Use Authorization

In presenting this thesis in partial fulfillment of the requirements for an advanced degree at Idaho State University, I agree that the Library shall make it freely available for inspection. I further state that permission to download and/or print my dissertation for scholarly purposes may be granted by the Dean of the Graduate School, Dean of my academic division, or by the University Librarian. It is understood that any copying or publication of this dissertation for financial gain shall not be allowed without my written permission.

Signature _____

Religiosity/Spirituality of Psychotherapists and Its Relationship to Evaluations of Religious/Spiritual Clients

by

Rhett H. Mullins

A Thesis

submitted in partial fulfillment of

the requirements for the degree of

Master of Science in the Department of Psychology

Idaho State University

Summer 2021

To the Graduate Faculty:

The members of the committee appointed to examine the thesis of RHETT H. MULLINS find it satisfactory and recommend that it be accepted.

Joshua Swift PhD,
Major Advisor

Robert Rieske PhD,
Committee Member

Ines Jindra PhD,
Graduate Faculty Representative

March 2, 2021
Rhett Mullins
Psychology
MS 8112
RE: Study Number IRB-FY2021-152: Religiosity/Spirituality of Psychotherapists and Its Relationship to Evaluations of Religious/Spiritual Clients

Dear Mr. Mullins:

I agree that this study qualifies as exempt from review under the following guideline: Category 2.(i). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording).

The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects.

This letter is your approval, please, keep this document in a safe place.

Notify the HSC of any adverse events. Serious, unexpected adverse events must be reported in writing within 10 business days.

You are granted permission to conduct your study effective immediately. The study is not subject to renewal.

Please note that any changes to the study as approved must be promptly reported and approved. Some changes may be approved by expedited review; others require full board review. Contact Tom Bailey (208-282-2179; fax 208-282-4723; email: humsubj@isu.edu) if you have any questions or require further information.

Sincerely,
Ralph Baergen, PhD, MPH, CIP
Human Subjects Chair

For Francesca, without whom this work would have been impossible.

Table Of Contents

List of Figures

List of Tables

List of Abbreviations

APA……American Psychological Association

ISS……..Intrinsic Spirituality Scale

RCI-10……Religious Commitment Inventory-10

R/S……..Religious/Spiritual

SES…….Socioeconomic Status

THCS…….Therapist Hops for Clients Scale

Religiosity/Spirituality of Psychotherapists and Its Relationship to Evaluations of Religious/Spiritual Clients

Thesis Abstract--Idaho State University (2021)

Treatment outcomes can be improved religious/spiritual adaptations are included in psychotherapy (Captari et al., 2018). However, little is known about the current religiosity/spirituality of psychotherapists. The current study seeks to understand therapist religiosity/spirituality and its impact on evaluations of religious/spiritual clients. One hundred fifty participants were recruited from state psychological associations, APA listservs, and the APA psychologist locator website. Participants were asked to read and respond to a vignette of a religious or non-religious client. Participants were also asked to complete items related to their personal religiosity/spirituality. Items related to therapist religiosity were generally lower for the current sample than for previous studies that have been conducted on similar populations and were significantly different from the general population. Therapist personal religiosity/spirituality was shown to significantly predict therapists' hope and expectations for religious clients. The results, limitations, future directions, and clinical implications are discussed.

Keywords: religiosity, spirituality, therapist expectations, client evaluations

Chapter 1: Religiosity/Spirituality of Psychotherapists and Its Relationship to Evaluations of Religious/Spiritual Clients

An abundance of research has now clearly established the effectiveness of psychotherapy (American Psychological Association, 2013; Tompkins & Swift, 2015). This research has demonstrated psychotherapy's effects across settings, disorders, and client types (i.e., Cody & Drysdale, 2013; Hunsley et al., 2014; Munder et al., 2019; Weisz et al., 1987). Although the existing research has shown psychotherapy to be generally effective, it does not work for everyone. Specifically, about 20% of clients choose to drop out of treatment prematurely (Swift & Greenberg, 2012) and approximately 10% of clients end treatment in a deteriorated state (Lambert, 2013).

Negative treatment outcomes, such as dropout and deterioration, are often significant issues for particular types of clients (Bohart & Wade, 2013). For example, research has shown that client cultural variables can have a significant impact on treatment outcomes (Ponterotto et al., 2010). Interestingly, a significant body of research has also demonstrated that treatment outcomes can be improved when psychotherapy is tailored to the individual client (Norcross & Wampold, 2010). Effective tailoring can be based on the following: the client's culture (Soto et al., 2018), preferences (Swift et al., 2018a), coping style (Beutler et al., 2018), attachment (Levy et al., 2018), gender (Budge & Moradi, 2018), sexual orientation (Moradi & Budge, 2018), and religiosity/spirituality (Captari et al., 2018), to name a few. Focusing specifically on client religiosity/spirituality, a recent meta-analysis with data from nearly 100 studies found that including religious/spiritual (R/S) adaptations in psychotherapy can result in significantly greater psychological and spiritual improvements for R/S clients (Captari et al., 2018). Although the existing research has shown that R/S adaptations can be helpful, less is known about what types

of adaptations are deemed valuable and which types of therapists (religious vs. non-religious) are best able to facilitate those adaptations.

The Constructs of Religiosity and Spirituality

In order to understand the role that religion and spirituality can play in psychotherapy, it is justifiably constructive to first gain an understanding of the definitions and operationalizations of these two constructs. However, that is a difficult task as the dissociability and semantic understanding of religiosity and spirituality have been heavily debated over the years (Moreira-Almeida et al., 2006). Traditionally, these concepts were viewed as largely inseparable, referring equally to institutional and individual factors. Some researchers who have maintained this mindset, continuing to view them as such, have contended that religiosity and spirituality are not distinct constructs and that spirituality should be examined as a factor nested within the broader topic of religion and religiosity (Zinnbauer et al., 2001). Researchers along this vein broadly define religiosity as "beliefs and practices related to a supernatural agent" (Sedikides, 2010, p. 3) and spirituality as "a general feeling of closeness and connectedness to the sacred" (Worthington et al., 2010, p. 205). Others, however, have narrowed the definitions of religiosity and spirituality to the degree that they are viewed as separate and distinct constructs (Hill et al., 2000). Two of the most common and accepted definitions of religiosity and spirituality are those of Koenig and colleagues (2001). They approach religiosity and spirituality as distinct constructs but also acknowledge their high levels of relatedness in defining them as follows (Koenig, 2001, p. 18):

> Religion: ''An organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality).''

> Spirituality: ‘‘The personal quest for understanding answers to the ultimate questions about life, about meaning, and about relationship with the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of a community.’’

In addition to distinctive definitions, some have contended that spirituality "may favor individualistic expression of connectedness with the sacred instead of traditional institutionalized forms" (Shafranske & Cummings, 2013, p. 25).

Just as there are differences in how religiosity and spirituality are defined, these two constructs have been operationalized in various ways. Historically, one of the most common methods of operationalizing religiosity was frequency of attendance at religious services (Hall, 2008). Over time, measures of religiosity have grown to include attendance at other religious events, such as Bible studies and prayer groups, as well as more internal or personal worship and devotion, such as degree of association with a given religion, frequency of prayer, and frequency of scripture study (Idler et al., 2001). Currently, one of the most commonly used methods to gauge religiosity is through assessing individuals' stated value or importance of religion in their lives (Shafranske & Cummings, 2013). Other prominent means to measure religiosity are the Centrality of Religiosity Scale (CRS), which assesses religiosity on the dimensions of public practice, private practice, religious experience, ideology, and intellectuality (Huber & Huber, 2012), and the Religious Commitment Inventory–10 (RCI–10), which assesses religious commitment and identification (Worthington et al., 2003).

Spirituality is most commonly quantified by asking individuals how important it is in their lives (Shafranske & Cummings, 2013). Two other commonly used measures to evaluate spirituality include the Spiritual Health and Life-Orientation Measure (SHALOM; Fisher, 2010)

and the Intrinsic Spirituality Scale (ISS; Hodge, 2003). One advantage of the ISS over the SHALOM is that it does not reference "God" or "Deity" in the items; instead, it evaluates the extent to which individuals feel their spirituality is important: it asks questions about life, and how spirituality affects their lives (Hodge, 2003).

In an attempt to fully understand the dissociation of these two constructs, it is also important to remember that: (1) virtually all organized religions are concerned with the spiritual, and (2) most form of R/S expression occurs in a social context (Hill et al., 2000). Furthermore, the lack of semantic stability of religiosity and spirituality respectively must be considered. Some have suggested that every generation may have to redefine the meaning of these constructs for themselves (Hill et al., 2000). In addition, the distinctiveness of these terms may be culturally and linguistically dependent. For example, in some languages, such as French, the term *religiosité* refers to both the individual and institutional factors (Angel, 2013).

Religiosity and Spirituality in America

Currently, religion and spirituality seem to play an important role in the lives of many Americans. This is evident through poll responses regarding whether people identify religion and spirituality as important in their lives as well as reported engagement in R/S behaviors. For example, in the most recent Gallup Poll, 72% of Americans reported that religion is important in their lives (Gallup, 2019a). A similar percentage (69%) was found in another survey of Americans when religion and spirituality were combined, but very different numbers were found when the categories were separated: 22% reported being religious but not spiritual, 18% were spiritual but not religious, 29% were both religious and spiritual, and 31% were neither religious nor spiritual (Raney et al., 2017). The American Religious Identification Survey (ARIS) found similar results, with 71% reporting they participated in a religious initiation ceremony such as

baptism or circumcision and 66% responding that they expect to have a religious funeral when they die (Kosmin & Keysar, 2009).

A recent publication of the Pew Research Foundation examined the prevalence of R/S associated beliefs and behaviors among Americans (Pew, 2018a). This study found that 72% of Americans report a belief in heaven, 58% report a belief in hell, 63% report an absolute or certain belief in God, 33% believe their sense of right and wrong comes directly from religion, and 59% of Americans report a sense of spiritual peace and well-being at least once a week (Pew, 2018a). In regard to prevalence of R/S associated behavior, this same survey found that about one third of the participants (36%) reported they attend a religious service weekly, 45% reported reading scriptures at least once a month, and 71% reported praying at least once a week (Pew, 2018a). Within the United States, prayer appears to be more of an individual experience than a religious rite. One recent poll found that 28% of individuals who report praying at least once every three months do not associate with a particular religion, and that 82% of these individuals pray silently and to themselves, with only 2% of those sampled praying in a group or religious congregation (Barna Group, 2017).

Although many Americans identify as religious and spiritual today, some interesting trends in religiosity and spirituality have been seen over the years. For example, in one nationwide poll, an 11% decrease in the number of people considering themselves to be both spiritual and religious was observed from 2012 to 2017 (Pew, 2017). An overall decline in religiosity has also been reported in a recent Gallup poll, which indicated that, from 1938 to 1998, between 68% and 76% of Americans reported being a member of a church, synagogue, or mosque and that currently only about 50% of the population report such memberships (Gallup, 2019a). This same poll found that, between the years of 1998 and 2000, 90% of U.S. residents

reported a religious affiliation, while between the years of 2016 to 2018, only 77% of Americans reported such an affiliation (Gallup, 2019a). In contrast to the declining religiosity reported in Americans, there is some evidence that spirituality might be on the rise. For example, a 2017 poll conducted by the Pew Research Foundation suggested an 11% increase in the number of Americans who identify as spiritual but not religious from 2012 to 2017. Another poll found the following data of those individuals who identify as spiritual but not religious: 67% are certain of a belief in God, 69% seldom or never attend religious services, 57% pray daily, and 73% report weekly feelings of spiritual peace and well-being (Pew, 2018b).

Individuals who identify as religiously unaffiliated seem to have experienced similar growth patterns as those who identify as spiritual but not religious. These religiously unaffiliated individuals are sometimes classified as "nones" in research for their response of "none" to survey questions regarding religious affiliation. Ironically, this group of "nones" appears to be one of the fastest growing religious affiliations in the United States (Pew, 2012). According to the General Social Survey (GSS), in 1972, 5% of respondents indicated they had no religious affiliation; in 2014, over 20% of respondents identified as spiritual but non-religious (Hout & Smith, 2015).

Religion and Spirituality in Psychotherapy

Just as religion and spirituality play a role in many Americans' lives, religion and spirituality may be able to play an important role in psychotherapy. Research suggests that many individuals, including those who seek counseling or psychotherapy, experience high levels of R/S distress (Bryant & Astin, 2008; Johnson & Hayes, 2003). For example, in one survey study that included data from over 5,000 university students, 26% of the respondents reported a significant level of R/S distress, and 6% reported extreme distress related to R/S issues (Johnson

& Hayes, 2003). In another study that included data from over 3,000 college students, a direct association between R/S distress and increased psychological distress (i.e., depression, stress, anxiety, and feeling overwhelmed) was found (Bryant & Astin, 2008). Other studies have found established high levels of R/S struggles for individuals who have experienced trauma (Wortmann et al., 2011), sexual abuse (Jouiles et al., 2019), adverse childhood experiences (McCormik et al., 2017), and divorce (Krumrei et al., 2009). Specific types of psychological symptoms and distress have also been found to be significantly related to R/S distress, including anxiety, phobic anxiety, depression, paranoid ideation, obsessive-compulsiveness, and somatization (McConnell et al., 2006).

Given that R/S distress can be associated with mental health issues, it is perhaps not surprising that many clients desire for religion and spirituality to be integrated into their mental health treatment (Cunha & Comin, 2019; Post & Wade, 2009). A number of studies have been conducted, specifically examining client preferences for R/S integration in psychotherapy. For example, in one study conducted at a private religious institution, 146 students who were receiving services at a university counseling center that offered R/S interventions (e.g., performing a spirituality assessment, referencing scriptural passages, and teaching spiritual concepts) were asked to evaluate the appropriateness and helpfulness of these interventions. Approximately 47% of the participants reported that these interventions provided them with increased insight and helped to reframe their perceptions, and 19% of the respondents stated that these spiritual interventions increased their personal comfort in sharing R/S related issues with their therapist (Martinez et al., 2007). In another study that included religiously and spiritually diverse clients from nine counseling centers, 63% of the participants reported that it is appropriate to discuss R/S issues in psychotherapy, 55% expressed a desire to address R/S issues,

and only 18% specifically did not want to discuss R/S issues in treatment (Rose et al., 2001). In another study that included both religious and non-religious individuals, the majority of religious (58%) and non-religious (63%) participants expressed some interest in integrating religiosity and spirituality in their treatment (Rosmarin et al., 2015). Additional research has similarly identified client preferences for R/S integration outpatient (Mohr & Hugeulet, 2014) settings, as well as for specific groups, such as military populations (Currier et al., 2018) and the elderly (Stanley et al., 2011).

Although some clients express a desire to integrate religiosity and spirituality in psychotherapy, the research regarding a preference for R/S therapists is more mixed. In one recent study that used a probability discounting method, a sample of religious clients were found to be willing to receive a significantly less effective intervention if it meant they were able to work with a therapist whose religious beliefs matched their own (Dimmick et al., 2020). In contrast, in another study, individuals who scored higher on the *Human Spirituality Scale* (HSS) were no more likely to select a counselor with religious expertise over an identical counselor with no religious expertise (Belaire & Young, 2000). In another recent study, participants were asked to rate potential therapists' trustworthiness, expertness, and attractiveness based on a vignette, some of which portrayed the therapist as being spiritual (Baldwin, 2019). Researchers found that therapist trustworthiness, expertness, and attractiveness did not significantly differ depending on whether they believed their therapist was spiritual or on their own spiritual background.

In addition to the research that indicates that many clients hold preferences for R/S integration in psychotherapy, a few studies have suggested a positive relationship between R/S integration and ratings of the therapeutic alliance. For example, Shumway and Waldo (2012)

found a positive relationship between the working alliance that was anticipated by participants of varied R/S levels and the inclusion of R/S issues in the informed consent process. Another recent study found a small but significant relationship between ratings of the therapeutic alliance and ratings of religious importance and frequency of religious attendance for adolescent clients who had committed sex-related crimes (Yoder & Bovard-Johns, 2017). Although the existing research suggests a positive relationship between R/S integration and the therapeutic alliance, more research is needed in this area.

A recent meta-analysis examined the relationship between R/S integration and treatment outcomes (Captari et al., 2018). Researchers found that when religiously/spiritually integrated therapy was compared with an alternate secular form of therapy for clients with varied levels of self-reported religiosity/spirituality, the clients enrolled in R/S-integrated therapy had better treatment outcomes on both spiritual (Hedges g = 0.74) and psychological measures (Hedges g = 0.74). However, upon further analysis, when both religiously/spiritually integrated and secular approaches were implemented under the same duration, there was no significant difference in psychological outcomes (Hedges g = 0.13), but there was still a difference in spiritual outcomes (Hedges g = 0.34). These results provide strong evidence in favor of including R/S techniques or approaches in psychotherapy with R/S clients, particularly when they have a preference for such integration.

Religiosity of Therapists

Although the existing research suggests that: (1) many individuals experience R/S distress in their lives (i.e. Johnson & Hayes, 2003; Jouiles et al., 2020), (2) clients have a preference to integrate religion and spirituality in psychotherapy (i.e. Martinez et al., 2007; Rosmarin et al., 2015), and (3) integration can lead to more positive ratings of the therapeutic

alliance and better treatment outcomes (i.e. Shumway & Waldo, 2012; Captari et al., 2018), some clients have negative experiences when they talk about religiosity or spirituality with their therapist. In one study, some clients reported feeling that their religious beliefs were marginalized in some way by their therapists (McVittie & Tiliopoulos, 2007). In another study, approximately 36% of R/S clients reported they experienced a religious micro-aggression by their therapist while in treatment (Trusty et al., 2019). These negative experiences may partially be due to differences in R/S beliefs between clients and therapists (Vervaeke et al., 1997), as well as a lack of competency for integrating religion and spirituality in psychotherapy by most therapists (Freitas, 2012). Thus, further research is needed to gain a better understanding of therapists' levels of religiosity and spirituality and their opinions about working with R/S clients.

In our search of the literature, we were able to identify 24 studies that, in some way, have assessed the R/S beliefs of therapists. Since the term "psychotherapy" can encapsulate a variety of professions, included in this search were analyses of R/S beliefs among clinical psychologists, counselors, psychiatrists, social workers, and marriage and family therapists, among others. Also, since there is wide variance of practice and belief of religiosity/spirituality between countries, we only included studies whose population was primarily based within the United States.

