groups did not. Both STI (B = -4.20, SE = .67) and RCI (B = 2.82, SE = .65) were significant predictors of perceived barriers. Higher spirituality predicted lower perceived barriers, whereas higher religious commitment predicted greater perceived barriers.

At Step 3, the overall model was again significant, $R^2 = .223$, F (5, 230) = 13.21, $p < .001$, but there was no significant change in R^2, $\Delta R^2 = .002$, F (1, 230) = .80, $p = .401$. Amount of training in R/S, STI, and RCI remained significant predictors, but the STI x RCI interaction was not significant.

Table 8

Results of Hierarchical Linear Regression Predicting Barriers to Addressing Spirituality in Group Therapy (BASS).

Predictor	R^2	ΔR^2	*B*	*B* 95% CI	*SE*	β	*t*
Step 1	.085**	.085**					
Training in R/S			-1.99	[-3.14, -.84]	.58	-.23	-3.41**
Spiritual Group			-2.72	[-5.57, .14]	1.45	-.12	-1.88
Step 2	.221**	.136**					
Training in R/S			-1.45	[-2.57, -.33]	.57	-.16	-2.55*
Spiritual Group			-2.16	[-4.85, .53]	1.37	-.10	-1.58
STI			-4.20	[-5.53, -2.88]	.67	-.47	-6.26**
RCI			2.82	[1.54, 4.11]	.65	.32	4.33**
Step 3	.223**	.002					
Training in R/S			-1.46	[-2.58, -.34]	.57	-.17	-2.57*
Spiritual Group			-2.12	[-4.81, .58]	1.37	-.10	-1.55
STI			-4.47	[-5.94, -3.01]	.74	-.50	-6.01**
RCI			3.22	[1.64, 4.80]	.80	.37	4.01**
STI x RCI			-.58	[-1.95, .78]	.69	-.06	-.84

Note: $N = 236$. $*p < .05$ $**p < .001$ STI = Spiritual Transcendence Index. RCI = Religious Commitment Inventory. Spiritual Group: 0 = have not led a spiritual issues group, 1 = have led a spiritual issues group.

Hypothesis 4: Predictors of reactions to spiritual discussions. In order to examine the fourth hypothesis that in-session reactions to spiritual discussions would be predicted by therapists' level of spirituality, a hierarchal linear regression was conducted with RSDS score as the criterion variable. Because amount of training, whether participants had led a spiritual issues group, and sex were correlated with RSDS score, they were entered in Step 1 as control variables. STI and RCI were entered in Step 2, and the STI x RCI interaction was

entered in Step 3. The model in Step 1 was significant, R^2 = .088, F (3, 221) = 7.09, p < .001 (see Table 9). Amount of training in R/S predicted more positive reactions (B = 1.76, SE = .73) and being female predicted more negative reactions (B = -3.72, SE = 1.38). Having led a spiritual issues group was not a significant predictor.

Table 9

Results of Hierarchical Linear Regression Predicting Self-Reported Reactions to Spiritual Discussions (RSDS).

Predictor	R^2	ΔR^2	B	B 95% CI	SE	β	t
Step 1	.088**	.088**					
Training in R/S			1.76	[.32, 3.19]	.73	.17	2.41*
Spiritual Group			3.30	[-.27, 6.86]	1.81	.13	1.82
Sex			-3.72	[-6.43, -1.01]	1.38	-.17	-2.70*
Step 2	.112**	.025*					
Training in R/S			1.22	[-.29, 2.74]	.77	.12	1.59
Spiritual Group			2.92	[-.65, 6.50]	1.81	.11	1.61
Sex			-4.24	[-6.96, -1.52]	1.38	-.20	-3.07*
STI			2.18	[.37, 3.98]	.92	.20	2.38*
RCI			-.73	[-2.48, 1.02]	.89	-.07	-.82
Step 3	.136**	.023*					
Training in R/S			1.22	[-.28, 2.72]	.76	.12	1.61
Spiritual Group			2.95	[-.58, 6.49]	1.79	.11	1.65
Sex			-3.98	[-6.68, -1.28]	1.37	-.19	-2.91*
STI			3.29	[1.29, 5.29]	1.02	.31	3.24**
RCI			-2.30	[-4.45, -.14]	1.09	-.22	-2.10*
STI x RCI			2.23	[.41, 4.05]	.92	.19	2.41*

Note: N = 225. *p < .05 **p < .001 STI = Spiritual Transcendence Index. RCI = Religious Commitment Inventory. Sex: 0 = male, 1 = female. Spiritual Group: 0 = have not led a spiritual issues group, 1 = have led a spiritual issues group.

The model in Step 2 was also significant, $R^2 = .112$, F (5, 219) = 5.55, $p < .001$, as was the change in R^2, $\Delta R^2 = .025$, F (2, 219) = 3.05, $p = .049$. Sex remained a significant predictor, but training in R/S did not. STI was also a significant predictor ($B = 2.18$, $SE = .92$), but RCI score was not.

Finally, the model in Step 3 was significant, $R^2 = .136$, F (6, 218) = 5.70, $p < .001$, as was the change in R^2, $\Delta R^2 = .023$, F (1, 218) = 5.82, $p = .017$. Sex and STI remained significant predictors. RCI became a unique predictor in this model ($B = -2.30$, $SE = 1.09$). Higher RCI scores predicted more negative reactions. In addition, the STI x RCI interaction was a significant predictor of reactions ($B = 2.23$, $SE = .92$).

In order to demonstrate how the STI x RCI interaction works, RCI was selected as the moderator. From Step 3 of the regression model, the portion of the unstandardized regression equation pertinent to the interaction is (training in R/S, experience leading spiritual issues groups, and sex were set to zero):

RSDS = 62.77 – 2.30(RCI) + 3.29(STI) + 2.23(Interaction)

This equation can be algebraically rearranged as:

RSDS = (3.29 + 2.23[RCI])(STI) + (-2.30[RCI] + 62.77)

With this rearranged equation, specific RCI values can be inserted to determine the slope of STI and the y-intercept at varying levels of religious commitment (Cohen & Cohen, 1983). Because the predictor variables were standardized, RCI values of -1, 0, and 1 are 1 standard deviation below the mean, the mean, and 1 standard deviation above the mean in this sample. When RCI equals -1, the slope of STI is 1.06 with a y-intercept of 65.07. When RCI equals 0, the slope of STI is 3.29 with a y-intercept of 62.77. When RCI equals 1, the slope of STI is 5.52 with a y-intercept of 60.47. Thus, this interaction suggests that as a practitioner has

more religious commitment, there becomes a stronger positive relationship between spirituality and reactions to in-session discussions of spirituality.

Hypothesis 5: Religion and spirituality would be viewed differently. In order to examine whether participants differed in perceived appropriateness and actual use of spiritual versus religious interventions, the five sets of interventions that differed only in the label used (spiritual/spirituality versus religious/religion) were compared using paired samples *t*-tests. Because 10 *t*-tests were conducted, a Bonferroni adjustment was utilized with an adjusted alpha level of .005 (.05/10). The results indicated that participants perceived each spiritual intervention to be more appropriate than its corresponding religious intervention (see Table 10). In addition, participants reported significantly greater use of each spiritual intervention compared to its corresponding religious intervention (see Table 10). Although these differences were small, the results consistently indicated that participants perceived spiritual and religious interventions to be different.