In one of the earliest empirical studies of therapists' R/S beliefs, Bergin and Jenson developed a national interdisciplinary survey on mental health values of psychotherapists (Jensen, 1986; Jensen & Bergin, 1988; Bergin & Jensen, 1990). Their sample consisted of 425 marriage and family therapists, clinical social workers, psychiatrists, and clinical psychologists. Participant religion and spirituality was assessed using a survey developed by the authors. They found that 41% of therapists attended religious services regularly and that 77% of therapists

attempted to live in accordance with their religious beliefs. Similarly, 46% agreed with the item, "My whole approach to life is based on my religion," with 68% reporting that they "Seek a spiritual understanding of the universe and one's place in it " (Jensen, 1986). This study demonstrated that at the time of the survey, a large percentage of psychotherapists endorsed R/S values.

In another study, Shafransky and Malony (1990) examined clinical psychologists' attitudes towards religion and spirituality in general as well as attitudes toward R/S integration in psychotherapy by surveying 409 members of American Psychological Association (APA) Division 12 (Division of Clinical Psychology). To do this, they used a 65-item measure assessing ideology, orientation, belief in a personal God, dimensions of religiosity, and attitudes and practices regarding R/S integration in psychotherapy. Of those surveyed, 40% endorsed a personal, transcendent God orientation, 53% rated religious beliefs as being desirable for people in general, 97% reported being raised within a particular religion, and 71% reported a current religious affiliation. Though the average religious attendance for clinical psychologists was less than 2 times per month and 49% reported no attendance, 74% of the therapists reported that R/S issues were relevant to their work. Similar to the previous study, this study provides evidence that, historically, many therapists have viewed religion and spirituality as highly important. One limitation to this study is that the sample may not be representative of practicing psychotherapists given the recruitment from only one APA division.

In another interesting study, Eckhardt et al. (1992) surveyed APA members about their endorsement of religion (including religiosity and religious ideology) and science as sources of knowledge. Their survey included 147 individuals listed in the 1990 APA registrar. A 37-item questionnaire designed by the authors was used to assess religiosity, religious ideology, scientific

ideology, and self-perceived conflict. Approximately one-third (33%) of participants reported a belief in a God whose teachings are true, while a similar percent (28.6%) reported engaging in daily prayer. In regard to attendance at religious services, 38% reported moderate to frequent attendance. In relation to the primary research question on religion versus science as sources of knowledge, 91% endorsed the notion that science provides a better explanation of the universe than religion. The results from this study showed substantially smaller levels of R/S endorsement than previous studies, which may have been due to the unique sample—APA members in general rather than practicing psychotherapists.

While collecting data on the role of forgiveness in therapeutic practices, DiBlasio and Proctor (1993) also gathered information on R/S beliefs of marriage and family therapists. One hundred twenty-eight members of the Association of Marital and Family Therapy responded to a mailed survey distributed by the authors. In addition to the study's primary measures, participants were presented with several items about R/S beliefs; 55% of the respondents reported their personal religious beliefs were very important to them. In regard to the impact of these beliefs on their therapeutic practice, 43% reported that it had a significant impact, 52% said some impact, and only 5% reported no impact. Although the vast majority reported their beliefs had some impact on their practice, 57% of the participants reported their religious beliefs and therapeutic interventions should be kept completely separate. While this study provided only limited insight on R/S prevalence among Marriage and Family Therapists, it is noteworthy that a large percentage of participants believed that their personal R/S beliefs had a direct impact on their practice.

In another study, Kelly (1995) analyzed values of members of the American Counseling Association (ACA). Their sample included 479 participants who responded to a mail-in survey.

Religiosity and spirituality were measured using Gorsuch and McPherson's (1989) revision of the Religious Orientation Scale (Allport & Ross, 1967), as well as items taken from Shafranske and Malony (1990). The study found that 63.8% of the participants reported a belief in a personal God, while 24.6% acknowledged a belief in a transcendent dimension to reality. Only 4.8% responded that the notions of spirituality and transcendence are illusions. Interestingly, 74.4% described themselves as religiously affiliated, with 44.9% being regularly active. This study provides information specific to members of the ACA, which may not be representative of all psychotherapists, but it does demonstrate a high prevalence for R/S beliefs among ACA members.

In their assessment on the relationship between therapist values, religiosity and spirituality, and gender on the initial assessment of sexual addiction, Hecker et al. (1995) collected basic R/S data from marriage and family therapists. One hundred ninety-nine members of the American Association for Marriage and Family Therapy (AAMFT) responded to a mail-in survey. R/S questions were limited to religious orientation and degree of religiosity. Of the participants, 91% reported a current religious orientation, with 30.6% of participants rating themselves as moderately religious, 29.6% strongly religious, 18.5% slightly religious, and 20.6% not religious. This study continues to demonstrate a high prevalence for religiosity and spirituality among subsections of psychotherapists and also provides a measure of the subjective strength of the religious orientation. A limitation of this study is that it failed to isolate only participants who were actively practicing psychotherapy.

A few years later, Bilgrave and Deluty (1998) examined the relationship between religious beliefs and therapeutic orientations with a broader sample of therapists. These researchers surveyed 237 members of APA divisions 12 (Clinical), 17 (Counseling), 29

(Psychotherapy), and 32 (Humanistic). They used a 65-item self-created questionnaire to assess a variety of factors related to R/S identification and therapeutic orientation. Of those surveyed, 66% reported a strong or very strong belief in God or a universal spirit and 74% considered religion to be moderately to extremely important in their lives. Of these participants, 72% reported their religious beliefs influence their practice of psychotherapy. The results suggested both that R/S beliefs were highly prevalent among members of the selected APA divisions in 1998 and that the majority of participants felt that these beliefs directly impacted their practice.

In another study, Prest et al. (1999) explored R/S attitudes among marriage and family therapy (MFT) students ($N = 66$). Many of the survey items that were used in their study were adopted from items created by Sheridan et al. (1992) and Derezotes and Talbot (1995). They found that 90.2% of their participants reported being raised in a particular religion, 60.8% reported "a belief in a personal God whose purpose will ultimately be worked out in history," and 25.5% reported a belief in a "transcendent or divine dimension found in all of nature." This study suggests that, at the turn of the century, MFT graduate students were highly religious, potentially suggesting that either factors related to career selection or education may impact their religiosity and spirituality. A related limitation is that none of the participants were actively engaging in the practice of psychotherapy.

McClure and Livingston (2000) assessed R/S factors of professional counselors, psychologists, and upper-level college students. Participants (137 professional counselors/psychologists and 198 college students) were surveyed with items from 3 author-developed scales: personal religiosity, religious enhancement, and religious negativity. Religiosity scores (range 2–8) differed between psychologists ($M = 5.84$, $SD = 2.30$), college students ($M = 6.65$, $SD = 2.27$), and professional counselors ($M = 7.49$, $SD = 1.98$). Religious

enhancement scores (range 8–32) also differed between psychologists (M = 23.12, SD = 4.16), college students (M = 21.23, SD = 5.53), and professional counselors (M = 22.95, SD = 3.91). Religious negativity (range 4–16) was as follows: psychologists (M = 7.63, SD = 2.34), college students (M = 6.11, SD =2.15), and professional counselors (M = 6.03, SD = 1.88). A strength of this study is that it allowed for direct comparisons between groups, finding that psychologist religiosity tended to be lower than both counselors and college students.

Graham et al. (2001) examined the relationship between religiosity and spirituality and coping with stress among graduate students in counseling programs. Survey respondents consisted of 115 counseling graduate students from a large southeastern university. The religiosity/spirituality of the graduate students was measured using the Religious/Spiritual Affiliation Self-Report (Koenig, 1997). Of the participants, 60.9% indicated they experienced spirituality through religious practice, 33.9% indicated being spiritual but with no specific religious belief system, 2.7% reported being spiritual but non-religious, and 0.9% of participants reported being neither religious nor spiritual. This study demonstrates that prior to graduating, many counseling graduate students report R/S affiliations.

Hodge (2002) compared R/S beliefs and practices of social workers with those of the general public using data from the General Social Survey (GSS). R/S items on the GSS address areas such as religious preference, religious service attendance, attitudes concerning life after death, and opinion on the Bible. Only 6% of the social workers reported no past history of religious affiliation. In the non-social worker population, 6% of the lower-class, 4% of the working-class, and 3% of the middle-class reported no past religious affiliation. In regard to strength of religious denomination affiliation, 38% of graduate-level social workers and 33% of bachelor-level social workers reported a strong association, with similar proportions of 36% and

41% for lower, working, and middle-class populations. For church attendance, 27% of graduate-level and 29% of bachelor-level social workers reported attending church once a week or more, while 21%, 27%, and 32% for lower, working, and middle-class populations respectively reported this level of attendance. This study was able to compare both graduate- and undergraduate-level providers and directly compare them with the general population, though this specific population of social workers may not be representative of psychotherapists as whole.

Carlson et al. (2002) explored a variety of R/S-related factors among members of the American Association for Marriage and Family Therapy (AAMFT). A mail-in survey on therapist religiosity/spirituality, as well as issues with addressing religiosity/spirituality in the context of therapy, was completed by 153 AAMFT members. The main measure used for this survey was a seven-instrument survey adapted from Prest et al. (1999). In this survey, 95% of participants consider themselves to be a spiritual person, with 82% responding that "they regularly spend time to get in touch with their spirituality" and 71% reporting regular prayer. In relation to religion, 62% of participants considered themselves to be religious, but only 32% considered organized religion to be a primary source of their spirituality. One limitation of this study is that it only measured spirituality.

In an update to their previous work, Bilgrave and Deluty (2002) collected information on psychotherapist R/S beliefs in their analysis of the relationship between R/S beliefs, political ideologies, and therapeutic orientations. Two hundred thirty-three psychologists responded to surveys sent to a sample of members from APA divisions: 12 from clinical psychology, 17 from counseling psychology, 32 from humanistic psychology, and 39 from psychoanalysis. Items for the questionnaire came from the survey previously created by the authors (Bilgrave & Deluty,

1998) as well as items from other existing measures such as Gallup polls. Of the sample, 71% reported holding religious or spiritual beliefs, with 44% believing in God or a supreme being and 27% believing in a universal essence or One; 21% strongly or totally endorsed religiosity with 50% strongly or totally endorsing spirituality; and 34% responded "totally true" to the statement, "My religious beliefs are behind my entire approach to life."

In relation to openness to discuss R/S concerns with clients, Weinstein et al. (2002) examined therapist attitudes towards discussing R/S factors in the context of therapy and integrating religion/spirituality into treatment. Eighty-six college counselors were surveyed from universities across the nation. The instrument used was a 30-item questionnaire created by the authors. The results showed that 70% of therapists surveyed stated that discussing R/S issues in therapy would depend on the client/situation, 23% believed that discussing R/S issues in therapy would be helpful, and approximately 7% believed that counselors should not discuss their own values when discussing religion/spirituality during a therapy session. One limitation of this study is that college counselors may not be representative of all practitioners.

In another study, Smith and Orlinsky (2004) examined R/S experiences among a large sample of (N = 975) psychotherapists from the United States, Canada, and New Zealand. Items in the survey came from the Religious Experience Profile (Orlinsky & Smith, 1995), as well as the "Development of Psychotherapists Common Core" questionnaire (Orlinsky et al., 1999). The conclusion of 94% of the participants was that they were raised in a particular religious tradition, although 44% indicated they currently had no religious affiliation. Average participant response to items gauging different dimensions of R/S beliefs ranged from 2.9 (Celebrating the beauty and dignity of the worship service) to 8.7 (Personal moral and ethical standards), on a 0 (Not at all important in my life) to 10 (The most important part of my life at present) scale. This study

provides evidence that some specific R/S experiences are highly valued amongst psychotherapists from a variety of backgrounds. One limitation of this study is that different countries may have different preexisting R/S tendencies, which was not accounted for in the analysis.

Cassidy (2006) evaluated the religiosity/spirituality of clinical and counseling graduate students in their final year of internship. Two hundred fifty-three participants completed a survey where religiosity and spirituality were assessed using the Religious Commitment Inventory–10 (RCI–10; Worthington et al., 2003) and the Personal Importance of Spirituality Scale (PISS; Prest et al., 1999). Results on both the RCI–10 and the PISS consistently demonstrated that counseling psychology interns had higher levels of religious commitment and spiritual importance when compared with clinical psychology interns. These results suggest there may be preexisting conditions related to therapist religiosity/spirituality that are either inherent in training programs or in career selection. It would be interesting to see if the same types of differences exist between brand-new graduate students and practicing therapists.

Delaney et al. (2007) surveyed members of several APA divisions regarding their religiosity/spirituality, including Division 12 (Clinical Psychology), Division 17 (Counseling Psychology), Division 29 (Psychotherapy), Division 39 (Psychoanalysis), Division 42 (Psychologists in Independent Practice), Division 43 (Family Psychology), Division 49 (Group Psychology and Group Psychotherapy), and Division 50 (Addictions); 258 individuals completed the survey. Items for this survey were taken from several existing surveys on religiosity/spirituality, including those of Bergin and Jensen (1990), the Index of Core Spiritual Experiences (Kass et al., 1991), and the Religious Background and Behavior Scale (Connors et al., 1996). In response to the item, “How important is religion in your life?,” 21% of the

respondents reported “very important” and 33% of the participants reported they had attended a church, synagogue, or mosque in the past seven days. For the item, “I try hard to live my life according to my religious beliefs,” 70% of the participants agreed. When asked to respond to the item, “My whole approach to life is based on my religion,” 35% agreed. This study was able to capture a very diverse group of psychologists from a variety of organizations.

Dwyer (2008) examined R/S behaviors and therapeutic interventions among members of the National Association of Social Workers (NASW) in Colorado. One hundred twenty-six social workers, who had practiced within the past 2 years, responded to the online survey, which included a combination of author-created items and those of Sheridan et al. (1992). Of their participants, 84.1% identified a past history with religiosity/spirituality and 74.5% identified with a specific religion, with 37.3% reporting high involvement and 36.5% reporting some involvement. A limitation to the study is that it may not be nationally representative because it focused on social workers in a single state.

In another study, Ying (2009) examined the relationship between R/S factors and graduate student well-being. Sixty-five participants were recruited from a Master of Social Work program at a university in the western United States. In addition to a R/S demographic question regarding religious affiliation, participants were presented two measures of religiosity and two measures of spirituality. Religiosity was measured with the seven-item Religiosity Scale (Rohrbaugh & Jessor, 1975) and the Religious Comfort and Strain Scale (Exline et al., 2000). Spirituality was assessed with the Spiritual Involvement and Beliefs Scale (Hatch et al., 1998) and the Miller Measure of Spirituality (Miller, 2004). The results indicated that 49.2% of participants identified with a specific religious organization. For measures of religiosity and spirituality, participants' average scores on religiosity fell below the midpoint and spirituality

scores fell above the midpoint, suggesting that this sample is much more spiritual than religious. This study may provide evidence that R/S trends among psychotherapists have mirrored those reported in the general population with a shift toward non-religious but spiritual (Pew, 2017); however, an objective assessment of religiosity might be difficult because the provided scales facilitate only a comparative analysis with other studies that have used the same or similar measures.

Langeland et al. (2010) examined R/S considerations of 206 members of the Michigan Counseling Association who responded to a mail-in survey. Items on the survey were created by the authors to assess R/S; 29% of participants responded, "very much so" to the item "How important is religion in your daily life?," and 55% of participants responded, "very much so" to the item, "How important is spirituality in your daily life?" This study demonstrates once again the current shift toward increased spirituality and decreased religiosity. These results may not generalize outside of Michigan, though, due to restrictions in the sampling method.

In one of the few studies on the topic conducted in the last decade, Francis (2011) examined R/S beliefs among 140 doctoral clinical and counseling students in their final year of internship. Survey items for this study were created by Shafranske and Pargament (2010) as part of the "Religious and Spiritual Attitudes and Practices of Clinical and Counseling Psychologists and Graduate Students in Clinical and Counseling Psychology Project." Of the participants who responded, 23.7% noted that religion was very important in their life; 41.7% indicated that spirituality is very important in their life; 40.3% responded that there is definitely a personal God; 64% of participants reported that they were secure in their current R/S views; 20.2% reported attending religious services once a week or more, and 30.5% reported praying once a

day or more. Finally, 56.1% reported they had experienced a moment of sudden spiritual insight or awakening.

Cornish et al. (2012) addressed counselor religiosity/spirituality in their study of 242 members of the American Group Psychotherapy Association (AGPA). This sample included clinical psychologists, counseling psychologists, psychiatrists, social workers, marriage and family therapists, and psychiatric nurses. Religiosity/spirituality was assessed using the Spiritual Transcendence Index (STI; Seidlitz et al., 2002) and the Religious Commitment Inventory–10 (RCI–10; Worthington et al., 2003). The average STI score was 32.6 (*SD* = 11.3), which is similar to community levels of spirituality (*M* = 33.3, *SD* = 10.7; Seidlitz et al., 2002); however, the average RCI–10 score was 22.1 (*SD* = 11.4), which is lower than the normative mean of 26.00 as estimated by the measure's authors (Worthington et al., 2003). An advantage of this study is that it measured religiosity in a way that has been normed with community samples, allowing for a direct comparison. However, a limitation is that the specific results of the STI scales can be difficult to interpret.

Rosmarin and colleagues (2013) examined R/S attitudes among 293 members of the Association for Behavioral and Cognitive Therapies (ABCT) through a survey that was distributed on the association's listserv. Measures of R/S factors included the Intrinsic Religious Orientation Scale (Koenig et al.,1997), adapted R/S items from similar studies (Bergin & Jensen, 1990; Delaney et al., 2007), author-created items assessing attitudes toward religiosity/spirituality and mental health/treatment, and training in R/S issues and mental health. Age or membership status was not associated with any R/S variable. Of the sample report, 22% noted an affiliation with a religious group and 46.7% reported no belief in a personal God, but 29% of this group did indicate a belief in a higher power. In regard to religious practice, 64% of

participants rarely or never attended religious services, with 57% praying once a month or less. For self-rated personal importance of religion, 51% reported that religion had little to no personal importance to them, but 54% reported that spirituality was important or very important. This study is valuable in that it allows for the examination of a specific group or orientation within the field of psychotherapy, though ABCT is a very specific group of providers, which may not be representative of the larger population.