Next, a paired-samples *t*-test was conducted to determine if there were differences in ratings between the single item assessing openness to addressing spirituality (i.e., "To what extent are you open to addressing spirituality in group therapy?") and the single item assessing openness to addressing religion (i.e., "To what extent are you open to addressing religion in group therapy?"). As hypothesized, participants endorsed significantly greater openness to addressing spirituality ($M = 3.81$, $SD = .98$) than they did openness to addressing religion ($M = 3.31$, $SD = 1.11$) in group therapy, $t(241) = 9.92$, $p < .001$. The mean difference between the two topics was .50 (approximately half of one standard deviation) on a 5-point scale, with a 95 percent confidence interval ranging from .40 to .60.

Table 10

Mean Differences in Perceived Appropriateness and Use of Spiritual Interventions Compared to Religious Interventions

Variable	Appropriateness			Use		
	M	95% CI	*SD*	*M*	95% CI	*SD*
Bringing up the topic of spirituality (vs. religion)	.599	[.460-.738]	1.10	.553	[.442-.665]	.87
Facilitating discussion about spirituality (vs. religion) after a group member brings it up	.375	[.278-.472]	.77	.378	[.273-.482]	.81
Asking group members about their spiritual (vs. religious) beliefs	.414	[.282-.546]	1.04	.354	[.260-.448]	.73
Self-disclosing one's own spiritual (vs. religious) beliefs	.326	[.220-.433]	.84	.259	[.175-.342]	.65
Using spiritual (vs. religious) language or concepts	.757	[.606-.908]	1.19	.579	[.462-.696]	.91

Note: Paired samples *t*-tests. Bonferroni adjustment .05/10 = .005. All mean differences significant at $p < .001$. Positive *M*s indicate the spiritual intervention was viewed as more appropriate or used more frequently than the corresponding religious intervention.

Themes regarding openness. After responding to each of the above questions, participants were asked, "For what reason(s) did you select this rating?" The open-ended responses provided by participants were coded into themes. In the first step of this coding process, an undergraduate research assistant grouped responses together according to similar content. This resulted in 20 specific categories (or themes) for spirituality and 26 for religion. In the next step, the research assistant examined the categories for commonalities and combined them into broader, overarching themes. This resulted in 7 themes for spirituality and 9 themes for religion. Finally, the author of this study analyzed the comments more closely using the 7 or 9 themes generated in the second round as a guide. In the final round, participants' responses were allowed to fall into more than one category. Through this process, 8 overarching themes emerged that applied to both the spirituality and the religion question. Many participants provided responses that fell into 2 or 3 categories, which resulted in more comments than participants. The 8 themes are presented in Table 11, along with the percentage of participants' comments categorized into each theme for spirituality and religion. As can be seen in the table, participants more frequently mentioned the therapeutic value of addressing spirituality than they mentioned the therapeutic value of addressing religion. In addition, comments about the potential for negative interactions among group members or unproductive group work were rare regarding spirituality, but were quite frequent regarding religion.

To exemplify the differences in the reasons for openness or lack of openness, responses are provided from participants scoring at each level of openness to addressing spirituality and to addressing religion. Table 12 includes responses to the question about

spirituality. Table 13 includes responses to the question about religion. The themes from Table 11 are included in parentheses within each response.

Table 11

Themes Regarding Openness or Lack of Openness to Addressing Spirituality and Religion in Group Therapy.

	% of Comments (frequency)	
Theme/Category	Spirituality	Religion
1. Should address topics the group brings up.	28.1% (80)	22.0% (63)
2. Important part of one's past and/or current life.	22.1% (63)	17.1% (49)
3. Discussions have therapeutic value.	19.3% (55)	9.4% (27)
4. Training/experience/comfort with the topic.	9.5% (27)	6.3% (18)
5. Need to pay attention to the context/purpose of the discussion.	14.4% (41)	13.2% (38)
6. Potential for negative interactions/ unproductive group work.	2.8% (8)	20.9% (60)
7. Try to focus on related themes/group process.	1.1% (3)	5.6% (16)
8. Not a relevant/appropriate topic for group.	2.8% (8)	5.6% (16)

Note: N = 285 spirituality comments. *N* = 287 religion comments. Percentages were derived by dividing the frequency of comments in each theme (for spirituality and religion separately) by the total number of comments on the topic (spirituality or religion).

Table 12

Sample Responses Explaining Ratings of Openness to Addressing Spirituality at Each Level of Openness Rating.

Level of Openness	Example Responses
Extremely	Spirituality is a key element in human lives (#1). Group therapy is a setting to discuss all areas of our lives and experience. Spirituality should not be off limits (#2). For many people it is central to meaning making and health (#3).
	Spirituality is an important part of one's identity (#2). It can be an access point for assisting patients in doing the "work" of psychotherapy (#3).
Very	I believe that anything that is brought up needs to be worked with, acknowledged, addressed etc. within the frame of group members' comfort and experience of personal safety (#1). The extent of processing a theme depends on where the members are, where the group process is, what goal or purpose the group has etc. and why it is brought up at this particular time and place and by whom (#5). I do not differentiate topics if it is spirituality, religion, politics, or sexual behaviors. Topics are brought up for a reason by members and need to be clinically processed (#1).
	If someone wants to address spirituality as an issue for themselves, I see it as just as relevant as any other issue (#1).
Moderately	I'm open to it IF it's brought up by a group member (#1) and the group agrees to discuss it/explore their feelings about it and reactions to each other (#5).
	While I believe this is a topic that can be most useful and beneficial for the group (#3) I also think it can become a function of the group moving away from issues that are more directly related to their lives and retreat into the more undefined territory of spirituality to hide or evade or avoid (#6).
Slightly	My training and experience are that spirituality can be a powerful and beneficial search but that it belongs in its own special group and not in a psychotherapy group where it can become entangled with various symptoms of group members (#8).
	If "spirituality" -- or any topic -- felt like an emotional retreat/defense, I may not pursue it as much as question why it is important in the moment for that individual or group-as-a-whole (#5).
Not at all	I am open about members bringing up the issue and discuss them. I leave the group discussing it but I don't express my opinions (#1).
	I work with clients from the public sector. Religion is not a fact that should be addressed (#8).

Note: Comments were edited for spelling errors and minor grammatical errors. Numbers in parentheses correspond to the numbered themes provided in Table 11.

Table 13

Sample Responses Explaining Ratings of Openness to Addressing Religion at Each Level of Openness Rating.

Level of Openness	Examples
Extremely	It is high time we move away from the dictum that religion cannot be discussed. As a group therapist, I am interested in what is positive and what is negative in religious experience. A healthy approach for any individual is to be able to distinguish between what was healthy and what was not in their own religious experience. Greater awareness includes awareness about this previously societally forbidden conversation topic (#3).
	Religion is a key aspect of clients' life experience both from family of origin and current life (#2).
Very	Religion is very important in many people's lives (#2). They need to feel able to discuss whatever they need to discuss (#1) to understand their experience. Questions of meaning are key to understanding and emotional balance (#3).
	I'm mostly open but at times have found that patients use religion to avoid dealing with group members/issues (#6).
Moderately	Religious paradigms and early childhood religious propaganda can be limiting to many. Discussing these issues as different from spirituality is often very liberating (#3).
	Religion is an important factor in the lives of many people and has helped shape their experience of themselves in relationship to the world (#2). As such, it warrants being addressed in group therapy. It may also be divisive, or, if used too abstractly, serve as a defense against a more immediate affective experience (#6).
Slightly	Discussions about religion are usually very different than discussions about spirituality. It depends on why the client wants to discuss the topic of religious beliefs (#5). Often, it is used to justify one's treatment of others or an attempt to convert someone else's beliefs to one's own. That is not helpful to the group process (#6).
	I live in a predominantly Christian community, it will come up and we have to be able to address it calmly and openly (#1).
Not at all	It distracts group members from work on the contract or goal that brought them to psychotherapy (#6). If they are on a religious search and not simply wanting to argue or convert others I would refer them to a more appropriate resource (#8).
	I would not ever bring it up. If the group or a member did, I would be inclined to explore it for possible deeper meaning for the group (#7).

Note: Comments were edited for spelling errors and minor grammatical errors. Numbers in parentheses correspond to the numbered themes provided in Table 11.

CHAPTER 5: DISCUSSION

The current study expanded the limited knowledge on the ways in which practitioners attend to religion and spirituality in group therapy. Prior to this study, there was no empirical research that examined the integration of religion and spirituality in group therapy not specifically designed to address these concerns. The current study provided important information about various aspects of religious and spiritual integration in group therapy from the perspective of therapists.

Appropriateness of Religious and Spiritual Interventions

Examining participants' perceived appropriateness of the individual religious and spiritual interventions demonstrated that group therapists vary in their ratings of the appropriateness of these interventions. Participants found it largely appropriate to facilitate discussions of both spirituality and religion when a group member first brings up the topic. Many comments in response to the openness question also revealed support for facilitating such discussions. This is not surprising given that most group therapists would discuss those issues that clients identify as important to them. Interestingly, the interventions of facilitating discussion of religion or spirituality after a group member brings it up did not have the same factor structure as the remaining intervention items. These interventions may not be viewed so much as "intentional interventions" than as responses to the content clients bring to group. Participants also found it to be fairly appropriate to bring up the topics of spirituality and religion. This is a more active intervention than facilitating a discussion after a group member brings it up, but it may still be viewed as more non-directive than the remaining interventions examined in this study.

In contrast, the results indicated that group therapists found explicitly religious interventions, such as praying in session, to be inappropriate. In heterogeneous groups, clients might find these active interventions to be offensive. Using explicitly religious interventions without the expressed consent of all group members would be unethical. Therapists would do well to be wary of employing such interventions in group therapy.

This pattern of results—that interventions that are less explicitly spiritual or religious are viewed as more appropriate—has been found in studies on individual therapy as well (e.g., Jones et al., 1992; Shafranske & Malony, 1990; Wade et al., 2007). In addition, Weinstein and colleagues (2002) found that individual therapists preferred discussions about religious and spiritual topics more than engaging in or suggesting religious or spiritual activities.

The hypothesis that therapists' level of spirituality and religious commitment would predict their perceived appropriateness of religious and spiritual interventions as measured by the PARSIS was only partially supported. Spirituality, but not religious commitment, predicted perceived appropriateness; the more spiritual therapists were, the more appropriate they found the interventions to be. Interestingly, age was found to correlate with perceived appropriateness and was thus included in the regression as a control variable. The results of the regression suggested that the older group practitioners were, the less appropriate they found the interventions to be. One possible explanation for this relationship is that younger therapists may have been trained more recently, during a time when spirituality and religion were viewed as elements of diversity that should be attended to in therapy. Even for those therapists who are older but were trained more recently, growing up in a time when religion

and spirituality were not part of the mental health discussion, nor typically a part of polite conversation, may also influence their present beliefs.

Use of Religious and Spiritual Interventions

This study found that group therapists used religious and spiritual interventions rather infrequently. Some of the interventions, such as reading or reciting religious scripture and allowing a group member to lead in-session vocal prayer, may have a severely limited place in groups not specifically devoted to religious or spiritual issues. Thus, their infrequent use is not surprising and is quite appropriate. However, therapists in this sample, on average, did not commonly engage in even more basic interventions such as bringing up the topics of religion or spirituality or facilitating a discussion about religion or spirituality after a group member brings it up. It is possible, then, that therapists may be missing opportunities to discuss the spiritual aspect of clients' lives, which is an important part of life for many clients (Pew Forum, 2008). Plante (2007) has written about the APA ethical principle of responsibility in the context of religion. Because religion and spirituality are important components of many individuals' lives, mental health practitioners have an ethical responsibility to be aware of and thoughtful about how religion and spirituality influence their clients. When appropriate, practitioners should make attempts to integrate discussions related to religion and spirituality while also attending to the needs of those clients for whom religion and spirituality are not important.

The hypothesis that therapists' level of spirituality and religious commitment would account for unique variance in the use of religious and spiritual interventions (as measured by the URSIS) above and beyond the variance accounted for by previous training in spirituality and their perceived appropriateness of the interventions was only partially supported. When

STI and RCI were entered into the regression equation at the same time, neither variable accounted for unique variance. Interestingly, though, the STI x RCI interaction was a significant predictor. In addition, adding this interaction resulted in STI also being a unique predictor. Examining this relationship further, it was concluded that there was not a significant relationship between spirituality and use of the interventions when religious commitment was low. When religious commitment was high, however, there was a stronger positive relationship between spirituality and use of the interventions. Thus, it may be only those practitioners who are both spiritual and religious who utilize religious and spiritual interventions on a fairly regular basis.

Barriers to Addressing Spirituality in Group Therapy

Group therapists in this study reported, on average, low levels of perceived barriers to addressing spirituality in group therapy. The barriers included in the BASS were selected from the literature on the use of religion in individual therapy and the general literature on group therapy. It is possible these barriers actually are not salient for group therapists. Another possibility, however, is that therapists in this sample did not report these barriers as salient because of their high level of experience. The average therapist in this sample had been working as a mental health professional for 25.1 years. Even though amount of time spent working as a mental health professional was not significantly correlated with barriers as measured by the BASS, this relationship may have emerged had more inexperienced therapists been included in the sample. Ninety-one percent of the sample had at least 10 years of experience, which is likely enough time to work through many of the barriers that may be more common among new therapists who have little experience handling the topic of religion and spirituality in group therapy.

The hypothesis that spirituality—but not religious commitment—would predict barriers to addressing spirituality in group therapy was only partially supported. Higher spirituality did predict fewer perceived barriers. Contrary to what was expected, religious commitment was also a significant predictor, although in a direction that at first seemed counterintuitive; higher religious commitment was predictive of greater perceived barriers. Because of this result, the relationship between religious commitment and barriers was explored in further depth. There was no zero order correlation between religious commitment and barriers and it was confirmed that in a bivariate regression analysis, religious commitment did not predict perceived barriers. However, when spirituality was entered into the regression equation, religious commitment predicted greater perceived barriers. This suggests an instance of suppression. As others have suggested (e.g., Hill et al., 2000), religion and spirituality often co-occur together. In the regression model, however, religious commitment was used as a predictor after controlling for variance due to spirituality. Thus, it appears that commitment to organized religion, after removing one's level of spirituality attached to that religious commitment, is actually related to greater perceived barriers to addressing spirituality in group therapy. This may be especially true for therapists whose belief system is different from that of most of their clients, although this hypothesis would need to be explored in future research.

Reactions to In-Session Discussions about Spirituality

The RSDS, which was created to measure self-reported in-session reactions to spiritual discussions, did not have the factor structure it was designed to have. Half of the items were created to measure general comfort and the other half were designed to measure perceived competence. Principal components analysis revealed one main factor, with the

qualified—unqualified dichotomy also loading on a second factor (this item was then removed from the RSDS). This was the one item that had the most variability, which may have led to it loading on a second factor. Overall, therapists in this sample reported high levels of comfort and perceived competence during these discussions. Once again, these results may have been different had the sample included therapists-in-training or relatively new therapists.