In the most recent study identified in the literature, Oxhandler et al. (2017) examined R/S beliefs across five helping professions, including social workers, psychologists, marriage and family therapists, nurses, and professional counselors. Five hundred fifty individuals completed an online survey that included several items from the General Social Survey, which focused on the religious affiliation (Smith et al., 2014), common R/S practices, and items from the Duke University Religion Index (DUREL; Koenig & Büssing, 2010). Reported attendance of religious services of "at least a few times a month" was as follows: LMFTs (70.2%), LPCs (61.1%), APNs (59.7%), LCSWs (55.9%), and psychologists (46.8%). Similar differences were detected for engaging in private R/S activities such as prayer, meditation, or studying religious texts once a week or more: LMFTs (83.9%), LPCs (81.6%), APNs (64.8%), LCSWs (64.2%), and psychologists (56.4%). This study is unique in that it directly compared individuals from a wide variety of helping professions; however, an associated limitation is that it also included professionals who may not have necessarily been providing therapy, such as the ANPs.

In summary, the examination of R/S beliefs among psychotherapists is a relatively recent phenomena, with much of the research occurring in the past 30 years. These studies consistently demonstrate a prevalence of R/S beliefs among many psychotherapists, as measured by R/S association and R/S behaviors (i.e., Bergin & Jensen, 1990; Delaney et al., 2007; Oxhandler et

al., 2017). They also demonstrate that many psychotherapists view R/S beliefs as important, both in their personal lives (i.e., Diblasio & Proctor, 1993; Bilgrave & Deluty, 2002; Francis, 2001) and in the context of therapy (i.e., Weinstien, 2002). In general, past research indicates that therapist religiosity is lower than reported levels of religiosity within the general population. For example, in their Survey of several APA divisions, Delany et al., (2007) found that 21% of their participants responded, "very much so" to the item, "How important is religion in your life?" In contrast, a Gallup poll from 2008 found that 54% of the general public responded, "very much so" to this same item (Gallup, 2019a). Among those studies that compared therapists across professions, clinical psychologists frequently reported lower levels of religiosity/spirituality than other provider groups (i.e., Bergin & Jensen, 1990; Oxhandler et al., 2017). Additionally, this research appears to demonstrate a historical preference toward religiosity that has diminished in recent years, as well as a comparable increase in spirituality (i.e., Ying, 2009; Langeland, 2010). Many therapists endorse being raised in a particular religion but report no current affiliation—preferring to identify as spiritual instead of religious (i.e., Carlson, 2002; Dwyer, 2008; Shafranske & Malony, 1990). Thus, while religiosity/spirituality of psychotherapists may be 42 the general population, they could be following a similar trend in R/S preferences.

While this past research has greatly increased our current understanding of the religiosity/spirituality of psychotherapists, there are several notable limitations of these studies. One such limitation is that many of the previous studies failed to separate practicing from non-practicing therapists in their samples (i.e., Bilgrave & Deluty, 1998; Bilgrave & Deluty, 2002; Delaney et al., 2007; Eckhardt et al.,1992; Francis, 2011; Hecker et al., 1995; Langeland et al., 2010; Oxhandler et al., 2017; Prest et al., 1999; Rosmarin et al., 2013), resulting in a limited understanding of the R/S beliefs of practicing therapists and the relationship between their

beliefs and views about R/S clients. Furthermore, some of the studies had samples with limited generalizability (Carlson et al., 2002; Cassidy, 2006; Cornish et al., 2012; DiBlasio & Proctor, 1993; Dwyer, 2008; Francis, 2011; Graham et al., 2001; Hodge, 2002; Kelly, 1995; Langeland et al., 2010; Rosmarin et al., 2013; Weinstein et al., 2002; Ying, 2009), and additional research is needed with nationwide samples.

Another limitation can be seen in the diversity of R/S instruments which have been used in past literature to assess for R/S beliefs among therapists. Previous authors have used several measures of R/S beliefs, associations, orientation, and behavior, including: The Duke University Religion Index (Koenig & Büssing, 2010), the Intrinsic Religious Orientation Scale (Koenig et al., 1997), the Spiritual Transcendence Index (Seidlitz et al., 2002), the 7-item Religiosity Scale (Rohrbaugh & Jessor, 1975), the Religious Comfort and Strain Scale (Exline et al., 2000), the Spiritual Involvement and Beliefs Scale (Hatch et al., 1998), the Miller Measure of Spirituality (Miller, 2004), the Index of Core Spiritual Experiences (Kass et al., 1991), the Religious Background and Behavior Scale (Connors et al.,1996), the Personal Importance of Spirituality Scale (Prest et al., 1999), the Religious Commitment Inventory–10 (Worthington et al., 2003), the Religious Experience Profile (Orlinsky & Smith, 1995), and the Religious/Spiritual Affiliation Self-Report (Koenig, 1997). Each of these measures contains unique items and conceptualizations of religiosity/spirituality which can make a comparison across studies difficult. Though it is worthy of note that several key items from Bergin and Jensen (1990) and Gallup polls (i.e., Gallup, 1985) have remained constant between studies, allowing for some comparison. Future research should isolate a few of the most common R/S measures to allow for comparisons over time.

In addition, previous research has yet to examine therapists' views of clients who identify as R/S and test how their own religiosity/spirituality may be associated with their views of clients. Previous research has demonstrated that therapists form impressions of the clients they work with. For example, Swift and colleagues (2018b) found that therapists hold prognostic expectations for their individual clients that differ from their prognostic expectations for clients in general. These expectations toward clients may be due to biases therapists hold toward particular types of clients, or they may be due to general attitudinal variables of the therapist. For example, Wisch and Mahalik (1999) presented male therapists with vignettes of clients who differed in sexual orientation and types of emotional expression. Although overall therapists' ratings of client likability, empathy, comfort, willingness to see, adjustment, and prognosis did not differ based on the vignette, there were significant differences when therapist gender role conflict was included in the model. Further illustrating that therapist general attitudinal variables can impact their views of clients, Kivlighan and Marmarosh (2018) found that therapists' personal attachment anxiety is directly related to their perceptions of the quality of the working alliance with clients. This is important because therapists' views of clients have been found to be significantly associated with actual treatment outcomes (Connor & Callahan, 2015; Swift et al., 2018b).

Particularly relevant to the current study, Allman and colleagues (1992) surveyed 285 therapists, asking about their perceptions of their clients' mystical experiences. In this study, mystical experiences were defined as "a transient, extraordinary psychological event marked by feelings of being in unity and harmonious relationship to the divine and everything in existence, plus one or more of the following effects: noesis, religiosity, loss of ego, time and space alterations, ineffability, affect change during the event, transformation effect, and passivity, i.e.,

experiencing no control of the event" (Allman et al., 1992, p. 565). They found that humanistic therapists (compared to cognitive, psychodynamic, and behavioral), those who had a personal history with mystical experiences, and those who identified as more spiritual held more positive attitudes toward clients with mystical experiences and viewed those experiences as less pathological. Interestingly, the therapists' religious identification was not related to their views of the clients with mystical experiences. Outside of the context of mystical experiences as pathological or normal, we know very little about the impact that client and therapist religiosity/spirituality can have on therapists' views of clients and the likelihood of treatment success. Again, this is an important research question to understand because therapists' views of clients have been found to relate to actual treatment outcomes (Connor & Callahan, 2015; Swift et al., 2018b).

Current Study

The current study attempted to build on previous research of R/S beliefs and behaviors of practicing psychotherapists by: (1) exploring current trends of religiosity/spirituality among psychotherapists, (2) comparing psychotherapists' reports of religiosity/spirituality with reports from the general population, (3) empirically testing whether therapists' outcome expectations for clients differ based on the client's described religiosity/spirituality, and (4) examining whether therapists' personal religiosity/spirituality was associated with outcome expectations for R/S clients.

Research Aim 1: Describe Current Religiosity/Spirituality of Practicing Psychologists

In an effort to build on past research, the first aim of this study was to assess current levels of religiosity/spirituality in psychotherapists. Levels of religiosity/spirituality were examined through scores on standardized measures (RCI–10 & ISS), as well as the endorsement

of specific religious/spiritual beliefs and behaviors taken from a frequently referenced national poll (Pew, 2018a). This was important in that it allowed us to better understand the landscape of religiosity/spirituality among current therapists. With more than 60 years of research collected relative to religiosity/spirituality in the general population (i.e., Gallup, 2019, Pew, 2018a), only a small handful of studies on current therapist religiosity have been conducted. Based on our literature review, it appeared that the current study will be only the fourth in the past ten years to examine therapist religiosity/spirituality and the first study to focus solely on practicing psychologists.

In addition to deepening our understanding of the religiosity/spirituality of therapists, given our use of commonly used measures and questions of religiosity, we were able to compare the results from the current sample with results from the existing literature on religiosity/spirituality (Bergin & Jensen, 1986; Bilgrave & Deluty, 1998; Cassidy, 2006; Delany et al., 2007; Eckhardt et al., 1992; Francis, 2011; Langeland et al., 2010; Oxhandler et al., 2017; Shafransky & Malone, 1990). Although the main purpose of this research aim was descriptive, we expected to visually see trends toward decreasing religiosity/spirituality in therapists over time. This hypothesis was based on data indicating decreased religiosity in the general population over time (Gallup, 2019b; Pew, 2017).

Research Aim 2: Compare Current Psychologist Religiosity/Spirituality With That of the General Population

For the second research aim, we compared participating psychologists' responses on some of the religiosity/spirituality questions to responses seen in the general population of the same questions (Pew, 2018a). While therapists should attempt to remain value-neutral in the context of therapy, it has long been understood that both client and clinician values play a key

role in psychotherapy (Bergin, 1991; Vervaeke et al., 1997). As such, it is important to understand the extent to which value discrepancies exist regarding R/S beliefs and behaviors of therapists and potential clients of psychotherapy. Based on previous findings, such as those of Jensen (1986), we predicted that current levels of religiosity/spirituality would be significantly lower for psychologists in our sample than for current levels of religiosity/spirituality found in the general population as collected through a recent nationwide poll (Pew, 2018a). Based on the results from Jensen (1986), a small effect was expected.

Research Aim 3: Test the Impact of Client Religiosity/Spirituality on Therapists' Evaluation of Clients

The third aim of this study was to empirically test the impact that therapists' knowledge of a client's religiosity/spirituality has on their outcome expectations and hope for that client to succeed in psychotherapy. Much of the previous research has examined the effects of client religiosity/spirituality on the client's expectations for therapy (i.e., Shumway & Waldo, 2012). However, if therapists hold different views of clients based on their religiosity/spirituality, these views may positively or negatively impact their work with R/S clients. An enhanced understanding of therapists' views is needed in order to facilitate recommendations for recognizing and integrating religion and spirituality in practice. Given the dearth of existing literature on this subject, no directional hypotheses were made. Since previous research suggested that descriptions of client sexual orientation or emotional expression did not impact therapists' attitudes on average (Wisch & Mahalik, 1999), a small effect size was predicted.

Research Aim 4: Test the Relationship Between Therapists' Personal Religiosity/Spirituality and Their Evaluations of R/S Clients

With this aim, we examined whether the therapists' level of personal religiosity/spirituality predicted their evaluation of a R/S client. This aim indirectly related to the question about whether some therapists might be better suited to work with R/S clients. If certain types of therapists (i.e., ones who identify as more R/S) hold more positive views toward R/S clients, they, in turn, may be more effective in their work with those clients (Swift et al., 2018b). Efforts can then be made specifically with non-R/S therapists to improve attitudes toward R/S clients in order to build their competencies in R/S integration. Based on research indicating that clients' levels of religiosity/spirituality were positively correlated with their views of R/S therapists (Dimmick et al., 2019) and research indicating that therapist spirituality was significantly correlated with view of clients' mystical experiences (Allman et al., 1992), we expected significant positive relationships between therapists' levels of religiosity/spirituality and their views of R/S clients. Based on findings from these previous studies (Allman et al., 1992; Dimmick et al., 2019), moderate strong relationships were expected. These relationships were expected to be present even in the context of items assessing therapists' formal training in R/S integration and experience in work with R/S clients.

Chapter 2: Method

Participant Characteristics

See Table 1 for a full breakdown of participant characteristics for each condition. Across the entire sample, the average participant age was 53.52 (*SD* = 14.11) years old, with ages ranging from 30 to 84. Regarding gender and sexual orientation, participants were primarily female (70.70%, male = 28.03%, other = 1.27%) and heterosexual (90.00%, 3.33% homosexual, 2.26% bi-sexual, 2.00% pansexual, 0.66% identifying as "queer," 1.33% unspecified). The majority of participants identified as White (88.66%, 2.00% Asian, 0.66% Latinx, 2.66% Black/African American, 0.66% Native American, 1.33% multiracial, 4.00% other/unspecified). Participants reported a variety of current religious identifications (see Table 1 for a full breakdown). Identifications included: Atheist (8.66%), general non-specified Christian (9.33%), Catholic (6.00%), spiritual (9.33%), not religious (20.00%), unspecified (19.33%), other specified Christian religion(17.33%), other specified non-Christian religion(5.33%), and Agnostic (3.33%).

Participants reported practicing in 42 different U.S. states and territories, but the most common states included: Oregon 37 (11 participants), New Hampshire 29 (10 participants), Minnesota 23 (9 participants), New York 32 (6 Participants), and Maine 19 (7 participants) (See Table 3 for a full break down). After removing one outlier, on average, participants saw 18.48 (*SD* = 9.13) clients each week. About a quarter (25.33%) of the participants reported they had received formal training on religious/spiritual integration in psychotherapy.

Procedures

Participants for this study were recruited in three phases. During the first phase of recruitment, requests were sent to post a study recruitment script on listservs for state

psychological associations in all of the United States and Washington D.C. In total, 14 state associations agreed to post our survey on their listservs (i.e., Connecticut, Washington, D.C., Georgia, Iowa, Maine, Minnesota, Missouri, Nebraska, New Hampshire, Oklahoma, Pennsylvania, South Carolina, Tennessee, and Wyoming). The second phase of recruitment involved posting the survey link on the listservs for APA divisions 29 (Society for the Advancement of Psychotherapy) and 42 (Psychologists in Independent Practice). During the third phase of recruitment, psychologists were contacted individually through the APA Psychologist locator website (https://locator.apa.org). The four largest cities were identified for each state, and five psychologist profiles in those cities were then randomly selected using a random number generator. In cases where two of the largest four cities in a state were near each other, a comparable alternative city was selected that was in a different area of the state. Where possible, search radius was expanded to providers located within a 100-mile radius of the selected city in order to include both urban and rural providers.

The study recruitment post included an online link that took participants directly to the study's informed consent page. This page included basic information about the study, potential risks and benefits, and contact information for the study's authors if they had any questions or concerns. Upon providing informed consent, participants were presented with a screening question verifying that they had practiced therapy within the past two years. After certifying that they had practiced therapy in the past two years, participants were allowed to begin to take the survey. The settings were set so that participants were not able to return to previous items on the survey once they had completed them. Participants were then presented with a clinical vignette (see Appendix I). The vignette included information about the client's mental health symptoms and attitude toward treatment. For half of the participants, their vignette also mentioned that their

client was highly religious and desired religiosity/spirituality to be addressed in treatment. The rest of the participants were presented with an identical vignette, with the exception that it did not include information concerning the client's religiosity. After reading the vignette, participants were asked to evaluate the client by completing the Therapist's Hope for Client Scale (THCS; Bartholomew et al., 2020), as well as four items of therapists' outcome expectations taken from Swift et al. (2018b). In addition to completing the THCS and expectation items, participants were presented with several open-ended questions on why they gave the hope and expectation ratings that they did.

After completing the vignette portion of the survey, participants were asked to complete the Religious Commitment Inventory–10 (RCI–10;Worthington et al., 2003), the Intrinsic Spirituality Scale (ISS; Hodges, 2003), five R/S items taken from recent Pew research polls (2018a), four items from Jensen's (1986) original study of psychotherapist religiosity/spirituality, and three items from the past research of others (Bilgrave & Deluty, 2002; Francis, 2011; Hodges, 2002). Finally, participants were asked to complete items relating to demographic (e.g., age, state of residence/practice, race/ethnicity, gender, and sexual orientation) and practice (e.g., degree, years of practice, theoretical orientation, number of psychotherapy clients seen per week, percentage of clients in which R/S issues are addressed in psychotherapy, whether or not formal training was received in R/S integration, and whether or not they practiced in a rural area) information. Following the completion of the survey, participants were asked to enter their email address if they wished to be eligible to win a $50 Amazon gift card. In total, the study was estimated to take approximately 15 to 20 minutes to complete.

Clinical Vignettes

Participants were presented with one of two clinical vignettes (see Appendix I). Both vignettes were identical, with the exception that one vignette mentioned that the individual was highly involved in their religious community, considered their religious values to be highly important to them, and desired religiosity to be addressed in treatment. The description of symptoms in the clinical vignettes was based on the DSM criteria for major depressive disorder (MDD), but also included information about family history, employment status, hobbies, and attitudes towards psychotherapy. Two attention-check items were included (client name and diagnosis) to make sure that participants actually read the vignette.

Measures

Therapist Outcome Expectations for Clients

Participants were presented with four questions asking about their expected treatment outcomes for the vignette client. These items are taken from Swift et al. (2018b) and were based on the expectation items from the client-rated Credibility/Expectancy Questionnaire (CEQ; Devilly & Borkovec, 2000). The four items included the following: “At this point, how much do you feel that therapy will help this client to reduce their symptoms?” rated on a 11-point Likert-type scale ranging from 0 (not at all) to 10 (very); “By the end of the therapy period, how much improvement in the client’s symptoms do you feel will occur?” rated in percentages ranging from 0% to 100% with 10% increments; “By the end of the therapy period, what do you feel this client’s chances of recovery are?” rated in percentages ranging from 0% to 100% with 10% increments; and “By the end of the therapy period, what do you feel this client’s chances of improvement are?” rated in percentages ranging from 0% to 100% with 10% increments. Scores on these items were summed to achieve a total expectation score, ranging from 0 to 40, with

higher scores representing more positive outcome expectations for the client. Swift et al. (2018b) found an adequate level of internal consistency for these four items (α = .84) and found they significantly predicted actual treatment outcomes for clients (r = .29). An internal consistency of a = .85 was found with the current sample.

Therapist Hope for Clients (THCS)

In response to the vignettes, participants were also asked to respond to an adapted version of the Therapists' Hope for Client Scale (THCS; Bartholomew et al., 2020). The THCS was based on Snyder's Hope Theory (Snyder, 2002) and was "designed to assess therapists' hope for each individual client with whom they work" (p 196; Bartholomew et al., 2020). It consists of 10 items, each recorded on an eight-point Likert-type scale, ranging from 1 (definitely false) to 8 (definitely true). Because the current study required participants to complete the THCS in response to a vignette of a theoretical client, the wording of the THCS was adapted to reflect the prospective client in the vignette. For example, Item 2 which read, "I believe my client is aware of what she or he wants to accomplish through counseling," was changed to "I believe this client is aware of what she or he wants to accomplish through counseling." The original measure and the adapted measure can be found in Appendix II. The THCS had three subscales, labeled Goal Identification, Commitment to Client, and Optimism for Client. The THCS total and subscale scores were calculated by summing responses to individual items. Total scores ranged from 10 to 80, with higher scores indicating a greater amount of hope for the client. Bartholomew et al. (2020) found an adequate level of internal consistency for the measure (subscales: α = .81-.85; total: α = .89). They also found evidence for construct validity through significant correlations between the THCS and other measures of hope, including the Adult Hope Scale (r = .33, p < .001), (Snyder et al., 1991), the Inventory of Therapist Work with Client Assets and Strengths (r

= .33, $p < .001$), (Harbin et al., 2013) and the helping skills self-efficacy subscale of the Counselor Activity Self-Efficacy Scale ($r = .33$, $p < .001$) (Lent et al., 2003). An internal consistency of $a = .79$ was found with the current sample.

Religious Identification Items From the Pew Research Foundation Survey (2018a)

Participants were presented with five items from the most recent Pew Research Foundation's survey of religiosity (2018a), including the following: items regarding religious behaviors, such as "How frequently do you attend religious services?" and "How frequently do you pray?"; internal states of being, or "How frequently do you experience feelings of spiritual peace and well-being?"; and affiliation, indicated by "Do you consider yourself to be a religious person?" and "Do you consider yourself to be a spiritual person?" All items were answered with a five-point Likert-type response, with responses ranging from 4 (daily/very religious) to 0 (seldom/not religious at all). Items were initially considered individually for analysis; however, due to detected differences in the scaling of the original and current study, only two items—"Do you consider yourself to be a spiritual person?" and "Do you consider yourself to be a religious person?"—could be statistically analyzed. All other items were analyzed qualitatively. Pew research items were included because they have been consistently used as measures of R/S beliefs and behavior among the general population, allowing for a direct comparison of R/S-associated behaviors and beliefs between therapists and the general population. They also target non-theistic spirituality, which is often an understudied aspect of R/S beliefs and behaviors.

Additional Religious Identification Items From Past Research

In addition to questions from recent polls, participants were presented with seven items from past research of therapist R/S beliefs and behaviors. Four of the items came from Jensen (1986), who was among the first to assess R/S-associated beliefs and behaviors among therapists.

Items from Jensen's original study were included in several subsequent studies on therapist R/S behaviors and beliefs (i.e., Bilgrave & Deluty, 2002; Delany et al., 2007; Oxhandler et al., 2017). These items included "I try hard to live my life according to my religious beliefs," "My whole approach to life is based on my religion," "I seek a spiritual understanding of the universe and one's place in it," and, "I actively participate in my religious affiliation." All items were responded to on a five-point Likert-type scale with responses ranging from 5 (strongly agree) to 1 (strongly disagree). In addition to Jensen (1986) items, three additional items from other researchers were presented to participants. These items emphasized spirituality and history of religious affiliation. These items included "Spiritual beliefs are very important to me" (2002; Francis, 2011), "I was raised in a particular religion" (Hodges, 2002; Prest et al., 1999; Shafranske & Malone, 1990), and "I am currently affiliated with a religious organization" (Dwyer, 2008; Francis, 2011; Kelly, 1995; Rosmarin et al., 2013; Shafranske & Malone, 1990; Ying, 2009). All items were responded to on a five-point Likert-type scale with responses ranging from 5 (very true) to 1 (not all true). Both Jensen's (1986) items and the additional items were analyzed on an item-by-item basis.

Religious Commitment Inventory–10 (RCI–10)

The RCI–10 (Worthington et al., 2003) is a brief measure designed to assess religious commitment. The measure's authors defined religious commitment 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, Worthington et al., 2003). The 10 items on the RCI–10 are all rated on a five-point Likert-type scale, with response options ranging from: 1 (not at all true of me) to 5 (totally true of me). Example items include "I often read books and magazines about my faith" and "I spend time trying to grow in understanding of my faith" (Worthington et al., 2003). Total scores were found

by summing response scores from each item; possible scores range from 10 to 50. Worthington et al. (2012) reported that mean RCI–10 scores for non-religious populations generally range from M = 21 to 26 (*SD = 10 to 12*). Thus, Worthington et al. (2012) suggested that scores at or above 38 should be considered highly religious. Internal consistency for the RCI–10 ranges from α = .88 to α = .98 (Worthington et al., 2003). Other recent studies found levels of internal consistency within this range as well (α = .94; α = .95) (Ashraf & Nassar, 2018; Dimmick et al., 2020). Test-retest reliability was found to range from r = .84 (5 months) to r = .87 (3 weeks) (Worthington et al., 2003). The RCI was also found to be correlated with self-rated spirituality (r = .58, $p < .0001$) and a single item measure of religious participation (r = .70, $p < .0001$) (Worthington et al., 2003). An internal consistency of a = .96 was found for the current sample.

Intrinsic Spirituality Scale (ISS)

The ISS is a brief measure of the extent to which spirituality serves as an individual's primary motivating factor (Hodge, 2003). It is different from other measures of spirituality in that it does not reference God or deity in an attempt to capture spirituality both within and without the context of religion, and thus, it increases validity for non-theistic populations. The ISS is a six-item measure of spirituality. It utilizes a phrase completion method where participants complete sentences to indicate their level of agreement on a scale of 0 to 10, with 0 representing an absence of the attribute and 10 representing the maximum amount of the attribute. Example items include "In terms of the questions I have about life, my spirituality answers . . . 0 (no questions) to 10 (absolutely all my questions)" and "Spirituality is . . . 0 (no part of my life) to 10 (the master motive of my life, directing every other aspect of my life)" (Hodge, 2003). Total scores were calculated by averaging the individual item scores. Possible total scores ranged from 0 to 10, with 0 representing a person for whom spirituality played

absolutely no role in their life and 10 representing a person who was highly motivated by their personal spirituality. In regard to internal consistency, the measure's authors reported a Cronbach's Alpha of .96 (Hodge, 2003). In their re-evaluation of the ISS, Gough et al. (2010) found an average inter-item correlation of $r = .65$ and a Gutman split-half reliability of $r = .91$. These same authors found convergent validity for the ISS with measures of other related constructs, including the Using Private Prayer as a Means of Coping scale ($r = .65$) (Ai et al., 2002), Prayer Frequency (Meisenhelder & Chandler, 2001) ($r = .50$), and the Connor-Davidson Resilience Scale (Connor & Davidson, 2003) ($r = .44$). An internal consistency of $a = .98$ was found for the current sample.

Data Analyses

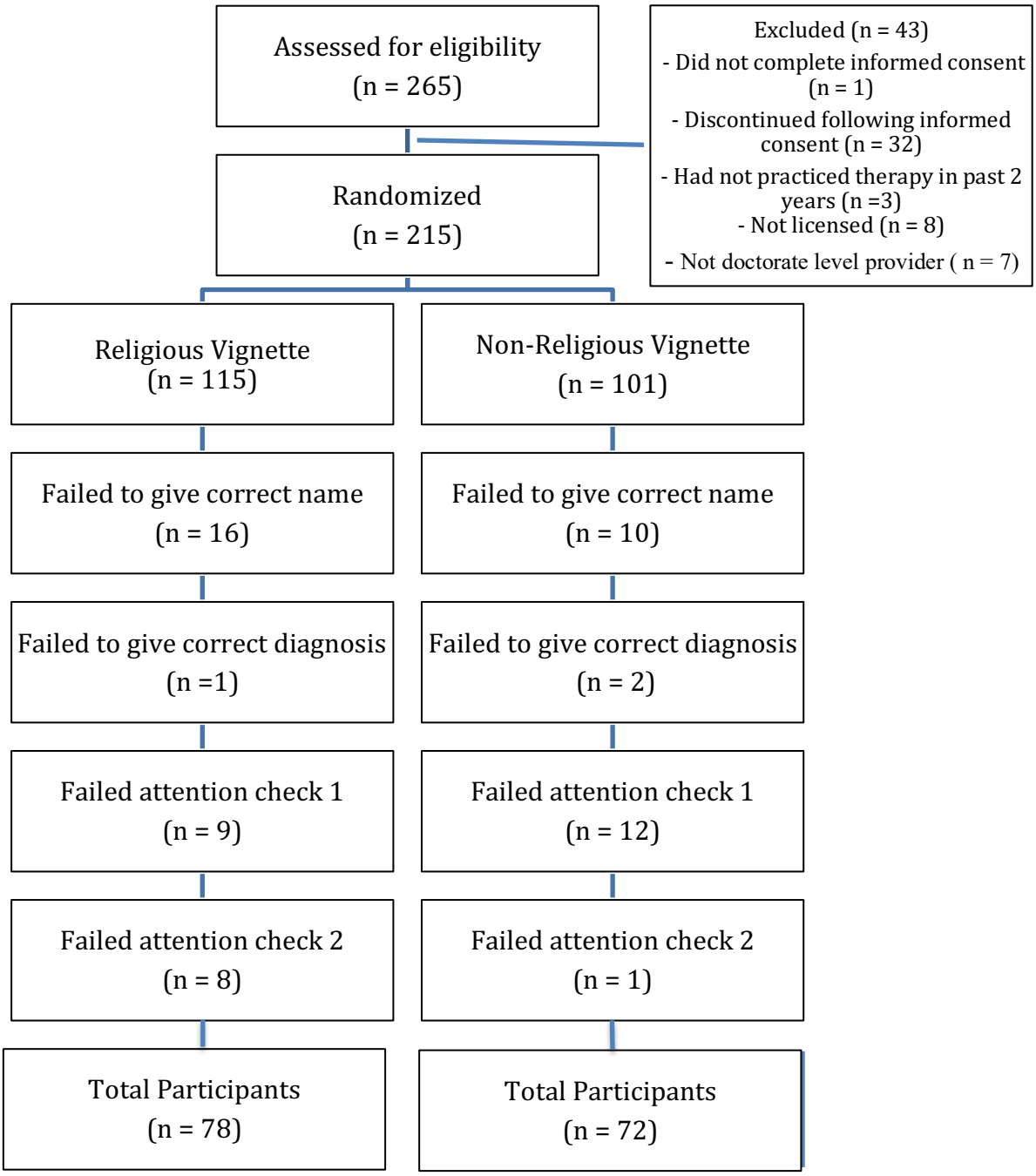
Participant Flow

A total of 265 individuals viewed the informed consent page for this study. Of these, one did not provide informed consent, 31 discontinued with the survey immediately after endorsing informed consent, eight reported they were not currently licensed to provide psychotherapy, seven did not hold doctoral level licensing, and three stated they had not practiced therapy in the past two years. The remaining 222 participants were randomly presented with either the religious or non-religious clinical vignette, 115 and 101 divided respectively. After reading through their respective clinical vignettes, participants were presented with two attention-check items, which required them to identify the name and diagnosis of the individual in the clinical vignette they had just read. Twelve individuals from the non-religious vignette condition and 17 individuals from the religious vignette condition failed to correctly identify the name of the individual in their clinical vignette or identify their DSM-V diagnosis (Major Depressive Disorder) and were dropped from the study.

In addition to the attention check items specific to the clinical vignette, participants were presented with two additional attention checks ("what is 1+1" and "select A") to help ensure they were paying attention throughout the study. A total of 21 participants (12 in the non-religious vignette condition and 9 in the religious vignette condition) failed to complete the first attention-check item correctly. An additional 9 (1 non-religious, 8 religious) participants were removed for not completing the second attention-check item correctly. The final sample size after data cleaning and quality checking was 150 (72 non-religious, 78 religious) participants. See Figure 1 for an outline of participant screening.

Figure 1

Participant Flow Diagram



Missing Data. Missing data was then analyzed for the final sample of 150 participants. After cleaning the data, the only outcome measure that included any missing data was the third

outcome expectation item taken from Swift et al. (2018b). This was due to an issue in survey distribution in which 32 participants were not presented with this item. Participants missing scores were calculated by averaging their score on the other three items for this measure.

Outliers. Outliers were identified as individual item scores that were 3.5 standard deviations or more from the mean for that item. No outliers were identified on the main variables of interest for this study.

Normality. Normality of the data was then assessed for the THCS, ISS, RCI-10, and Expectation items. THCS scores had a skewness of -0.35 *(SE = 0.19)* with a kurtosis of 0.33 (*SE* = 0.39). ISS scores had a skewness of -0.18 (*SE* = 19.86), with a kurtosis of -1.36 (*SE* = 0.39). The RCI-10 scores had a skewness of 0.73 (*SE* = 0.19) with a kurtosis of -0.88 (*SE* = 0.38). The expectation total scores had a skewness of -1.73 (*SE* = 0.20), with a kurtosis of 1.4 (*SE* = 0.39). These values were all in the acceptable range for normality (between 2 and -2; George & Mallery, 2010).

Differences Between Conditions. Differences between the conditions on the continuous variables were checked using independent samples' *t*-tests. No significant differences were found between the two groups for number of hours of training in R/S integration, with $t(144.35) = 0.56$ and $p = 0.57$; number of clients seen each week, with $t(77) = 1.35$ and $p = 0.18$; number of years practicing as a psychologist, with $t(145.82) = 1.11$ and $p = 0.27$; percentage of clients that they discuss R/S issues with in treatment, with $t(142.96) = 0.50$ and $p = 0.62$; percentage of clients where R/S is integrated into treatment, with $t(130.53) = 1.20$ and $p = 0.23$, the number of hours they had received of formal R/S integration training, with $t(144.35) = 0.56$ and $p = 0.57$, or participant age, with $t(143.91) = 1.95$ and $p = 0.053$.

For the categorical variables, chi-squared tests of independence were used to test for differences between the vignette conditions. No significant differences were found based on gender ($\chi^2 = 15.63$, $p = .47$), sexual orientation ($\chi^2 = 6.59$, $p = .16$), race ($\chi^2 = 6.39$, $p = .60$), state of practice ($\chi^2 = 68.05$, $p = .78$), credentials ($\chi^2 = 3.84$, $p = .15$), professional discipline ($\chi^2 = 1.24$, $p = .54$), theoretical orientation ($\chi^2 = 4.15$, $p = .66$), practice setting ($\chi^2 = 3.78$, $p = .58$), participant's current religious identification ($\chi^2 = 78.49$, $p = 0.53$), or whether or not they had received training in R/S integration into therapy ($\chi^2 = 0.15$, $p = .70$). Additionally, those who identified as being atheist, spiritual but not religious, not religious, or agnostic were grouped as "Not Religious," while those who identified as being a member of any religious organization were categorized as "Religious." Of those surveyed, 41.33% fell in the "Not Religious" category. No significant differences between the two vignette conditions ($\chi^2 = 3.62$, $p = .057$), were found based on these groupings.

Research Aim 1: Describe Current Religiosity/Spirituality of Practicing Psychologists

The initial plan for this research aim was to assess religiosity/spirituality of the participating therapists using total scores from both the RCI–10 and ISS, as well as individual R/S items previous research (Bergin & Jensen, 1990; Bilgrave & Deluty, 2002; Dwyer, 2008; Francis, 2011; Hodge, 2002; Kelly, 1995; Prest et al., 1995; Rosmarin et al., 2013; Shafranske & Malone, 1990; Ying, 2009). Frequencies, means, standard deviations, and ranges were reported as appropriate to describe the current levels of religiosity/spirituality among the participating therapists. Given that this aim is descriptive in nature, no statistical tests were conducted. However, responses on the other previous research religious items were graphed in a bar chart to provide a visual comparison with responses obtained in previous studies of therapist religiosity/spirituality.

Research Aim 2: Compare Current Psychologist Religiosity/Spirituality With That of the General Population

Through this aim, we tested for differences in religiosity/spirituality between the general population and the participating psychotherapists in this study on R/S items from the most recent Pew (2018a) research polls. We hypothesized that the participating psychotherapists would report significantly lower levels of religiosity/spirituality on all items. The initial plan was to examine this with five one-sample *t*-tests for five items from the Pew research survey (2018a). During the data analysis, it was discovered that there were marked differences in scaling of three of the items that prevented them from being analyzed with a one-sample *t*-test. Because of this, one-sample *t*-tests were conducted for two of the items from the Pew Research poll (2018a), and a qualitative comparison was made for the other three variables. With regard to the *t*-tests, given an estimated small effect with a .01 alpha level and .80 power, 99 participants were needed to identify a significant difference. A two-tailed option was used for this test in order to take a conservative approach and allow for the possibility of higher levels of religiosity/spirituality in the current sample compared to the general population. A Holm-Bonferroni method was used for the alpha level in order to control the family-wise error rate.

Research Aim 3: Test the Impact of Client Religiosity/Spirituality on Therapists' Evaluation of Clients

Through this aim, we tested the impact of including R/S information in the vignette on therapists' evaluations of the described client. No directional hypotheses were made; instead, we were interested in testing whether a difference of any type (positive or negative) would be found. Two independent sample *t*-tests were used to test for differences between groups: one for therapists' outcome expectation scores and one for scores on the THCS. Given an estimated

small effect with a .025 alpha level and .80 power, 314 participants were needed to identify a significant difference. A two-tailed option was used for this test as well as the Holm-Bonferroni method in order to control the family-wise error rate.

Research Aim 4: Test the Relationship Between Therapists' Personal Religiosity/Spirituality and Their Evaluations of R/S Clients

Through this aim, we tested whether therapist personal religiosity/spirituality as measured by the RCI–10 and ISS could predict their evaluation of the R/S client above-and-beyond therapist responses to questions about formal training in R/S integration and experience in working with R/S clients. Two (one predicting therapist outcome expectations and one predicting THCS scores) two-step multiple regressions were conducted. In the first step, scores on formal training in R/S integration (yes or no) and experience working with R/S clients (% of caseload where religiosity/spirituality are discussed) were entered in the model. In the second step, RCI–10 scores and ISS scores were entered, and the R^2 change value was examined for significance. We hypothesized that these variables would add significantly to the variance explained for both outcome variables. Given an estimated medium effect with a .05 alpha level, .80 power, and four total predictors, 68 participants were needed to identify a significant difference. It is noted that the analyses for this research aim was conducted only with data from participants who viewed the vignette that described the client as religious; thus, at least 68 participants were needed in that condition.