The hypothesis that therapists' spirituality would account for unique variance in reactions above and beyond those accounted for by training in religion and spirituality was supported. Greater spirituality did predict more positive reactions. The hypothesis that there would be no significant difference in reactions between those who were spiritual but not religious and those who are spiritual and religious was not supported. In the full regression model, religious commitment was a negative predictor of reactions. In addition, the STI x RCI interaction was significant. Upon examining this interaction, it was determined that the positive relationship between therapists' spirituality and their in-session reactions became stronger as therapists' religious commitment increased. Previous research on individual and group therapy has not examined in-session reactions to spiritual discussions, so this result cannot be compared to other findings. What these results suggest, however, is that having high religious commitment has a weak negative relationship with reactions to spiritual discussions. Yet, being both religious and spiritual strongly predicts positive reactions. With low religious commitment, however, there is only a weak positive relationship between spirituality and reactions. Perhaps because the general population typically experiences religion and spirituality together (Hill et al., 2000), the spiritual discussions of clients often occur within the context of a religious faith tradition. These discussions may fit most closely

with the experiences of practitioners who are both religious and spiritual, whereas they may be inconsistent for practitioners who are spiritual but not religious or religious but not very spiritual. This consistency or inconsistency with personal experience may be the driving force underlying their reactions to such discussions.

Perceived Differences Between Religion and Spirituality

The results of this study showed that group practitioners did distinguish between the concepts of religion and spirituality. This was demonstrated in several ways. First, participants in this study rated spiritual interventions as more appropriate to use in group therapy compared to religious interventions. Although this distinction has not been examined frequently in the literature, a study of marriage and family therapists (Carlson et al., 2002) found the same pattern of results—spiritual interventions were viewed as more appropriate than religious interventions. The exception in that study was that there was no difference in perceived appropriateness between asking about spirituality and asking about religion. That difference was present in the current study.

The second demonstration of the perceived differences between religion and spirituality was that participants used the spiritual interventions more frequently than they used the religious interventions. Third, therapists reported being more open to addressing spirituality in group therapy than they reported being open to addressing religion in group therapy. The comments participants provided to explain their level of openness were also illuminating in terms of the perceived differences between religion and spirituality. Participants were more likely to mention the therapeutic value of addressing spirituality, whereas they were more likely to mention the potential negative consequences of addressing religion.

The distinction therapists made between religion and spirituality highlights the care researchers should take when examining this topic. Simply referring to a combined religion/spirituality or utilizing only one of the terms may influence the results of the study. This may have occurred in the current study for the results on barriers and in-session reactions because only the term *spirituality* was utilized. This was done for two reasons. First, it reduced the number of questions asked. Second, in this study spirituality was defined as a broader construct that could also include religion. Despite providing the definitions of religion and spirituality, participants may not have relied heavily on these definitions when answering questions. Had the term *religion* been used in place of spirituality, participants may have reported more barriers and less positive in-session reactions, especially given the comments some participants provided about their lack of openness to addressing religion.

Implications

A consistent finding in this study was that practitioners' degree of spirituality—and sometimes religious commitment—was related to how they handled the topics of religion and spirituality in group therapy. This suggests that practitioners may rely on their own personal experiences to determine the extent to which they attend to religion and spirituality in group therapy. Depending on therapists' degree of spirituality and religious commitment, then, this reliance on personal experiences as a guide could result in overutilization of spiritually-oriented interventions by some therapists and underutilization by others. It might not be the clients' needs, but rather the therapists' preferences, that determine how religion and spirituality are addressed in group therapy. This can be detrimental to clients on both ends of the spectrum. On the one hand, highly spiritual or religious clients may feel that an important

part of their life is being ignored. On the other hand, non-spiritual or non-religious clients may feel uncomfortable with a therapist who places emphasis on religion or spirituality.

In addition, practitioners should not rely on their own spirituality or religion as a main source of competence on the subject. Personal experience is not viewed as an adequate source of competence for factors such as ethnicity, race, and sexual orientation and should also not be considered adequate for competence in religion and spirituality (Gonsiorek, Richards, Pargament, & McMinn, 2009). Without appropriate professional training in the subject, however, practitioners are likely to rely on those personal experiences as a guide, a practice that would not be considered ethical by many. This highlights the need for greater attention to clients' religion and spirituality in training programs and continuing education courses. Practitioners need these sources of training in order to establish professional competence in attending to clients' religion and spirituality.

This study also found infrequent use of religious and spiritual interventions. As indicated earlier, several of the interventions examined in this study have a very limited place in group therapy and may not be ethical in all group therapy contexts. Thus, the rare use of those interventions was an expected finding. However, the results also indicate that many therapists infrequently utilize interventions such as bringing up the topic of religion/spirituality or facilitating a discussion about religion/spirituality after a client first brings it up. Once again, clients may be missing out on an important treatment component if practitioners are avoiding such discussions. Clients may be unsure whether they can approach religion and spirituality in therapy (Leach et al., 2009), so if practitioners are also avoiding the subject, the topic may be completely overlooked. Perceiving barriers to addressing spirituality would likely influence use of religious and spiritual interventions, but

therapists in this sample reported relatively low levels of perceived barriers. Other factors, then, may be involved in therapists' overall infrequent use of the interventions.

For example, it is quite possible that many practitioners have negative perceptions about spirituality, especially within the context of religion. Some of these negative perceptions about religion were revealed in participants' open-ended responses regarding their openness or lack of openness to addressing religion. Not only would these negative perceptions limit the attention paid to religion and spirituality within group therapy, but they could also be detrimental to clients. If therapists cannot manage their personal biases, religious clients might feel disparaged or ostracized. In order to minimize this possibility, training once again becomes important. Practitioners need to become aware of their personal beliefs and biases and learn ways to prevent those biases from harming clients. In addition, therapists should identify situations in which they should refer clients to appropriate resources, such as clergy or therapists who practice from a religious perspective. Establishing collaborative relationships with clergy members could be helpful when working with religious clients (McMinn, Aikins, & Lish, 2003).

Limitations

The sample in this study was skewed toward practitioners with low religious commitment. Although this was not surprising given that other researchers have found mental health professionals to score low on religiosity (e.g., Delaney et al., 2007), it may have limited the predictive ability of the RCI. Had therapists with a wider range of religious commitment been sampled, some of the results may have been different. Therapists' level of spirituality, as measured by the STI, was found to be a significant predictor in most of the regression analyses. It is difficult to know whether it truly is a better predictor or whether it

accounted for more variance simply because there was a greater range in participants' responses on that measure. In addition, the STI and RCI were moderately correlated. Thus, including the two scales simultaneously in the regression equations likely reduced the variability accounted for by each measure because they both controlled for the variability of the other.

A second limitation is that prior to data collection it was not known that individuals outside the United States were included in AGPA membership. Because of this lack of knowledge, a question was asked about participants' residence within the United States with no option of indicating international residence. Fourteen participants included in the data analysis did not answer this question. It is assumed that some of these individuals were not from the United States, but there is no way to know for certain. It is also possible that some individuals answered the residence question for their own country, rather than for the U.S. Due to this oversight, region was not used as a possible demographic variable of interest. Means and standard deviations of all the scales were conducted with the participants not responding to the residence question removed. The descriptive data did not change. However, because it cannot be determined which individuals were from the U.S., the generalizability to U.S. group therapists is somewhat threatened. Attending to religion and spirituality in other countries may be different than attending to it in the United States.

The low response rate for this study is another limitation. Those who participated may have differed from those who did not participate. Although it is encouraging to see that the sample was not biased toward those with high levels of spirituality or religious commitment or toward those interested in the topic of religion and spirituality in therapy, there may be other ways in which this sample is biased that were not measured in this study.