Chapter 3: Results

Table 1

Participant Characteristics Separated by Vignette Condition.

	Non-Religious (n = 72)	Religious (n = 78)
Age	M = 51.24 (SD = 13.93)	M = 55.74 (SD = 14.01)
Gender		
Male	27.78%	30.77%
Female	72.22%	66.67%
Other	0.00%	2.56%
Sexual orientation		
Heterosexual	86.11%	93.58%
Homosexual	5.55%	1.28%
Bi-sexual	2.77%	2.56%
Pansexual	4.16%	0.00%
Other	1.38%	2.56%
Race		
White/Caucasian	88.89%	88.46%
Asian	1.39%	2.56%
Latinx	1.39%	0.00%

Black/African American	2.78%	2.56%
Native American/Indigenous	0.00%	1.28%
Multiracial	2.78%	0.00%
Other/Unspecified	2.78%	5.12%
Current religious identification		
Atheist	13.88%	3.84%
Jewish	4.17%	2.56%
Unitarian/Universalist	0.00%	5.13%
General Christian	4.17%	14.10%
Catholic	6.94%	5.12%
Spiritual	11.11%	7.69%
Lutheran	1.38%	2.56%
Not Religious	22.22%	17.94%
Episcopalian	2.77%	5.13%
Quaker	0.00%	1.28%
Presbyterian	0.00%	1.28%
Church of Jesus Christ of Latter-day Saints	2.77%	2.56%
Multiple	1.38%	0.00%
Agnostic	2.77%	3.84%

Buddhist	1.38%	2.56%
Evangelical	1.38%	1.28%
Greek Orthodox	1.32%	1.28%
Baptist	1.38%	1.28%
Anglican	1.38%	0.00%
Methodist	1.38%	0.00%
Other	17.12%	19.23%
In transition	1.32%	1.28%
State of practice		
Alabama	1.39%	0.00%
Alaska	1.39%	1.28%
Arizona	1.39%	0.00%
Arkansas	1.39%	0.00%
California	2.78%	0.00%
Colorado	1.39%	0.00%
Connecticut	1.39%	0.00%
Washington DC	2.78%	0.00%
Florida	1.39%	1.28%
Hawaii	1.39%	1.28%
Georgia	1.39%	1.28%
Idaho	1.39%	1.28%
Illinois	1.39%	1.28%

Indiana	1.39%	1.28%
Iowa	4.17%	1.28%
Kansas	0.00%	1.28%
Kentucky	0.00%	1.28%
Louisiana	1.39%	5.13%
Maine	4.17%	5.13%
Maryland	5.56%	3.85%
Massachusetts	4.17%	2.56%
Michigan	2.78%	2.56%
Minnesota	5.56%	5.13%
Missouri	2.78%	3.85%
Nebraska	1.39%	3.85%
New Hampshire	6.94%	6.41%
New Jersey	4.17%	3.85%
New Mexico	4.17%	3.85%
New York	4.17%	3.85%
North Carolina	4.17%	1.28%
North Dakota	0.00%	1.28%
Oklahoma	4.17%	2.56%
Oregon	4.17%	1.28%
Pennsylvania	4.17%	1.28%
Puerto Rico	1.39%	0.00%

South Carolina	1.39%	1.28%
Tennessee	0.00%	1.28%
Texas	4.17%	1.28%
Utah	1.39%	1.28%
Virginia	2.78%	1.28%
Washington	1.39%	1.28%
Wisconsin	2.78%	1.28%
Wyoming	5.56%	1.28%
Credentials		
PhD/PsyD	98.61%	92.31%
LPC/LMHC	1.38	1.28%
Other	2.63%	5.13%
Discipline		
Clinical Psychology	76.38%	70.51%
Counseling	20.83%	21.79%
Psychology		
Other	2.77%	7.69%
Theoretical orientation		
Behavioral	1.39%	3.85%
Cognitive	2.78%	3.85%
Cognitive-Behavioral	30.56%	38.46%

Humanistic/Client-Centered	8.33%	10.26%
Integrative	29.17%	20.51%
Psychodynamic/ Psychoanalytic	13.89%	8.97%
Other	13.89%	17.95%
Setting		
Academic/University	4.17%	7.69%
Hospital	2.78%	2.56%
Inpatient	1.39%	1.28%
Outpatient community clinic	5.56%	2.56%
Outpatient private/group practice	81.94%	74.36%
Other	4.17%	10.26%
General experience		
Mean years practiced	*M* = 19.94 (*SD* = 13.05)	M = 22.34 (*SD* = 13.30)
Mean number of clients per week	*M* = 17.09 (*SD* = 9.01)	*M* = 19.77 (*SD* = 9.10)
Member of an interdisciplinary team	26.38%	30.76%

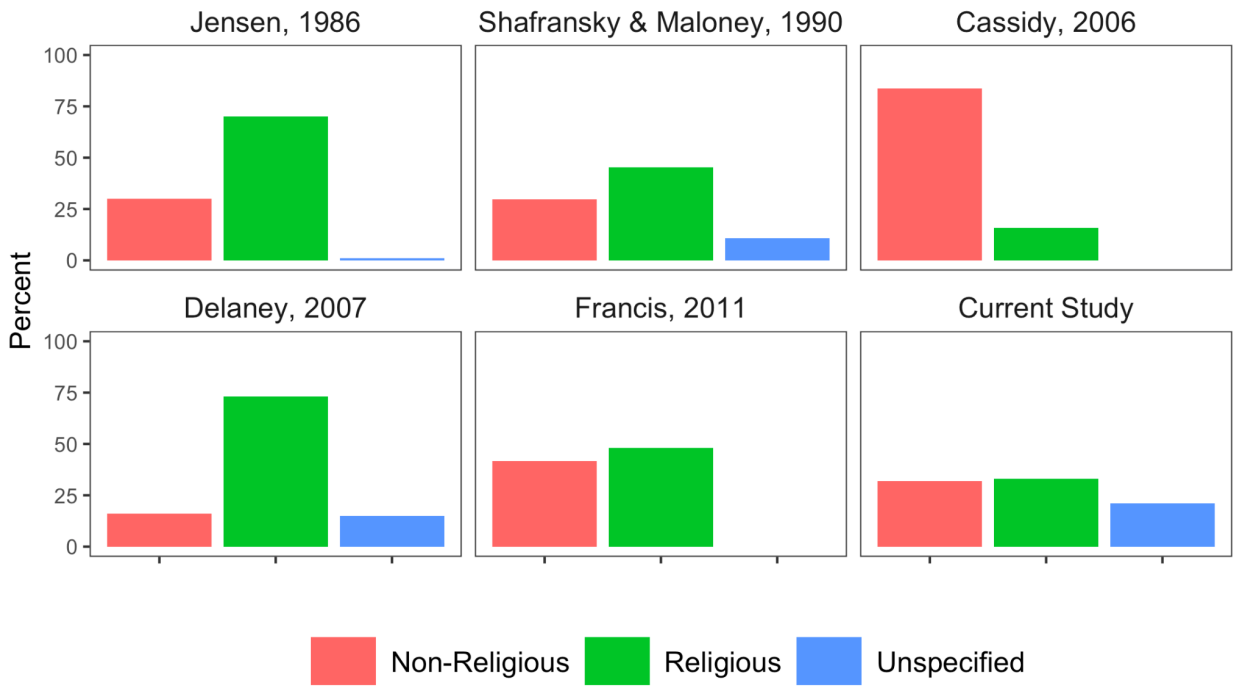
R/S practice experience		
Received formal training on R/S integration	27.77%	23.07%
Mean number of hours of R/S integration training	*M* = 5.33 (*SD* = 15.21)	*M* = 9.08 (*SD* = 14.98)
Mean percent of clients that discuss R/S issues	*M* = 14.01 (*SD* = 25.22)	*M* = 16.19 (*SD* = 26.75)

Research Aim 1: Describe Current Religiosity/Spirituality of Practicing Psychologists

In an effort to broadly understand the landscape of religiosity and spirituality among psychotherapists, our initial research aim was to describe the current religiosity and spirituality of practicing psychologists using standardized measures and questions from previous research and national polls. Although this research aim is descriptive in nature, we did hypothesize that we would see a general decrease in reported levels of religiosity/spirituality over time, consistent with trends observed in the general population (Gallup, 2019b; Pew, 2017). In Figure 2, the religious affiliation of participants was dichotomized into those who identified as being religious/spiritual and those who did not. For the purpose of this illustration, those who identified as agnostic, atheist, or non-religions were grouped with the non-religious group, while those who identified with a specific religious denomination were grouped as being religious. Those who identified as being spiritual were not included in this figure. In the current sample, 33.06% of the sample identified as being religious, 32.00% identified as being non-religious, and 21.00% did not specify a religious affiliation.

Figure 2

Percent of Psychologists Who Identify as Religious by Study



In the current sample, participants' mean religiosity as measured by the RCI–10 was *M* = 19.03 (*SD* = 9.24), with scores ranging from 10 to 40. The RCI–10 authors found that for non-religious populations, average scores typically ranged from *M* = 21 to *M* = 26 (*SD* = 10 to 12) (Worthington et al., 2003); thus, the score for the current sample represented a low level of religiosity. While the RCI–10 is most often used with general population samples, two studies were identified that examined RCI–10 scores in psychotherapy providers. Cornish (2012) found an average score of *M* = 22.1 (*SD* = 11.4) for 242 members of the American Group Psychotherapy Association, which included clinical psychologists, counseling psychologists, psychiatrists, social workers, and marriage and family therapists. Cassidy (2006) examined RCI–10 scores among 253 counseling and clinical psychology students during their predoctoral internship. Among clinical psychology students, the average RCI–10 score was *M* = 22.63 (*SD* = 11.33), while among counseling students, the average was *M* = 26.49 (*SD* = 11.11). Again, scores in the current sample indicated a lower level of religiosity compared to previous research.

Participant spirituality was measured by the ISS. The average score on this measure with the current sample was *M* = 4.74 (*SD* = 3.23), with participant scores ranging from 0 to 10. The only study that we were able to locate which utilized the ISS on a population of therapists examined ISS scores on a sample of 600 social workers; average ISS scores were *M* = 6.76 (*SD* = 2.23) (Larsen, 2011). We were also able to identify several studies that reported ISS mean scores for other populations. In one study, which assessed 140 individuals from Israel with a gambling disorder, average ISS scores were *M* = 5.92 (*SD* = 3.05) (Gavriel-Fried et al., 2020). Another study that examined intrinsic spirituality levels among sexual minority populations found mean ISS scores of *M* = 4.59 (*SD* = 1.84) (Wright & Stern, 2016). A third study investigated intrinsic spirituality among caregivers of Alzheimer's patients and found a mean ISS

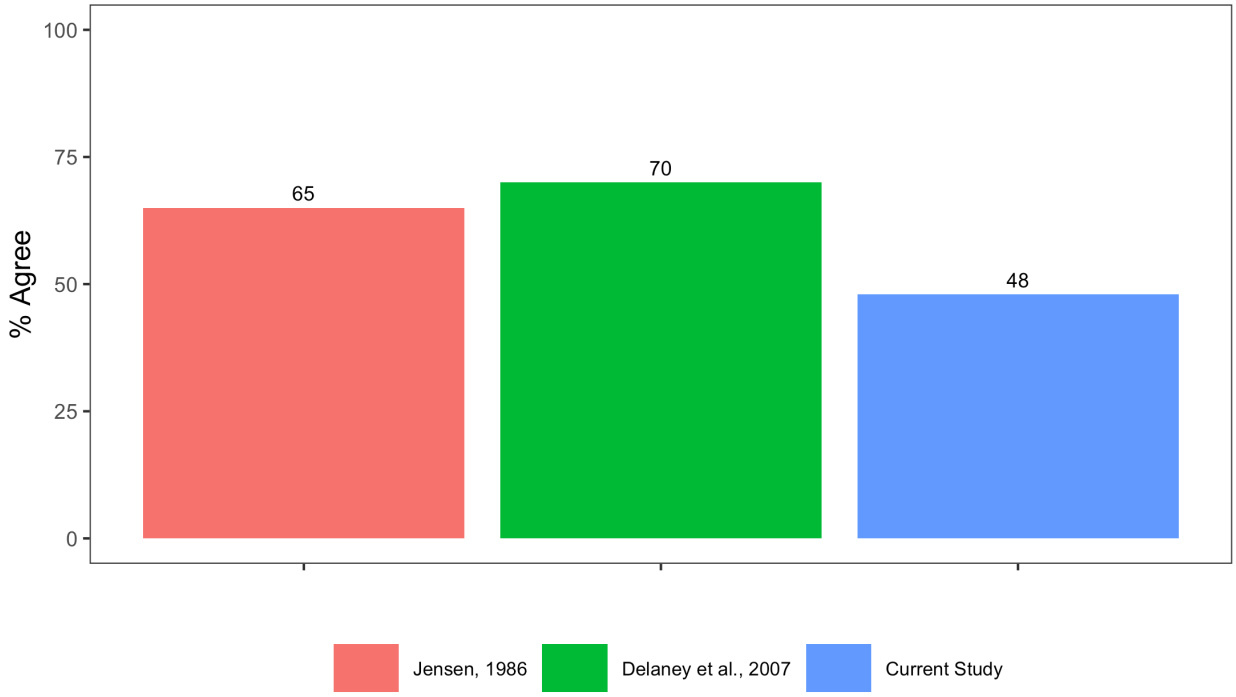
score of $M = 7.6$ ($SD = 2.15$) (Wilks, 2006). Thus, compared to other populations, the mean ISS scores obtained from the current sample appeared to fall on the lower end of what has been detected.

In this study, therapist religiosity/spirituality was additionally assessed by utilizing a number of items from previous research, including four items taken from Jensen (1986) assessment of therapist's values: "I try hard to live my life according to my religious beliefs," "My whole approach to life is based on my religion," "I seek a spiritual understanding of the universe and one's place in it," and "I actively participate in my religious affiliation." All items were rated with a five-point Likert scale response ranging from 5 (strongly agree) to 1 (strongly disagree).

For the item, "I try hard to live my life according to my religious beliefs," participant response was $M = 3.09$ ($SD = 1.56$). Figure 3 compared responses on the current survey with those from two other studies (Jensen, 1985, Delaney et al., 2007) which asked mental health providers the same question; a lower percentage of participants in the current sample agreed with this item than either of the two previous studies.

Figure 3

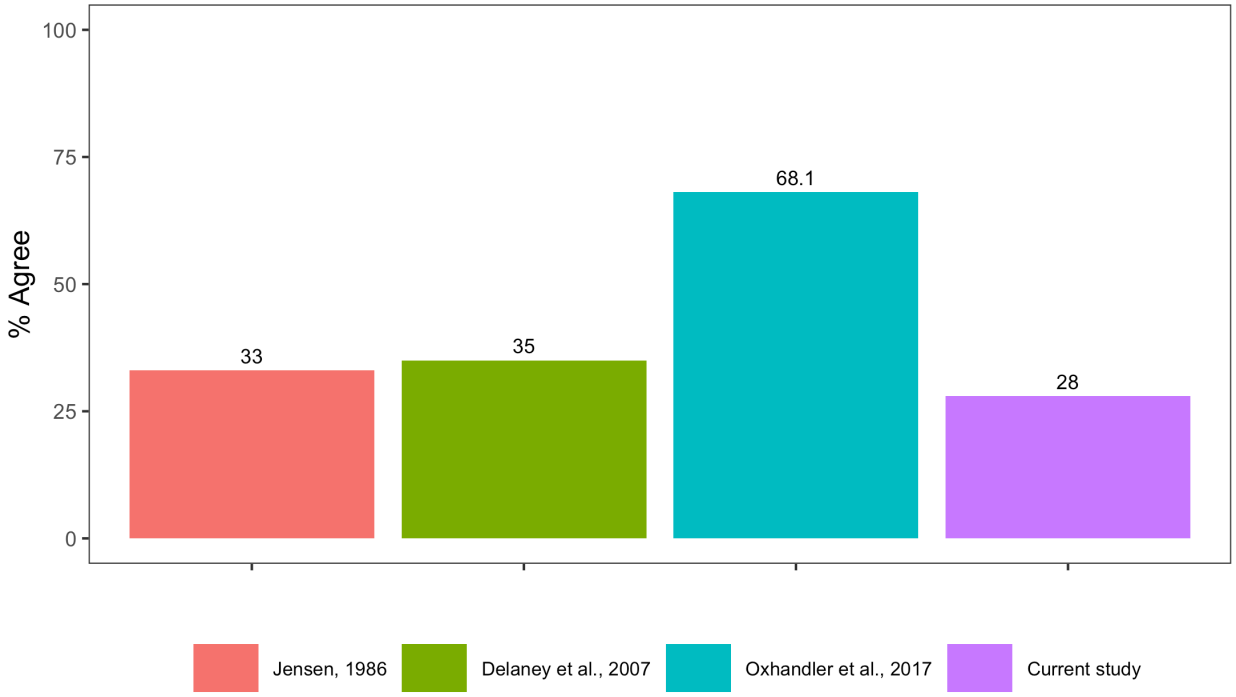
I Try Hard to Live My Life According to My Religious Beliefs



For the item, “My whole approach to life is based on my religion,” average participant response was $M = 2.30$ ($SD = 1.43$). Figure 4 compares responses on the current study with those of three previous studies (Jensen, 1986; Delaney et al., 2007; Oxhandler et al., 2017). A lower percentage of participants agreed with this item than any of the previous studies.

Figure 4

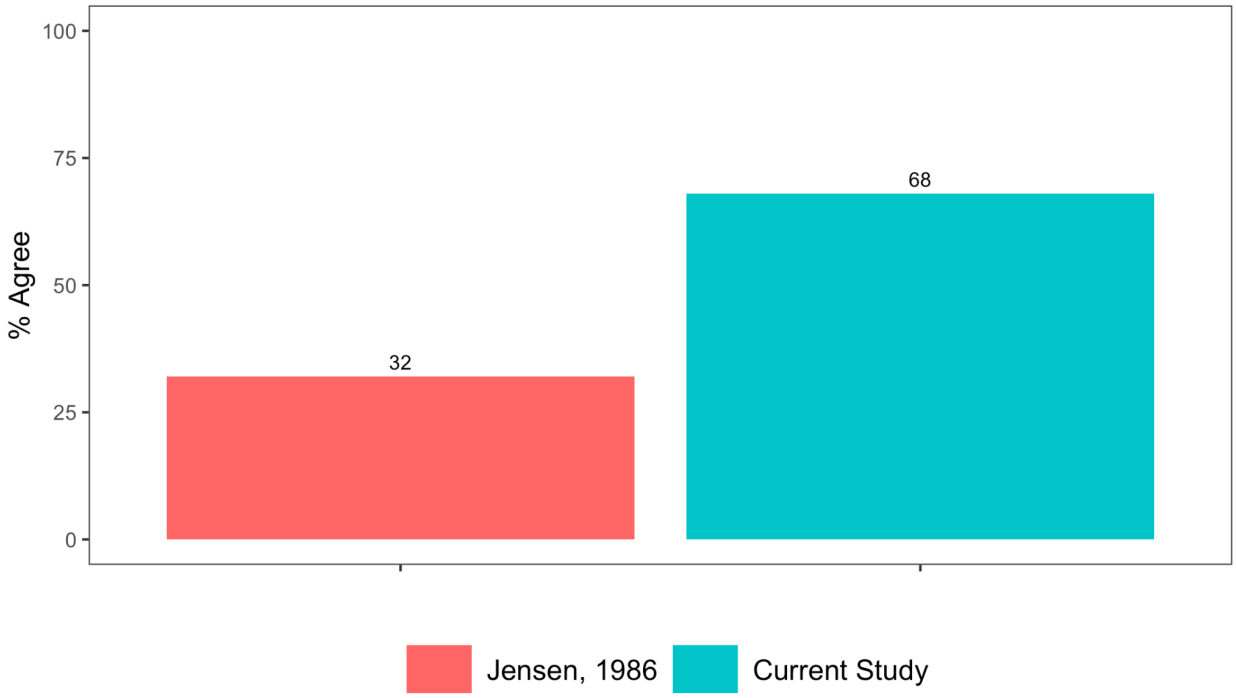
My Whole Approach to Life Is Based on My Religion



Concerning the third item, “I seek a spiritual understanding of the universe and one's place in it,” average participant response was $M = 3.53$ ($SD = 1.47$). Figure 5 compares the responses on the current sample with those of the only other study we were able to identify that utilized this same item on a population of therapists (Jensen, 1986). Participant responses on the current survey were higher than those from Jensen (1986).

Figure 5

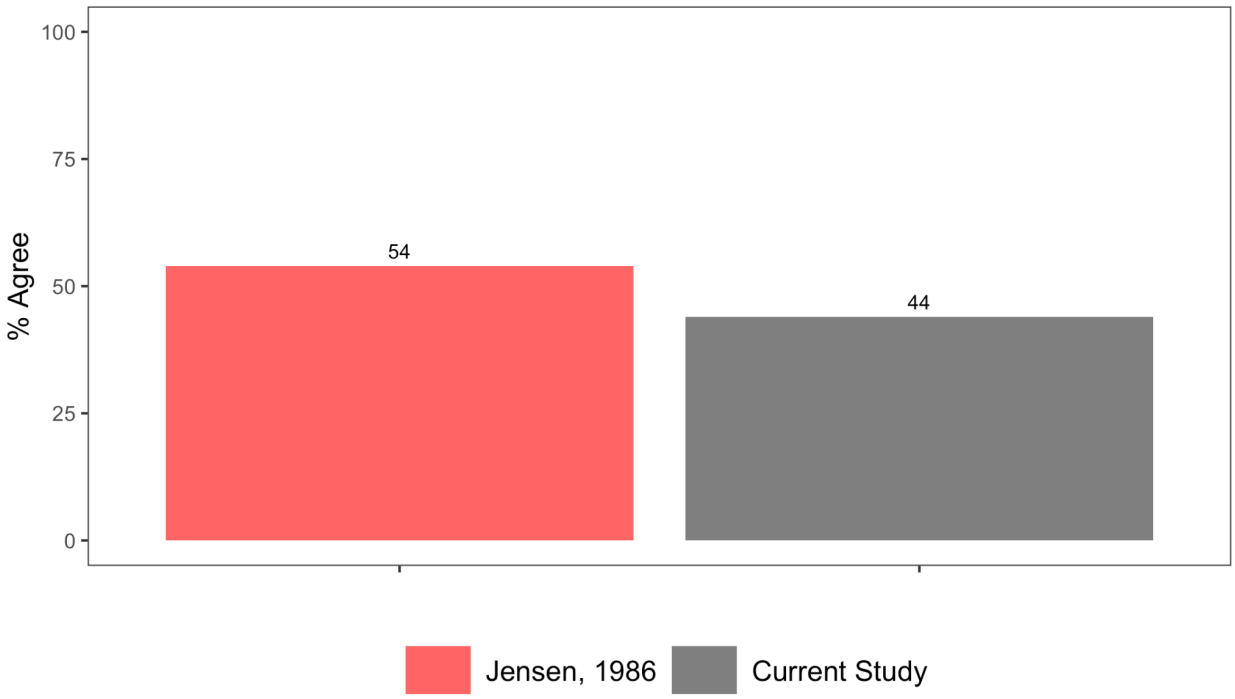
I Seek a Spiritual Understanding of the Universe and One's Place in It



The final item from Jensen (1986), "*I actively participate in my religious affiliation,"* had an average score of $M = 2.48$ ($SD = 1.57$). Figure 6 compares the response from the current study with those of Jensen (1986). Approximately 10% fewer participants in the current sample agreed with this item compared with the study conducted by Jensen (1986).

Figure 6

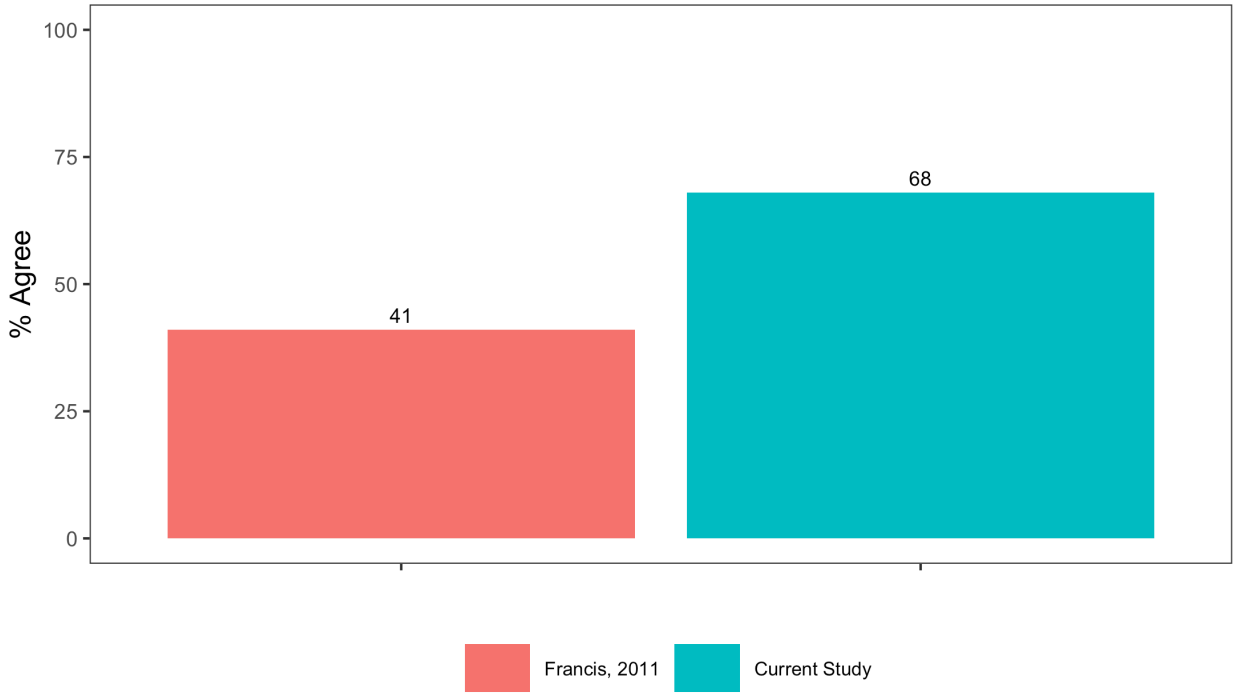
I Actively Participate in My Religious Affiliation



In addition to items taken from Jensen (1986), participants were presented with three additional items that have been used in multiple studies. The first of these items was “Spiritual beliefs are important to me.” Responses to this item were rated on a five-point Likert scale ranging from 1 (not at all true) to 5 (very true). For the current sample, mean response was M = 3.04 (SD = 0.84). Of participants in our sample, 50% responded to this item with a score of 4 or 5. Figure 7 compares responses from our sample with that of Francis (2011), which used this same item.

Figure 7

Spiritual Beliefs Are Very Important to Me



Participants were also asked about past and current religious affiliation. In response to the item, “I was raised in a particular religion,” average participant response for the current sample was $M = 3.24$ ($SD = 0.80$). Figure 8 compares the percent of individuals from the current study who agreed with this item compared with those from previous research on therapists’ religiosity/spirituality (Shafranske and Maloney, 1990; Prest et al., 1999; Hodge, 2002). Percent on individuals who agreed to this item on the current study was lower than those reported in the previous studies. In relation to current affiliation, participants responded to the item, “I am currently affiliated with a religious organization.” Average response to this item was $M = 2.97$ ($SD = 0.85$). Figure 9 compares the responses of this study’s participants with those of past research (Shafranske and Maloney, 1990; Kelly et al., 1995; Francis, 2011; Rosmarin et al., 2015).

Figure 8

I Was Raised in a Particular Religion

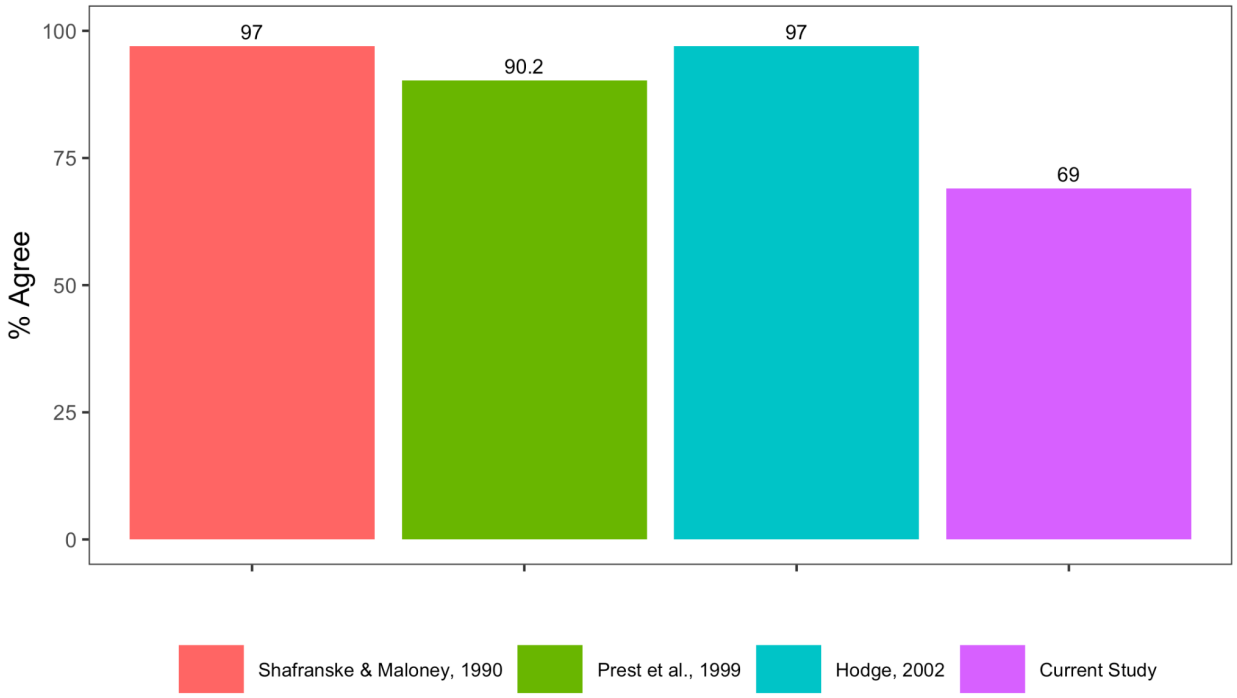
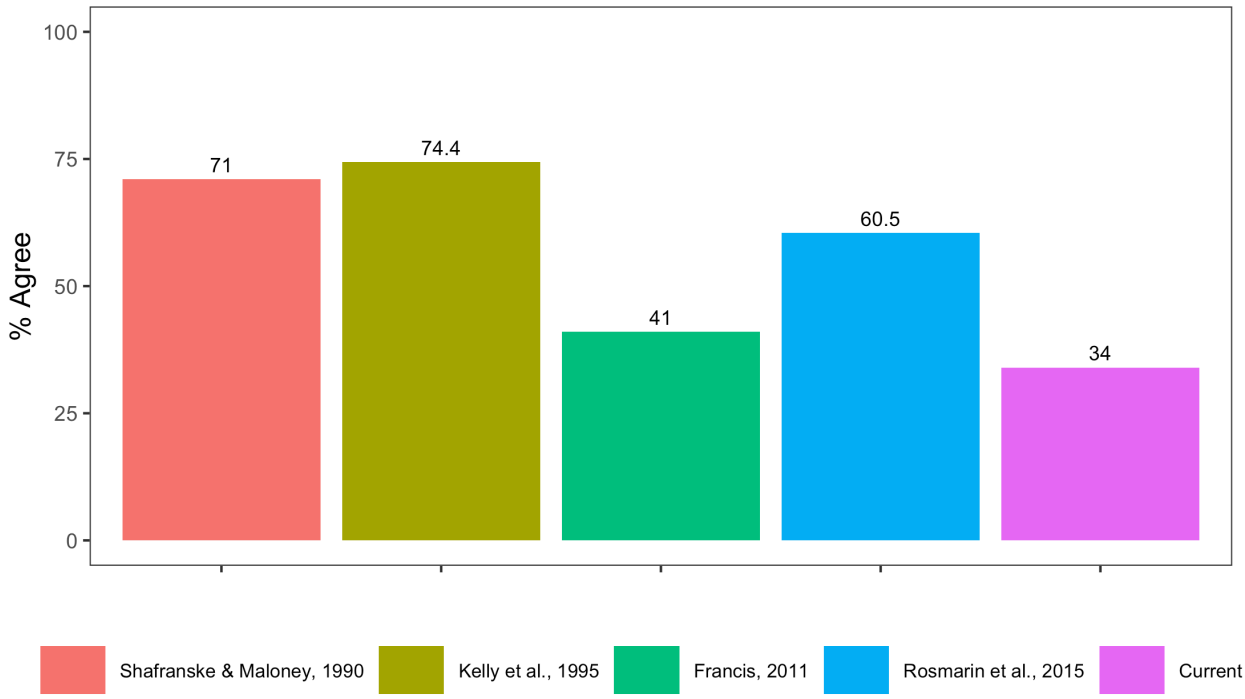


Figure 9

I Am Currently Affiliated With a Religious Organization



In summary, while no statistical analyses were conducted for the current research aim, several qualitative differences were observed between the participants in the current sample and those from past research. Specifically, lower levels of agreement were observed for the items: "*I try hard to live my life according to my religious beliefs,*" "*My whole approach to life is based on my religion,*" "*I actively participate in my religious affiliation,"* and *"I was raised in a particular religion."* For the item, *"I am currently affiliated with a religious organization,"* participants from the current study endorsed levels of agreement that were lower than three of the previous studies, and equal to one. Higher levels of agreement were reported for the item, "*I seek a spiritual understanding of the universe and one's place in it."* This partially supported our hypothesis on a general trend toward decreasing religiosity/spirituality over time, in that items related to religiosity were lower for the current sample than for previous samples; however, the one item related to spirituality showed an increase in percentage of participants who agreed with it compared to the previous study.

Research Aim 2: Compare Current Psychologist Religiosity/Spirituality With That of the General Population

In an effort to better understand any value discrepancy that existed between psychologists and the general population, therapist's scores on items related to religiosity/spirituality from the Pew Research Survey (2018a) were contrasted with those of the general population using one-sample *t*-tests. Initially, the intention was to compare therapists' scores on five items from the Pew Research Survey (2018a); however, due to differences in the scaling of responses for three of the items ("How frequently do you attend religious services?," "How frequently do you pray?," and "How frequently do you experience feelings of spiritual peace and wellbeing?") only two items ("Do you consider yourself to be a religious person?" and "Do you consider yourself

to be a spiritual person?") were able to be statistically compared. The other three items were qualitatively compared.

In the current therapist sample, the average score for "Do you consider yourself to be a religious person?" was $M = 1.09$ ($SD = 1.39$) on a scale that ranges from 0 (not religious) to 4 (very religious). From the general population, the average response score to this item was $M = 2.60$ ($SD = 1.03$). The difference between these scores was significant with a large effect, $t(148) = 13.209$, $p < .001$, $d = 1.09$, suggesting a lower level of religiosity among our therapist participants compared to the general population.

With the current therapist sample, the average score for "Do you consider yourself to be a spiritual person?" was $M = 2.29$ ($SD = 0.78$) on a scale that ranged from 0 (not spiritual) to 4 (very spiritual). From the general population, the average response score to this item was $M = 2.05$ ($SD = 0.92$). The difference between these scores was also significant, with $t(79) = 2.71$ and $p < 0.01$; however, it had only a small effect ($d = 0.25$), suggesting that therapist spirituality was only slightly higher than what is seen in the general population.

In relation to the item "How frequently do you attend religious services?," responses in the current study were rated on a five-point Likert-type scale, with responses ranging from 0 (Seldom) to 4 (Daily). Average participant response for the current sample was $M = 0.81$ ($SD = 1.16$). For the general population, participants responded to this item on a six-point Likert scale with responses ranging from 1 (More than once a week) to 6 (Never). The average response from the general population was $M = 3.43$ ($SD = 1.69$).

Concerning the item "How frequently do you pray?," responses in the current sample ranged from 0 (Seldom) to 4 (Daily). Average participant response for the current sample was $M = 1.46$ ($SD = 1.63$). The general population responses were rated on a seven-point Likert-scale

with responses ranging from 1 (Several times a day) to 7 (Never). The average participant response from the general population was $M = 3.08$ ($SD = 2.28$).