In addition to the potential bias introduced by the low response rate, the selection procedures resulted in a sample that was highly experienced. Only certain membership categories of AGPA were selected for this study in order to ensure that participants actually had experience working with groups. This successfully provided a sample of practitioners who had worked as group therapists for some time and who had experiences with the questions being asked. Because of the membership categories used, however, there were very few participants who had been working as mental health professionals for only a few years. Some of the results may have differed if participants with a wider range of experience had been sampled.

A major limitation of the current study is that there was a lack of validated measures on the topic of spirituality in group therapy. Established scales were used to measure participants' level of spirituality and religious commitment. However, the remaining measures were created specifically for this study. Both principal components analysis and measures of internal consistency suggested the items measured a single concept reliably. Still, these measures have not been validated and the factor structure has not been replicated in other samples. Therefore, the conclusions must be considered tentative until the measures can be further validated.

Another limitation is that all the measures were self-report. Much of the study examined perceptions about attending to religion and spirituality in group therapy, which can arguably be most accurately measured through self-report. However, the research questions about actual use of religious and spiritual interventions in group therapy and reactions to spiritual discussions can only be partially answered through self-report. Other methods of

data collection should be utilized to examine these areas in more depth and perhaps with greater accuracy.

Directions for Future Research

The current study has begun to fill the gap in knowledge about the use of religion and spirituality in group therapy. There is still much to be explored regarding this topic, however. In order to overcome some of the limitations of the current study, future researchers should strive to select from a wide range of religious commitment and degree of spirituality. Researchers could also examine whether therapists' faith tradition influences their openness to addressing religion and spirituality in group therapy. Therapists who have congruence between their own faith tradition and the traditions of group members may be more open to spiritual discussions compared to therapists who experience incongruence. In addition, future researchers should examine this topic with therapists who have a broader range of experience to examine whether the results differ according to level of experience.

This topic could also be explored very effectively through qualitative methods. Researchers could use focus groups or qualitative interviews to better grasp therapists' experiences with handling the topic of religion and spirituality in group therapy. For example, it could lead to a better understanding of the religious and spiritual interventions included in this study. It is likely that participants utilized those interventions in different ways. It is also possible that therapists use interventions other than those included in this study. Therapists' reactions to spiritual discussions may also be better examined through qualitative methods. Having therapists respond on a 1 to 7 scale about their various reactions to spiritual discussions is quite different than talking with therapists about their reactions after they have just facilitated a group in which the topic of spirituality came up. The

knowledge gained through qualitative inquiries may even lead to the development of better measures of therapists' perceptions regarding the use of spirituality in group therapy, as well as barriers to addressing spirituality in group therapy.

Researchers should also attempt to identify other factors that might influence therapists' perceived appropriateness of religious and spiritual interventions, barriers to addressing spirituality in group therapy, and in-session reactions to such discussions because the regression models predicting these variables left a large amount of variance unaccounted for. Thus, researchers are encouraged to identify and test additional factors that may influence therapists' attention to religion and spirituality in group therapy.

Finally, the research questions examined in this study should not be examined only from the perspective of group practitioners. Instead, researchers should also examine clients' perceptions of the use of religion and spirituality in group therapy. Previous research has demonstrated that clients are open to discussing spirituality in individual therapy (Rose et al., 2001). Yet, group therapy clients may have different preferences due to the nature of group therapy.

As these more fundamental questions become answered by future studies, researchers can begin developing guidelines for the integration of religion and spirituality in group therapy that actually have an empirical basis. Training programs and continuing education courses can also begin addressing some of the barriers to attending to religion and spirituality in therapy in general and group therapy in particular. Perhaps as practitioners receive more training and guidance in how to address clients' religious and spiritual concerns, this aspect of clients' life that is often fundamental to their functioning and well-being will be more successfully attended to in the treatment process.

CHAPTER 6: REFERENCES

Aiken, L., & West, S. G. (1991). *Multiple regression: Testing and interpreting interactions.* Newbury Park, CA: Sage.

American Counseling Association. (1995). *Ethical standards.* Alexandria, VA: Author.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychological Association. (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47*, 1597-1611.

American Psychological Association. (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist, 48*, 45-48.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*, 1060-1073.

Ball, R. A., & Goodyear, R. K. (1991). Self-reported professional practices of Christian psychologists. *Journal of Psychology and Christianity, 10*, 144-153.

Bergin, A. E., & Jensen, J. P. (1990). Religiosity of psychotherapists: A national survey. *Psychotherapy, 27*, 3-7.

Brabender, V. A., Fallon, A. E., & Smolar, A. I. (2004). *Essentials of group therapy.* Hoboken, NJ: John Wiley & Sons.

Brawer, P. A., Handal, P. J., Fabricatore, A. N., Roberts, R., & Wajda-Johnston, V. A. (2002). Training and education in religion/spirituality within APA-accredited clinical psychology programs. *Professional Psychology: Research and Practice, 33*, 203-206.

Carlson, T. D., Kirkpatrick, D., Hecker, L., & Killmer, M. (2002). Religion, spirituality, and marriage and family therapy: A study of family therapists' beliefs about the appropriateness of addressing religious and spiritual issues in therapy. *American Journal of Family Therapy, 30,* 157-171.

Chappelle, W. (2000). A series of progressive legal and ethical decision-making steps for using Christian spiritual interventions in psychotherapy. *Journal of Psychology and Theology, 28,* 43-53.

Cohen, J., & Cohen, P. (1983). *Applied multiple regression/correlation analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates.

Cole, B. S. (2005). Spiritually-focused psychotherapy for people diagnosed with cancer: A pilot outcome study. *Mental Health, Religion & Culture, 8,* 217-226.

Cole, B., & Pargament, K. (1999). Re-creating your life: A spiritual/psychotherapeutic intervention for people diagnosed with cancer. *Psycho-Oncology, 8,* 395-407.

Corey, G. (2008). *Theory and practice of group counseling* (7th ed.). Belmont, CA: Thomson Brooks/Cole.

Delaney, H. D., Miller, W. R., & Bisonó, A. M. (2007). Religiosity and spirituality among psychologists: A survey of clinician members of the American Psychological Association. *Professional Psychology: Research and Practice, 5,* 538-546.

DeLucia-Waack, J. L., & Donigian, J. (2004). *The practice of multicultural group work: Visions and perspectives from the field.* Belmont, CA: Thomson Brooks/Cole.

DeLucia-Waack, J. L., Gerrity, D. A., Kalodner, C. R., & Riva, M. T. (Eds.). (2004). *Handbook of group counseling and psychotherapy.* Thousand Oaks, CA: Sage Publications.

Dufrene, P. M., & Coleman, V. D. (1992). Counseling Native Americans: Guidelines for group process. *The Journal for Specialists in Group Work, 17*, 229-234.

Emmons, R., & McCullough, M. (2003). Counting blessings versus burdens: An experimental investigation of gratitude and subjective well-being in daily life. *Journal of Personality and Social Psychology, 84*, 377-389.

Frame, M. W. (2003). *Integrating religion and spirituality into counseling: A comprehensive approach.* Pacific Grove, CA: Brooks/Cole.

Frazier, P. A., Tix, A. P., & Barron, K. E. (2004). Testing moderator and mediator effects in counseling psychology research. *Journal of Counseling Psychology, 51*, 115-134.

Gear, M. R., Faigin, C. A., Gibbel, M. R., Krumrei, E., Oemig, C., McCarthy, S. K., et al. (2008). The Winding Road: A promising approach to addressing the spiritual struggles of college students. *Spirituality in Higher Education Newsletter, 4*(4), 1-8.