For the final item "How frequently do you experience feelings of spiritual peace and wellbeing?," responses in the current sample ranged from 0 (Seldom) to 4 (Daily). Average participant response for the current sample was $M = 2.24$ ($SD = 1.34$). For the general population, responses were rated on a five-point Likert-type scale with responses ranging from 1 (At least once a week) to 5 (Never). Average response from the general population was $M = 1.95$ ($SD = 1.51$).

Research Aim 3: Test the Impact of Client Religiosity/Spirituality on Therapists' Evaluation of Clients

In order to empirically test the impact that therapists' knowledge of clients' religiosity/spirituality had on their outcome expectations and hope for the client to succeed in psychotherapy (THCS scores), two independent sample *t*-tests were conducted comparing therapist response to the vignette conditions. Concerning THCS scores, among participants who were presented with the religious vignette, the average THCS score was $M = 60.54$ ($SD = 7.24$). For the non-religious vignette group, the average THCS score was $M = 61.78$ ($SD = 8.31$). This difference was not significant $t(141.39) = 0.97$, $p = .33$, $d = 0.16$. The average outcome expectation score for the religious vignette condition was $M = 42.26$ ($SD = 24.35$). For the non-religious vignette group, the average outcome expectation score was $M = 46.63$ ($SD = 30.4$). This difference was also not significant $t(134.1) = .96$, $p = .34$, $d = .16$.

In addition to completing measures on therapists' hopes and expectations, participants were presented with several open-ended questions regarding why they gave the evaluations that they did. Participants were asked five questions regarding their reasoning behind the evaluation

that they gave the client. Responses were qualitatively analyzed and grouped based on shared themes. The first item that participants responded to was: "*Why did you evaluate this client the way that you did?*". The majority (40.16%) of responses centered around the symptoms presented in the vignette. Other common themes included the participants' clinical experience (22.13%), the client's attitude toward treatment (13.11%), and resiliency factors (11.48%). The second item was: "*What factors influenced your evaluation of this client?*". The most common responses related to Resiliency factors (39.02%), followed by symptoms (33.33%), and clinician experience (7.32%). The Third item was: "*What factors increased your motivation to work with this client?*". Most clinicians (38.52%) stated resiliency factors, followed by clinician experience (36.88%). The fourth item was: "*What factors decreased your motivation to work with this client?*." The most common responses related to attitudes toward treatment (25.80%), followed by incompatibility/personal preferences (16.94%), and difficulties associated with depression (13.71%). The final item was: "*Which client factor do you think will contribute the most to this client's success for treatment?*" Most common responses related to the client's support network/resiliency factors(49.21%), individual motivation (35.71%), and the client/provider relationship (11.90%).

Research Aim 4: Test the Relationship Between Therapists' Personal Religiosity/Spirituality and Their Evaluations of R/S Clients

The final aim of this study focused exclusively on therapist scores from the religious vignette condition. We were interested in testing whether therapist personal religiosity/spirituality, as measured by the RCI–10 and ISS, could predict their evaluation of the religious client above and beyond their responses to questions about formal training in R/S integration and experience in working with R/S clients. Two multiple regression models with

two steps were utilized for this analysis, with one predicting THCS scores and one predicting outcome expectation scores. Means, standard deviations, and correlations for each variable utilized in this aim can be found in Table 2. Regarding correlations between variables, high levels of correlation were found between RCI–10 and ISS items *(r* = .71).

Table 2

Descriptive Statistics and Correlations for Main Research Aim 4

Variable	M (SD)	1	2	3	4	5	6
1. THSC	60.52 (7.31)	1.00	0.06	0.08	0.24	0.33*	0.53***
2. R/S Training (yes)	24.84%	--	1.00	0.35	0.46***	0.37**	0.07
3. Percent R/S Clients	15.58 (26.39)		--	1.00	0.09	0.29*	0.04
4. RCI-10	20.54 (9.63)			--	1.00	0.71***	0.17
5. ISS	5.38 (3.3)				--	1.00	0.15
6. Expectation	31.69(4.16)					--	1.00

Note. Ranges and possible scores were as follows: THCS (10 – 80), R/S Training (Yes/No), Percent R/S Clients (0 – 100), RCI-10 (10 – 50), ISS (0 – 10), Expectation (0 – 40)

***p <.001 ** p <.01 *p <.05

For the model predicting THCS scores in the first step, training in R/S integration and percentage of clients where religiosity/spirituality is discussed were not significant predictors of THCS scores, $R = .16$, $F(2,71) = 1.95$, $p > .05$, $R^2 = .02$. For the second step, which included therapists' RCI–10 and ISS scores, $R = .36$, $F(4,69) = 2.12$, $p > .05$, $R^2 = .13$, the model as a whole did not significantly predict THCS scores. However, the change was significant, with R^2 change = 0.11, $F(2,69) = 4.16$, $p < .05$. Table 3 summarizes the findings for each predictor in the model. While no single variable was a significant unique predictor, RCI–10 and ISS scores significantly added to the model as hypothesized.

For the model predicting outcome expectation scores, neither the original, $R = .12$, $F(2,67) = 0.51$, $p > .05$, $R^2 = .012$, nor the augmented model, $R = .22$, $F(4,67) = 0.58$, $p > .05$, $R^2 = .05$, significantly predicted outcome expectations. The change between the two models was also not significant R^2 change = 0.05, $F(2, 67) = 1.66$, $p > .05$. Taken together as scores associated with a therapists' religiosity/spirituality (RCI–10/ISS) increase, therapists' hopes for clients also increased.

Table 3

Model Summary for Predicting THCS Scores

Variable	ß	95% Confidence Interval		t-value	p-value
		Lower	Upper		
RS training	0.19	-3.98	4.62	0.15	0.88
Percent R/S					
client	-0.01	-1.06	1.01	-0.04	0.97
RCI–10	0.10	-2.42	0.26	0.06	0.95
ISS	0.30	-0.06	1.39	1.83	0.07

*** p < .001 **p<.01 *p<.05

Chapter 4: Discussion

The overall purpose of this study was to better understand the religiosity/spirituality of therapists and its potential impact on evaluations of a religious client. Within this overall purpose, the following four research aims were examined: (1) describe current religiosity/spirituality of practicing psychologists, (2) compare current psychologist religiosity/spirituality with that of the general population, (3) test the impact of a fictitious client's religiosity on therapist evaluations, and (4) test the relationship between therapists' personal religiosity/spirituality and their evaluations of a fictitious religious client.

Research Aim 1: Describe Current Religiosity/Spirituality of Practicing Psychologists

This study used multiple methods to identify therapists' levels of religiosity and spirituality. The first was to use standardized measures, including the RCI-10 and the ISS. Mean RCI-10 scores for the therapist sample in the current study were M = 19.03 (SD = 9.24), which, according to the measure creators (Worthington et al., 2003), falls in the low religiosity range. This average also falls below what has been reported in previous studies of therapists, including members of the American Group Psychotherapy Association (M = 22.1, SD = 11.4; Cornish, 2012) and clinical and counseling students on predoctoral internship (M =22.63, SD = 11.33; Cassidy, 2006). Mean ISS scores for the current sample were M = 4.74 (SD = 3.23) which the measure's authors indicated represents moderate levels of spirituality (Hodge, 2002). This score falls below what has been reported in previous studies on social workers (M = 6.76, SD = 2.23; Larsen, 2011), individuals with a diagnosed gambling disorder (M = 5.92, SD = 3.05; Gavriel-Fried et al., 2020), and caregivers of Alzheimer's patients (M = 7.6, SD = 2.15; Wilks, 2006). ISS scores from the current sample appear similar to those detected among sexual minority populations (M = 4.59, SD = 1.84; Wright & Stern, 2016).

In addition to measuring therapists' religiosity/spirituality with the use of broad measures, therapists' religiosity was assessed with single items that have been commonly used in previous studies. Specifically, six studies were identified that asked therapists about their religious affiliation. The earliest of these studies dated back to 1986 (Jensen, 1986) allowing for comparison of attitudes over time. For the item, "*I try hard to live my life according to my religious beliefs,*" 48% of the participants in our study agreed. This was lower than previous rates of endorsement detected in past research (Delaney et al., 2007; Jensen, 1986). Similar patterns were observed for the items: "*My whole approach to life is based on my religion,"* (28% agreed); "*I actively participate in my religious affiliation,*" (44% agreed)*;"I was raised in a particular religion,"* (69% agreed); and "*I am currently affiliated with a religious organization,"* (34% agreed). Across all items related to religion, participants in the current sample scored lower than participants in previous studies. For the items that addressed spirituality: *"Spiritual Beliefs are important to me,"* (68% agreed); and "*I seek a spiritual understanding of the universe and one's place in it*," (68% agreed); participants in the current study reported higher levels of agreement than previous research.

Although this research aim was descriptive in nature, a trend was observed of lower levels of endorsement of items related to religiosity and higher levels of spirituality compared to previous studies on therapists' religiosity/spirituality. In general, this appears to be consistent with national trends of lower levels of religious engagement and increased spirituality (Pew, 2017). Some have posited that spirituality is an inherently more individualistic expression (Shafranske & Cummings, 2013). While psychologist individualism is beyond the scope of this study, it may serve a potential explanatory factor. Some have proposed that the rise in individualism among practicing psychologists is largely responsible for decreasing levels of

religiosity (Slife et al., 2016). Along this vein, previous research has demonstrated relationships between socioeconomic status (SES) and individualism, in that those from a higher SES are more likely to be individualistic (Santos et al., 2017). Thus, it may be that psychologist's SES is related to their preference of a more individualistic form of worship. Additionally, other factors have been found to explain at least some of the shift from organized religion towards spirituality, including political ideology, race, marital status, and whether or not their parents were divorced (Zhai, 2008). While we were not able to find any studies that explicitly examined these factors among therapists, it may be that some of these factors in therapists account for some of the changes in their R/S beliefs.

Bergin (1980) proposed that there are popular value systems within psychotherapy that are often incompatible with theistic beliefs. It has been suggested that "the naturalism and pragmatism of psychology leaves it open to a straightforward implementation of the values of the dominant social system" (Slife et al., 2016, p. 595). It may be that values of psychologists simply mirror "the dominant social system," which in relation to R/S beliefs, appear to be shifting toward non-religious but spiritual (Pew, 2017).

Research Aim 2: Compare Current Psychologist Religiosity/Spirituality With That of the General Population

The second research aim of this study was to compare current levels of psychologist religiosity/spirituality with that of the general population. Items from the Pew Research Survey (2018a) were completed by survey participants and results for two of those items were then compared to those of the general population using one sample *t*-tests. In relation to the item, *"Do you consider yourself to be a religious person?,"* therapist agreement was found to be significantly lower than the general population with a large effect size. Regarding the item, *"Do*

you consider yourself to be a spiritual person?," therapist scores were significantly higher than those found in the general population with a small effect size.

Taken together, these results supported previous studies that have found lower levels of religiosity among therapists than the general population (i.e., Bergin & Jensen, 1990; Oxhandler et al., 2017). Additionally, it also provided some evidence that the shift from organized religion toward spirituality (Pew, 2017) may be occurring at a higher rate for psychologists than for the general population. This is important in that it highlights potential value discrepancies that exist in the context of psychotherapy. It may be that, with time, the size of these discrepancies will continue to widen. This finding was particularly important given that it has been argued that value discrepancies between therapists and clients are directly associated with therapists' overall effectiveness and a variety of therapeutic outcomes (Jensen, 1986; Vervaeke et al., 1999; Bergin & Jensen, 1990; Bergin, 1991). Based on previous research, it may be that other factors such as therapist SES moderate therapists' preference towards spirituality over organized religion (Santos et al., 2017). Thus, a value discrepancy may be the result of different life experiences and living conditions between therapists and their potential clients.

Research Aim 3: Test the Impact of Client Religiosity/Spirituality on Therapists' Evaluation of Clients

The third aim of this study was to test the impact of a client's religiosity/spirituality on therapists' hope and outcome expectations. For this aim, participants were divided into two groups and presented with either a clinical vignette of an individual who identified as being religious, or a vignette which mentioned nothing about religiosity. Contrary to our hypothesis, differences in therapists' hope and outcome expectation were not observed. These results appear to be consistent with previous research that has also used clinical vignettes to examine the impact

that client sexual orientation has on therapists' evaluations of clinical vignettes (Wisch & Mahalik), which found no direct relationship between client sexual orientation and therapeutic evaluations. However, researchers found that under certain conditions (such as the client expressing anger) therapist expressed different expectations based on their clients sexual orientation. Thus, in regard to the current study, it may be that under specific contexts, therapist's spirituality/religiosity is more likely to impact their evaluations of potential clients. For example, Allman (1992) found that therapist spirituality significantly predicted their evaluations of client mystical experiences.

Additionally, there are a number of factors that have been shown to impact therapists expectations of clients, such as perceived familiarity with the client, and length of the time that the client has been in treatment (Keum, 2020). While it was beyond the scope of the current study to explore therapist familiarity with the client as a potential moderator, it may be that these factors would moderate the relationship between client religiosity/spirituality and therapist evaluations.

Research Aim 4: Test the Relationship Between Therapists' Personal Religiosity/Spirituality and Their Evaluations of R/S Clients

The fourth and final aim of this study was to test the relationship between therapists' personal religiosity/spirituality and their evaluations of the fictitious religious client. For this aim, only data from those who were presented with the religious vignette were included. Two, two-step multiple regression models were used to determine if therapists' personal religiosity and spirituality could predict their evaluations (hope and outcome expectations) of the client in the vignette above and beyond their past training in R/S integration and the percentage of clients that they typically work with who discuss R/S issues. Although therapists' personal religiosity and

spirituality did significantly predict therapists' hopes for clients, they did not significantly predict their outcome expectations. Specifically, regarding hope, greater therapist religiosity and spirituality was associated with higher levels of hope for the client. Research that has examined therapist expectations in the context of the client's race has found that client race impacted therapists' expectations for treatment, but that this relationship was more salient when clients were matched with a therapist of a similar race (Murphy et al., 2004). Other research has found that value similarities, not similarities of personal characteristics, is associated with improved working alliance scores as measured by the client (Hersoug et al., 2001). Thus, in regard to the current study, because only the religious vignette group was analyzed, higher score on the RCI-10 and ISS resulted in increased similarity between the individual in the vignette and the therapist, thus increasing expectations.

Limitations

Several limitations should be considered in relation to this study. First, while participants from this study came from diverse geographical areas, the current sample may not have been representative of all psychologists in the United States in terms of religiosity/spirituality. Although we used several recruitment methods, including posting our survey on state psychological associations, posting on APA division listservs for Divisions 29 and 42, and contacting psychologists individually through the APA psychologist locator website, these methods may have resulted in only a select group of psychologists receiving study announcements. Specifically, only about 22% of our current sample reported practicing in a rural area. Rural communities have been shown to have higher levels of religiosity (Gallup, 2003), and as such, the urban communities used may skew the sample towards lower levels of religiosity.

Second, the sample size was smaller than hoped for. Based on our original power analysis, we had hoped to have a response of at least 345 participants. This would have allowed for adequate power for all of the proposed analyses plus an additional 10% to account for dropout and unusable data. This desired response rate was due to our required sample size for research aim 3, given an estimated power of .80 at $a = 0.025$. Because our current sample only included data from 157 participants, we might not have had sufficient power to detect a difference between the groups.

Third, limitations can be seen with the comparisons to past research on therapist religiosity and spirituality. Many measures been used to assess religiosity and spirituality of both therapists and the general population in the past. This makes comparisons of therapist religiosity and spirituality over time difficult. We were able to make comparisons on a few measures based on results from two to three past studies, but it would have been helpful if a standard set of religiosity and spirituality questions were used across studies which would have allowed for a more comprehensive picture of trends. In comparing across individual studies, although the samples were comparable in that they were all composed of therapists, there were a variety of factors such as sample size, participant demographics, types of therapists, and so on, which could have impacted scores. Regarding types of therapists, in our review of the literature, all studies that examined religiosity/spirituality across various types of therapists (Jensen, 1986; Oxhandler et al., 2017) found significant differences across professions. Factors that lead to these differences are not understood, but they may stem from education, career selection, and personality characteristics.

Fourth, while previous studies have used clinical vignettes as a method of assessing potential evaluations of clients and therapists, vignettes measured in a study setting may not

accurately portray what might be seen in real world practice. Religious or spiritual behavior in the session may have a stronger impact on therapist evaluations than information presented during a clinical vignette. Previous research has reported that religious micro-aggression by therapists do occur during therapy (Trusty et al., 2019), which at least in part appear to be due to difference in R/S values between therapist and clients (Vervaeke et al., 1999) and lack of R/S experience (Freitas, 2013). Observational studies in real world settings may thus better capture therapists' values and beliefs. Additionally, real world settings would allow for researchers to account for other factors such as familiarity with the client which have been shown to impact expectations (Keum, 2020). Social desirability responding may have also been a factor with this study, which results when participants attempt to respond in a manner which they believe is most socially acceptable. This has been shown to impact participants when they are asked to respond to a vignette in a research setting (Stolte, 2021).

It is possible that the amount of information on the religiosity of the client was not salient or powerful enough to elicit particular feelings from the therapists. Specifically, the vignettes simply reported that the client was actively involved in her religious community and that she desired to address R/S issues in therapy. It may have had a stronger impact if specific R/S beliefs and behaviors were listed instead. Furthermore, the current study measured religiosity and spirituality broadly rather than evaluating affiliation with a specific denomination. It is likely the observable behaviors of the highly religious/spiritual vary greatly depending on the specific religious/spiritual affiliation of the individual. It may also be that specific religious minorities are more prone to stigma or negative evaluations in the context of therapy.

Fifth, there was an error that was made regarding the Pew research items, which limited our ability to make statistical comparisons between the current sample and the general

population. Originally, five independent *t*-tests were planned to be made for items from Pew (2018a); however, it was detected just before data analysis that three items on the original Pew research survey were scaled differently from items in the current sample. This appears to be due to an error that occurred when creating the survey for the current study. Due to this mistake, we were much more limited in the comparisons we were able to make with the general population.

Future Directions

With the previously mentioned limitations in mind, future research should continue to investigate therapist religiosity/spirituality and its potential impact on client evaluations. Further investigation should continue to examine trends in therapist religiosity/spirituality with diverse samples. If consistent measures and items are used, statistical tests could then be conducted examining the trends over time. Use of consistent measures and items could also be helpful in comparing the religiosity and spirituality of therapists to other helping professions, including social workers and medical providers. Several studies (Jensen, 1986; Oxhandler et al., 2017) have detected differences in religiosity/spirituality between different helping professions, but the cause of these differences remains to be understood. It would also be interesting to test how psychologists in practice differ from students in training. Further, research could compare the religiosity and spirituality of practicing psychologists to those in academic or research settings. This would allow us to determine if the nature of clinical practice or other factors contribute to differential levels of religiosity/spirituality in various helping professions.