Gear, M. R., Krumrei, E. J., & Pargament, K. I. (2009). Development of a spiritually-sensitive intervention for college students experiencing spiritual struggles: Winding Road. *Journal of College & Character, 10*(4), 1-5.

Goldstein, E. D. (2007). Sacred moments: Implications on well-being and stress. *Journal of Clinical Psychology, 63*, 1001-1019.

Gonsiorek, J. C., Richards, P. S., Pargament, K. I., & McMinn, M. R. (2009). Ethical challenges and opportunities at the edge: Incorporating spirituality and religion into psychotherapy. *Professional Psychology: Research and Practice, 40*, 385-395.

Griffith, J. L., & Griffith, M. E. (2002). *Encountering the sacred in psychotherapy: How to talk with people about their spiritual lives.* New York: The Guilford Press.

Hathaway, W. L., Scott, S. Y., & Garver, S. A. (2004). Assessing religious/spiritual functioning: A neglected domain in clinical practice? *Professional Psychology: Research and Practice, 35,* 97-104.

Hill, P. C., Pargament, K. I., Hood, R .W., Jr., McCullough, M. E., Swyers, J. P., Larson, D. B., et al. (2000). Conceptualizing religious and spirituality: Points of commonality, points of departure. *Journal for the Theory of Social Behaviour, 30,* 51-77.

Johnson, C. V., & Hayes, J. A. (2003). Troubled spirits: Prevalence and predictors of religious and spiritual concerns among university students and counseling center clients. *Journal of Counseling Psychology, 50,* 409-419.

Jones, S. L., Watson, E. J., & Wolfram, T. J. (1992). Results of the Rech conference survey on religious faith and professional psychology. *Journal of Psychology and Theology, 20,* 147-158.

Kehoe, N. C. (1998). Religious-issues group therapy. In R. D. Fallot (Ed.), *Spirituality and religion in recovery from mental illness* (pp. 45-55). San Francisco: Jossey-Bass Publishers.

Koening, H. G., McCullough, M. E., & Larson, D. B. (2001). *Handbook of religion and health.* New York: Oxford University Press.

Leach, M. M., Aten, J.D., Wade, N. G., & Hernandez, B. C. (2009). Noting the importance of spirituality during the clinical intake. In J.D. Aten & M.M. Leach (Eds.). *Spirituality and the therapeutic process: A guide for mental health professionals* (pp.75-92). Washington, DC: APA Books.

Lindgren, K. N., & Coursey, R. D. (1995). Spirituality and serious mental illness: A two-part study. *Psychosocial Rehabilitation Journal, 18*(3), 93-111.

Mack, M. L. (1994). Understanding spirituality in counseling psychology: Considerations for research, training, and practice. *Counseling and Values, 39*, 15-31.

McCorkle, B. H., Bohn, C., Hughes, T., & Kim, D. (2005). "Sacred Moments": Social anxiety in a larger perspective. *Mental Health, Religion, & Culture, 8*, 227-238.

McMinn, M. R., Aikins, D. C., & Lish, R. L. (2003). Basic and advanced competence in collaborating with clergy. *Professional Psychology: Research and Practice*, *34*, 197-202.

Miller, G. (2003). *Incorporating spirituality in counseling and psychotherapy: Theory and technique.* Hoboken, NJ: John Wiley & Sons.

Miller, W. R. (Ed.). (1999). *Integrating spirituality into treatment: Resources for practitioners*. Washington, DC: American Psychological Association.

Moon, G. W., Willis, D. E., Bailey, J. W., & Kwasny, J. C. (1993). Self-reported use of Christian spiritual guidance techniques by Christian psychotherapists, pastoral counselors, and spiritual directors. *Journal of Psychology and Christianity, 2*, 24-37.

Norsworthy, K. L., & Horne, A. M. (1994). Issues in group work with HIV-infected gay and bisexual men. *Journal for Specialists in Group Work, 19*, 112-119.

O'Rourke, C. (1997). Listening for the sacred: Addressing spiritual issues in the group treatment of adults with mental illness. *Smith College Studies in Social Work, 67*(2), 177-196.

Pargament, K. I. (2007). *Spiritually integrated psychotherapy: Understanding and addressing the sacred.* New York: The Guilford Press.

Pew Forum on Religion and Public Life. (2008, February). *U.S. Religious Landscape Survey.* Retrieved November 14, 2009 from http://religions.pewforum.org/pdf/report-

religious-landscape-study-full.pdf

Phillips, R. E., Lakin, R., & Pargament, K. I. (2002). Development and implementation of a spiritual issues psychoeducational group for those with serious mental illness. *Community Mental Health Journal, 38,* 487-495.

Plante, T. G. (2007). Integrating spirituality and psychotherapy: Ethical issues and principles to consider. *Journal of Clinical Psychology, 63,* 891-902.

Propst, L. R., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and non religious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology, 60,* 94-103.

Richards, P. S., & Bergin, A. E. (Eds.). (2000). *Handbook of psychotherapy and religious diversity.* Washington, DC: American Psychological Association.

Richards, P.S., & Bergin, A. E. (2005). *A spiritual strategy for counseling and psychotherapy* (2nd ed.). Washington, DC: American Psychological Association.

Richards, P. S., Berrett, M. E., Hardman, R. K., & Eggett, D. L. (2006). Comparative efficacy of spirituality, cognitive, and emotional support groups for treating eating disorder inpatients. *Eating Disorders, 14,* 401-415.

Richards, P. S., Owen, L., & Stein, S. (1993). A religiously oriented group counseling intervention for self-defeating perfectionism: A pilot study. *Counseling and Values, 37,* 96-104.

Richards, P. S., & Potts, R. W. (1995). Using spiritual interventions in psychotherapy: Practices, successes, failures, and ethical concerns of Mormon psychotherapists. *Professional Psychology: Research and Practice, 26,* 163-170.

Rodriguez, G. M. (2001). DeAlmas Latinas (The souls of Latina women): A psychospiritual culturally relevant group process. *Women and Therapy, 24*(3-4), 19-33.

Ronel, N. & Tim, R. (2003). Grace Therapy: Meeting the challenge of group therapy for male batterers. *Clinical Social Work Journal, 31,* 63-80.

Rose, E. M., Westefeld, J. S., & Ansley, T. N. (2001). Spiritual issues in counseling: Clients' beliefs and preferences. *Journal of Counseling Psychology, 48,* 61-71.

Rye, M. S., & Pargament, K. I. (2002). Forgiveness and romantic relationships in college: Can it heal the wounded heart? *Journal of Clinical Psychology, 58*, 419-441.

Rye, M. S., Pargament, K. I., Pan, W., Yingling, D. W., Shogren, K. A., & Ito, M. (2005). Can group interventions facilitate forgiveness of an ex-spouse? A randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *73*, 880-892.

Sageman, S. (2004). Breaking through the despair: Spiritually oriented group therapy as a means of healing women with severe mental illness. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 32*, 124-141.

Seidlitz, L., Abernethy, A. D., Duberstein, P. R., Evinger, J. S., Chang, T. H., & Lewis, B. L. (2002). Development of the Spiritual Transcendence Index. *Journal for the Scientific Study of Religion, 41*, 439-453.

Shafranske, E. P. (Ed.). (1996). *Religion and the clinical practice of psychology*. Washington, DC: American Psychological Association.

Shafranske, E. P., & Malony, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 27*, 72-78.

Shapiro, J. L., Peltz, L. S., & Bernadett-Shapiro, S. (1998). *Brief group treatment: Practical training for therapists and counselors.* Pacific Grove, CA: Brooks/Cole Publishing.

Souza, K. Z. (2002). Spirituality in counseling: What do counseling students think about it? *Counseling and Values, 46,* 213-217.

Sperry, L. (2001). *Spirituality in clinical practice: Incorporating the spiritual dimension in psychotherapy and counseling.* Philadelphia, PA: Brunner Routledge.

Sperry, L., & Shafranske, E. P. (Eds.). (2005). *Spiritually oriented psychotherapy.* Washington, DC: American Psychological Association.

Sweifach, J. & Heft-LaPorte, H. (2007). A model for group work practice with ultra-orthodox Jewish victims of domestic violence: A qualitative study. *Social Work with Groups*, *30*(3), 29-45.

Tabachnick, B. G., & Fidell, L. S. (2001). *Multivariate statistics* (4th ed.). Needham Heights, MA: Allyn & Bacon.

Tarakeshwar, N., Pearce, M. J., & Sikkema, K. J. (2005). Development and implementation of a spiritual coping group intervention for adults living with HIV/AIDS: A pilot study. *Mental Health, Religion & Culture, 8*(3), 179-190.

Tisdale, T. C. (2003). Listening and responding to spiritual issues in psychotherapy: An interdisciplinary perspective. *Journal of Psychology and Christianity, 22,* 262-272.

Wachholtz, A. B., & Pargament, K. I. (2005). Is spirituality a critical ingredient of meditation? Comparing the effects of spiritual meditation, secular meditation, and relaxation on spiritual, psychological, cardiac, and pain outcomes. *Journal of Behavioral Medicine, 28,* 369-384.

Wade, N. G., Worthington, E. L., Jr., & Vogel, D. L. (2007). Effectiveness of religiously tailored interventions in Christian therapy. *Psychotherapy Research, 17*, 91-105.

Weinstein, C. M., Parker, J., & Archer, J., Jr. (2002). College counselor attitudes toward spiritual and religious issues and practices in counseling. *Journal of College Counseling, 5*, 164-174.

Williams, C. B., Frame, M. W., & Green, E. (1999). Counseling groups for African American women: A focus on spirituality. *Journal for Specialists in Group Work, 24*, 260-273.

Worthington, E. L., Jr. (1998). The pyramid model of forgiveness: Some interdisciplinary speculations about unforgiveness and the promotion of forgiveness. In E. L. Worthington, Jr. (Ed.), *Dimensions of forgiveness: Psychological research and theological perspectives* (pp. 107-137). Radnor, PA: Templeton Foundation Press.

Worthington, E. L., Jr., Dupont, P. D., Berry, J. T., & Duncan, L. A. (1988). Christian therapists' and clients' perceptions of religious psychotherapy in private and agency settings. *Journal of Psychology and Theology, 16*, 282-293.

Worthington, E. L., Jr., Kurusu, T. A., McCullough, M. E., & Sandage, S. J. (1996). Empirical research on religion and psychotherapeutic processes and outcomes: A 10-year review of research prospectus. *Psychological Bulletin, 119*, 448-487.

Worthington, E. L., Jr., Wade, N. G., Hight, T. L., Ripley, J. S., McCullough, M. E., Berry, J. W., et al. (2003). The Religious Commitment Inventory—10: Development, refinement, and validation of a brief scale for research and counseling. *Journal of Counseling Psychology, 50*, 84-96.

Yalom, I. D. (with Leszcz, M.). (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

Young, J. S., Cashwell, C., Wiggins-Frame, M., & Belaire, C. (2002). Spiritual and religious competencies: A national survey of CACREP-accredited programs. *Counseling and Values, 47,* 22-33.

Zinnbauer, B. J., Pargament, K. I., & Scott, A. B. (1999). The emerging meanings of religiousness and spirituality: Problems and prospects. *Journal of Personality, 67,* 889-919.

APPENDIX: STUDY MEASURES

Perceived Appropriateness of Religious and Spiritual Interventions Scale (PARSIS)

Please select the number that *most closely* describes how appropriate or inappropriate you believe the following interventions are for group therapy.	*1 = completely inappropriate* *2 = mostly inappropriate* *3 = somewhat inappropriate* *4 = somewhat appropriate* *5 = mostly appropriate* *6 = completely appropriate*					
1. Bringing up the topic of spirituality.	1	2	3	4	5	6
2. Bringing up the topic of religion.	1	2	3	4	5	6
3. Facilitating discussion about spirituality after a group member brings it up.	1	2	3	4	5	6
4. Facilitating discussion about religion after a group member brings it up.	1	2	3	4	5	6
5. Asking group members about their spiritual beliefs.	1	2	3	4	5	6
6. Asking group members about their religious beliefs.	1	2	3	4	5	6
7. Self-disclosing one's own spiritual beliefs.	1	2	3	4	5	6
8. Self-disclosing one's own religious beliefs.	1	2	3	4	5	6
9. Using spiritual language or concepts.	1	2	3	4	5	6
10. Using religious language or concepts.	1	2	3	4	5	6
11. Reading/reciting religious scripture.	1	2	3	4	5	6
12. Having a moment of silence for personal prayer.	1	2	3	4	5	6
13. Allowing a group member to lead in-session vocal prayer.	1	2	3	4	5	6
14. Leading in-session vocal prayer.	1	2	3	4	5	6

Note: Items #3 and #4 were removed from the PARSIS scale after conducting a principal components analysis on the study data.

Use of Religious and Spiritual Interventions Scale (URSIS)

Please select the number that *most closely* describes how frequently you use the following interventions in group therapy.	*1 = never* *2 = rarely* *3 = occasionally*			*4 = fairly often* *5 = very often* *6 = almost always*		
1. Bringing up the topic of spirituality.	1	2	3	4	5	6
2. Bringing up the topic of religion.	1	2	3	4	5	6
3. Facilitating discussion about spirituality after a group member brings it up.	1	2	3	4	5	6
4. Facilitating discussion about religion after a group member brings it up.	1	2	3	4	5	6
5. Asking group members about their spiritual beliefs.	1	2	3	4	5	6
6. Asking group members about their religious beliefs.	1	2	3	4	5	6
7. Self-disclosing one's own spiritual beliefs.	1	2	3	4	5	6
8. Self-disclosing one's own religious beliefs.	1	2	3	4	5	6
9. Using spiritual language or concepts.	1	2	3	4	5	6
10. Using religious language or concepts.	1	2	3	4	5	6
11. Reading/reciting religious scripture.	1	2	3	4	5	6
12. Having a moment of silence for personal prayer.	1	2	3	4	5	6
13. Allowing a group member to lead in-session vocal prayer.	1	2	3	4	5	6
14. Leading in-session vocal prayer.	1	2	3	4	5	6

Note: Items #3 and #4 were removed from the URSIS after conducting a principal components analysis on the study data.

Barriers to Addressing Spirituality Scale (BASS)

Please select the number that *most closely* describes how true or untrue the following statements are for you.	*1 = completely untrue* *2 = mostly untrue* *3 = somewhat untrue* *4 = somewhat true* *5 = mostly true* *6 = completely true*					
1. Spirituality is an important component of diversity.	1	2	3	4	5	6
2. I prefer NOT to address issues related to spirituality in group therapy.	1	2	3	4	5	6
3. I worry about how other group members might react to discussions related to spirituality.	1	2	3	4	5	6
4. Group therapy can be an effective place for a client to work on issues related to spirituality.	1	2	3	4	5	6
5. Spiritual concerns are better dealt with in individual therapy.	1	2	3	4	5	6
6. I have enough training to effectively address spirituality in group therapy.	1	2	3	4	5	6
7. I worry that some group members might feel left out if spirituality were discussed in group therapy.	1	2	3	4	5	6
8. I fear I might impose my own values on clients if I addressed spirituality in group therapy.	1	2	3	4	5	6
9. I believe clients can benefit from the discussion of spirituality in group therapy.	1	2	3	4	5	6
10. I feel uncertain about what to do when spirituality is brought up in group therapy.	1	2	3	4	5	6
11. I worry that conflict among group members might arise if spiritual issues were discussed in group therapy.	1	2	3	4	5	6
12. I feel confident in my ability to address spirituality in group therapy.	1	2	3	4	5	6

Note: Item #1 was removed from the BASS after conducting a principal components analysis on the study data. Items #4, #6, #9, and #12 are reverse scored in the BASS.

Reactions to Spiritual Discussions Scale (RSDS)

"During a group therapy session, if/when a client brings up issues related to spirituality, I generally feel_____" (please place a check at the most appropriate place for you along each continuum).

Relaxed	1	2	3	4	5	6	7	Tense
Unprepared	1	2	3	4	5	6	7	Prepared
Qualified	1	2	3	4	5	6	7	Unqualified
Anxious	1	2	3	4	5	6	7	Calm
Unskilled	1	2	3	4	5	6	7	Skilled
Composed	1	2	3	4	5	6	7	Agitated
Uncomfortable	1	2	3	4	5	6	7	Comfortable
Competent	1	2	3	4	5	6	7	Incompetent
Naïve	1	2	3	4	5	6	7	Experienced
Sure	1	2	3	4	5	6	7	Hesitant
Guarded	1	2	3	4	5	6	7	Open
Capable	1	2	3	4	5	6	7	Inept

Note: The qualified—unqualified item was removed from the RSDS after conducting a principal components analysis on the study data. The relaxed—tense, composed—agitated, competent—incompetent, sure—hesitant, capable—inept items are reverse scored in the RSDS.

Items Assessing Openness to Addressing Spirituality and Religion in Group Therapy

To what extent are you open to addressing spirituality in group therapy?

a) Not at all open b) Slightly open c) Moderately open
d) Very open e) Extremely open

For what reason(s) did you select this rating?

To what extent are you open to addressing religion in group therapy?

a) Not at all open b) Slightly open c) Moderately open
d) Very open e) Extremely open

For what reason(s) did you select this rating?

Spiritual Transcendence Index (STI)

STI: Please select the rating that *most closely* describes the extent to which you agree or disagree with each statement.	*1 = strongly disagree* *2 = disagree* *3 = slightly disagree* *4 = slightly agree* *5 = agree* *6= strongly agree*					
1. My spirituality gives me a feeling of fulfillment.	1	2	3	4	5	6
2. I maintain an inner awareness of God's presence in my life.	1	2	3	4	5	6
3. Even when I experience problems, I can find a spiritual peace within.	1	2	3	4	5	6
4. I try to strengthen my relationship with God.	1	2	3	4	5	6
5. Maintaining my spirituality is a priority for me.	1	2	3	4	5	6
6. God helps me to rise above my immediate circumstances.	1	2	3	4	5	6
7. My spirituality helps me to understand my life's purpose.	1	2	3	4	5	6
8. I experience a deep communion with God.	1	2	3	4	5	6

Note: Taken from Seidlitz et al. (2002)

Religious Commitment Inventory—10 (RCI—10)

RCI: Please select the number that *most closely* describes the extent to which the statement is true of you.	*1 = not at all true of me* *2 = somewhat true of me* *3 = moderately true of me* *4 = mostly true of me* *5 = totally true of me*				
1. My religious beliefs lie behind my whole approach to life.	1	2	3	4	5
2. I spend time trying to grow in understanding of my faith.	1	2	3	4	5
3. It is important for me to spend periods of time in private religious thought and reflection.	1	2	3	4	5
4. Religious beliefs influence all my dealings in life.	1	2	3	4	5
5. Religion is especially important to me because it answers many questions about the meaning of life.	1	2	3	4	5
6. I often read books and magazines about my faith.	1	2	3	4	5
7. I enjoy working in the activities of my religious organization.	1	2	3	4	5
8. I enjoy spending time with others of my religious affiliation.	1	2	3	4	5
9. I keep well informed about my local religious group and have some influence in its decisions.	1	2	3	4	5
10. I make financial contributions to my religious organization.	1	2	3	4	5

Note: Taken from Worthington et al. (2003)

Demographic Questions

Your Age_____ Gender _____

What is your race/ethnicity?
a) Asian American/Pacific Islander
b) Black/African American
c) Latino/a
d) Native American/Native Alaskan
e) White/Caucasian
f) Other _____

In what region of the country do you live?
a) West b) Midwest
c) South d) Northeast

What is the religion or spiritual worldview that you currently identify with?

a) Agnosticism	b) Atheism	c) Baha'i	d) Buddhism
e) Catholicism	f) Hinduism	g) Islam	h) Jainism
i) Judaism	j) Mormonism	k) Protestant Christianity	l) Shinto
m) Sikhism	n) Taoism	o) Unitarianism/Universalism	p) Wicca

q) Other _____

What was the religion or spiritual worldview of your family while growing up?

a) Agnosticism	b) Atheism	c) Baha'i	d) Buddhism
e) Catholicism	f) Hinduism	g) Islam	h) Jainism
i) Judaism	j) Mormonism	k) Protestant Christianity	l) Shinto
m) Sikhism	n) Taoism	o) Unitarianism/Universalism	p) Wicca

q) Other _____

In what area did you receive your degree?

a) Clinical psychology	b) Therapy psychology	c) Therapist education
d) Marriage and family therapy	e) Pastoral therapy	f) Psychiatry
g) Social work	h) Other _____	

What is the highest degree you have achieved?
a) Masters b) Doctorate c) Other _____

Are you licensed as a mental health practitioner?
a) Yes b) No

How many years have you been practicing as a mental health professional (exclude work prior to your degree, but include work prior to your license)? _____

How much of your clinical work is devoted to group therapy?
a) None or almost none b) Less than 25% c) 25-50%
d) 50-75% e) More than 75% f) All or almost all

In which setting(s) do you facilitate group therapy? (select all that apply)
a) private practice b) group practice c) community mental health center
d) outpatient hospital e) inpatient hospital f) public college/university
g) private college/university h) public K-12 school i) private K-12 school
j) other _____

Which type(s) of groups do you facilitate? (select all that apply)
a) process-oriented groups
b) psychoeducational groups
c) support groups
d) other _____

To what extent are you interested in the topic of spirituality/religion and therapy?
a) Not at all interested b) A little interested c) Moderately interested
d) Very interested e) Extremely interested

Have you ever facilitated any therapy groups in which a main focus is the discussion of spiritual or religious issues?
a) Yes, I am currently facilitating such a group.
b) I am not currently facilitating such a group, but I have in the past.
c) No, I have never facilitated such a group

What types of training and experiences (if any) have you had in the area of spirituality/religion in therapy? (please select all that apply).
a) Took a graduate course specifically devoted to this topic
b) Took a graduate course that included this topic
c) Took a continuing education course devoted to this topic
d) Attended a conference or seminar on this topic
e) Read book(s) on this topic
f) Read journal article(s) on this topic
g) Conducted research on this topic
h) Had a practicum/internship experience with a focus on this topic
i) Received supervision on this topic
j) Attended graduate school at a religiously-affiliated institution
k) Had post-doctoral training at a religiously-affiliated institution
l) Worked as a mental health professional at a religiously-affiliated institution/practice
m) None