Future research could also alter the manner in which client religiosity or spirituality is reported to therapists. This could be through the client's use of religious symbols (wearing a cross or a yarmulke) during a session, through their explicit request to integrate religiosity/spirituality into their treatment, or through conversations about religiosity. This could

be especially important because the majority of research on religious micro-aggressions thus far has occurred in the context of in-person sessions (Trusty et al., 2019).

Future research could also study these variables in diverse settings. For example, it would be relevant to test whether therapist views of an R/S client differ between in-person and telehealth sessions, or between rural and urban areas. Religious symbols and behavior are likely more salient in person versus via telehealth, and it would be interesting to see if there is still a significant impact. Additionally, research with minority religious groups might be valuable. For example, do therapists' opinions of clients differ depending if the client is described as Christian, Buddhist, Jewish, Scientologist, and so on? This would relate well with the previous comments on familiarity and shared background. Individuals from minority religious populations are likely to have fewer people (including therapists) who understand their unique experiences, traditions, and beliefs, all of which are important aspects of their lives. Furthermore, specific religious populations are likely to be more stigmatized, or at least less familiar. Consistent with the research on the impact of value similarity and therapist expectations for clients, it may be that if the current sample had included more individuals from diverse religious/spiritual backgrounds, we would have seen lower therapist expectations for those groups with which the therapist had less experience. Future research should investigate this effect on a religiously/spiritually diverse sample to better understand this effect on a group-by-group basis. It may be that religious/spiritual affiliation has a stronger impact than reported levels of religiosity/spirituality due to the fact that high levels of religiosity/spirituality will look different for individuals based on their religious/spiritual background.

Conclusions and Clinical Implications

Taken together, the results of this study suggest that therapists may be endorsing behaviors and beliefs associated with individual spirituality at higher rates than those associated with organized religion and that current levels of religiosity and spirituality of therapists are lower than those detected over the past 30 years. Therapists in this study were also significantly less religious than the general population, but they were more spiritual. These results potentially indicate that the national trend of moving away from organized religion toward personal spirituality may be occurring at a higher rate for psychologists. However, the current study found that client religiosity as presented in a clinical vignette, therapist religiosity and spirituality, and therapist-reported experience with training in R/S integration and experiences in working with R/S clients did not appear to be related to their evaluations (hope or outcome expectations) for a potential client.

From a clinical perspective, although lower levels of therapist religiosity/spirituality did not change therapists' expectations for clients, it may create a barrier for treatment, potentially making it more difficult for therapists to understand the unique experiences of individuals from R/S communities. Additionally, it heightens the need for awareness regarding potential religious microaggressions, especially due to some evidence that suggests these negative experiences may occur more frequently when there is a gap in belief systems between the therapist and the client (Vervaeke et al., 1997). Even though nationally, we see religiosity is decreasing, a majority of people in the population still identify as being religious/spiritual (Gallup, 2019a). Furthermore, we see that religiosity/spirituality are important in treatment due to the fact that high numbers of individuals experience R/S associated distress (Bryant & Astin, 2008) and that a many individuals are wanting to integrate it into their treatment (Cunha & Comin, 2019). When R/S

factors are integrated into treatment, we see improved treatment outcomes for both spiritual and psychological distress (Captari et al., 2018).

With the overall prevalence of R/S beliefs and the desire that many clients have to address R/S issues in therapy, there is need for training on integrating religiosity/spirituality into therapy appears to be well-established. However, it would appear that as a field clinical psychology is falling behind in this area (Vieten et al., 2013). The American Psychiatric Association has long recommended that training programs explicitly include training on R/S factors as part of their programs (Campbett et al., 2012). Other fields such as nursing, social work, and professional counseling have encouraged training on R/S factors for some time (Leeuwen et al., 2008; Hodge, 2002; Young et al., 2002), yet as many as 90% of psychologists have reported that they did not receive training on R/S integration during their education (Vieten et al., 2013). Given the findings from the current study and past research regarding the discrepancy of R/S beliefs between psychologist and the general population as well as the potential impacts of those belief discrepancies, it may be necessary for clinical psychology training programs to include R/S issues as a core aspect of their training programs.

References

A. F., & Mahalik, J. R. (1999). Male therapists' clinical bias: Influence of client gender roles and therapist gender role conflict. *Journal of Counseling Psychology, 46*(1), 51–60. https://doi.org/10.1037/0022-0167.46.1.51

Ai, A. L., Peterson, C., Bolling, S. F., & Koenig, H. (2002). Private prayer and optimism in middle-aged and older patients awaiting cardiac surgery. *The Gerontologist*, *42*(1), 70–81. https://doi.org/10.1093/geront/42.1.70

Allman, L. S., de la Rocha, O., Elkins, D. N., & Weathers, R. S. (1992). Psychotherapists' attitudes toward clients reporting mystical experiences. *Psychotherapy: Theory, Research, Practice, Training*, *29*(4), 564–569. https://doi.org/10.1037/0033-3204.29.4.564

Allport, G. W., & Ross, J. M. (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology*, *5*(4), 432–443. https://doi.org/10.1037/0022-3514.5.4.432

American Psychological Association. (2013). Recognition of psychotherapy effectiveness. *Journal of Psychotherapy Integration*, *23*(3), 320–330. https://doi.org/10.1037/a0033179

Angel HF. (2013) Religiosity. In: Runehov A.L.C., Oviedo L. (Eds) *Encyclopedia of Sciences and Religions*. Springer, Dordrecht. https://doi.org/10.1007/978-1-4020-8265-8_1503

Ashraf, A., & Nassar, S. (2018). American Muslims and vicarious trauma: An explanatory concurrent mixed-methods study. *American Journal of Orthopsychiatry*, *88*(5), 516–528. https://doi.org/10.1037/ort0000354

Baldwin, M. (2019). *The effects of the counselor's spiritual background and the participant's spirituality on the participant's perceptions of the expertness, attractiveness, and*

trustworthiness of the counselor. (Publication No. 22583370) [Doctoral dissertation, University of Memphis]. ProQuest Dissertations & Theses A&I.

Barna Group. (2017). Silent and solo: How Americans pray. Retrieved May 19, 2020, from https://www.barna.com/research/silent-solo-americans-pray/

Bartholomew, T. T., Gundel, B. E., Scheel, M. J., Kang, E., Joy, E. E., & Li, H. (2020). Development and initial validation of the therapist hope for clients scale. *The Counseling Psychologist*, *48*(2), 191–222. https://doi.org/10.1177/0011000019886428

Belaire, C., & Young, J. S. (2000). Influences of spirituality on counselor selection. *Counseling and Values*, *44*(3), 189–197.https://doi.org/10.1002/j.2161-007X.2000.tb00171.x

Bergin, A. E., & Jensen, J. P. (1990). Religiosity of psychotherapists: A national survey. *Psychotherapy: Theory, Research, Practice, Training*, *27*(1), 3–7. https://doi.org/10.1037/0033-3204.27.1.3

Bergin, A. E. (1991). Values and religious issues in psychotherapy and mental health. *American Psychologist*, *46*(4), 394–403. https://doi.org/10.1037/0003-066X.46.4.394

Beutler, L. E., Kimpara, S., Edwards, C. J., & Miller, K. D. (2018). Fitting psychotherapy to patient coping style: A meta-analysis. *Journal of Clinical Psychology*, *74*(11), 1980–1995. https://doi.org/10.1002/jclp.22684

Bilgrave, D. P., & Deluty, R. H. (1998). Religious beliefs and therapeutic orientations of clinical and counseling psychologists. *Journal for the Scientific Study of Religion*, *37*(2), 329–349. https://doi.org/10.2307/1387532

Bilgrave, D. P., & Deluty, R. H. (2002). Religious beliefs and political ideologies as predictors of psychotherapeutic orientations of clinical and counseling psychologists.

Psychotherapy: Theory, Research, Practice, Training, *39*(3), 245–260. https://doi.org/10.1037/0033-3204.39.3.245

Bohart, A. C., & Wade, A. G. (2013). The client in psychotherapy. In Lambert, M. J. (Ed.). *Bergin and Garfield's handbook of psychotherapy and behavior change*. (pp. 219–257). John Wiley & Sons.

Budge, S. L., & Moradi, B. (2018). Attending to gender in psychotherapy: Understanding and incorporating systems of power. *Journal of Clinical Psychology*, *74*(11), 2014–2027. https://doi.org/10.1002/jclp.22686

Bryant, A. N., & Astin, H. S. (2008). The correlates of spiritual struggle during the college years. *The Journal of Higher Education,* 79(1), 1–27. https://doi.org/10.1080/00221546.2008.11772084

Captari, L. E., Hook, J. N., Hoyt, W., Davis, D. E., McElroy-Heltzel, S. E., & Worthington Jr, E. L. (2018). Integrating clients' religion and spirituality within psychotherapy: A comprehensive meta-analysis. *Journal of Clinical Psychology*, *74*(11), 1938–1951. https://doi.org/10.1002/jclp.22681

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. *The American Journal of Family Therapy*, *30*(2), 157-171, https://doi.org/10.1080/01926180275357386 7

Cassidy, E. J. H. (2006). *Religion and spirituality in professional psychologist training: A survey of interns* (Publication No. 3225355) [Master's thesis, West Virginia University]. ProQuest Dissertations & Theses A&I.

Cody, R. A., & Drysdale, K. (2013). The effects of psychotherapy on reducing depression in residential aged care: A meta-analytic review. *Clinical Gerontologist*, *36*(1), 46–69. https://doi.org/10.1080/07317115.2012.731474

Connor, D. R., & Callahan, J. L. (2015). Impact of psychotherapist expectations on client outcomes. *Psychotherapy, 52*(3), 351–362. https://doi.org/10.1037/a0038890

Connor, K. M., & Davidson, J. R. T. (2003). Development of a new resilience scale: The Connor-Davidson Resilience Scale (CD-RISC). *Depression and Anxiety*, 18(2), 76–82. https://doi.org/10.1002/da.10113

Connors, G. J., Tonigan, J. S., & Miller, W. R. (1996). A measure of religious background and behavior for use in behavior change research. *Psychology of Addictive Behaviors, 10*(2), 90–96. https://doi.org/10.1037/0893-164X.10.2.90

Cornish, M. A., Wade, N. G., & Post, B. C. (2012). Attending to religion and spirituality in group counseling: Counselors' perceptions and practices. *Group Dynamics: Theory, Research, and Practice*, *16*(2), 122–137. https://doi.org/10.1037/a0026663

Cunha, V. F., & Comin, F. S. (2019). Religiosity/Spirituality (R/S) in the clinical context: Professional experiences of psychotherapists. *Temas Em Psicologia*, *27*(2), 427–441. https://doi.org/10.9788/TP2019.2-10

Currier, J. M., Pearce, M., Carroll, T. D., & Koenig, H. G. (2018). Military veterans' preferences for incorporating spirituality in psychotherapy or counseling. *Professional Psychology: Research and Practice, 49*(1), 39–47. https://doi.org/10.1037/pro0000178

Dimmick, A., Swift, J. K., & Trusty, W. T. (2020). Latter-Day Saint clients' preferences for a religious match with a psychotherapist. *Spirituality in Clinical Practice, 7*(2), 134–143. https://doi.org/10.1037/scp0000211

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, 38*(5), 538–546. https://doi.org/10.1037/0735-7028.38.5.538

Derezotes, D. S., & Evans, K. E. (1995). Spirituality and religiosity in practice: In-depth interviews of social work practitioners. *Social Thought*, *18*(1), 39–56. https://doi.org/10.1080/15426432.1995.9960214

DiBlasio, F. A., & Proctor, J. H. (1993). Therapists and the clinical use of forgiveness. *American Journal of Family Therapy*, *21*(2), 175–184. https://doi.org/10.1080/01926189308250915

Dwyer, M. (2008). *Religion, spirituality, and social work : A quantitative study on the behaviors of social workers in conducting individual therapy*. [Master's thesis, Smith College]. Retrieved October 29, 2020, from https://scholarworks.smith.edu/theses/1229

Eckhardt, C. I. (1992). Religious beliefs and scientific ideology in psychologists: conflicting or coexisting systems? *Psychological Reports*, *71*(5), 131-145. https://doi.org/10.2466/PR0.71.5.131-145

Exline J.J., Yali, A. M., & Sanderson, W. C. (2000). Guilt, discord, and alienation: The role of religious strain in depression and suicidality. *Journal of Clinical Psychology*, 56(12) 1481–1496. https://doi.org/10.1002/1097-4679(200012)56:12<1481::AID-1>3.0.CO;2-A

Fisher, J. (2010). Development and application of a spiritual well-being questionnaire called SHALOM. *Religions*, *1*(1), 105–121. https://doi.org/10.3390/rel1010105

Francis, J. (2011). *Religious and spiritual beliefs, practices, professional attitudes and behaviors of clinical and counseling psychology interns.* (Publication No. 3466394) [Master's thesis, Pepperdine University]. ProQuest Dissertations & Theses A&I.

Freitas, M. H. D. (2013). Relações entre religiosidade e saúde mental em imigrantes: Implicações para a prática psi. *Psico-USF*, *18*(3), 437–444. https://doi.org/10.1590/S1413-82712013000300010

Gallup. (1985) *Religion in America.* Retrieved August 22, 2020, from https://journals.sagepub.com/doi/10.1177/0002716285480001014

Gallup. (2003, March 11). *Age, Religiosity, and Rural America*. Gallup.Com. https://news.gallup.com/poll/7960/Age-Religiosity-Rural-America.aspx

Gallup. (2018, April 6). *The Religious Regions of the U.S.* Retrieved October 29, 2020 from https://news.gallup.com/poll/232223/religious-regions.aspx

Gallup. (2019a, September 4). Religion considered important to 72% of Americans. Retrieved September 24, 2019, from https://news.gallup.com/poll/245651/religion-considered-important-americans.aspx

Gallup. (2019b, September 12). U.S. church membership down sharply in past two decades. Retrieved November 8, 2019, from https://news.gallup.com/poll/248837/church-membership-down-sharply-past-two-decades.aspx

Gavriel-Fried, B., Moretta, T., & Potenza, M. N. (2020). Associations between recovery capital, spirituality, and DSM-5 symptom improvement in gambling disorder. *Psychology of Addictive Behaviors*, *34*(1), 209–217. https://doi.org/10.1037/adb0000492

George, D. & Mallery, M. (2010). SPSS for Windows step by step: A simple guide and reference, 17.0 update (10a ed.) Boston: Pearson.

Gorsuch, R. L., & McPherson, S. E. (1989). Intrinsic/Extrinsic measurement: I/E-revised and single-item scales. *Journal for the Scientific Study of Religion*, *28*(3), 348–354. https://doi.org/10.2307/1386745

Graham, S., Furr, S., Flowers, C., & Burke, M. T. (2001). Research and theory religion and spirituality in coping with stress. *Counseling and Values*, *46*(1), 2–13. https://doi.org/10.1002/j.2161-007X.2001.tb00202.x

Hall, D. E., Meador, K. G., & Koenig, H. G. (2008). Measuring religiousness in health research: review and critique. *Journal of Religion and Health*, *47*(2), 134–163. https://doi.org/10.1007/s10943-008-9165-2

Harbin, J. M., Gelso, C. J., & Perez Rojas, A. E. (2013). Therapist work with client strengths: development and validation of a measure. *The Counseling Psychologist*, 42, 345–373. https://doi.org/10.1177/0011000012470570

Hatch, R., Burg, M. A., Naberhaus, D. S., & Hellmich, L. K. (1998). The spiritual involvement and beliefs scale: development and testing of a new instrument. *Journal of Family Practice,* 46(6), 476–487. Retrieved October 29, 2020 from https://mdedge-files-live.s3.us-east-2.amazonaws.com/files/s3fs-public/jfp-archived-issues/1998-volume_46-47/JFP_1998-06_v46_i6_the-spiritual-involvement-and-beliefs-sc.pdf

Hecker, L. L., Trepper, T. S., Wetchler, J. L., & Fontaine, K. L. (1995). The influence of therapist values, religiosity and gender in the initial assessment of sexual addiction by family therapists. *The American Journal of Family Therapy*, *23*(3), 261–272. https://doi.org/10.1080/01926189508251356

Hill, P. C., Pargament, K., II., Hood, J. . R. W., McCullough, M. E., Swyers, J. P., Larson, D. B., & Zinnbauer, B. J. (2000). Conceptualizing religion and spirituality: points of commonality, points of departure. *Journal for the Theory of Social Behaviour*, *30*(1), 51-77. https://doi.org/10.1111/1468-5914.00119

Hodge, D. R. (2002). Equally devout, but do they speak the same language? Comparing the religious beliefs and practices of social workers and the general public. *Families in Society, 83*(5), 573–584. https://doi.org/10.1606/1044-3894.56

Hodge, D. R. (2003). The intrinsic spirituality scale. *Journal of Social Service Research*, *30*(1), 41–61. https://doi.org/10.1300/j079v30n01_03

Hout, M., & Smith, T. (2015). *Fewer Americans affiliate with organized religions, belief and practice unchanged: Key findings from the 2014 General Social Survey*. GSS Data Explorer. https://gssdataexplorer.norc.org/documents/904/display

Huber, S., & Huber, O. W. (2012). The centrality of religiosity scale (CRS). *Religions*, *3*(3), 710–724. https://doi.org/10.3390/rel3030710

Hunsley, J., Elliott, K., & Therrien, Z. (2014). The efficacy and effectiveness of psychological treatments for mood, anxiety, and related disorders. *Canadian Psychology/Psychologie Canadienne*, *55*(3), 161–176. https://doi.org/10.1037/a0036933

Idler, E. L., Ory, M., Musick, M., Pargament, K. I., Ellison, C. G., Powell, L. H., George, L. K., Underwood, L., Krause, N., & Williams, D. (2001). *NIA/Fetzer short form for the measurement of religiousness and spirituality* [Database record]. APA PsycTests. https://doi.org/10.1037/t01435-000

Jensen, J. (1986). *Mental health values of professional therapists: A national interdisciplinary survey.* (Publication No. 8610397) [Doctoral dissertation, Brigham Young University]. ProQuest Dissertations & Theses A&I.

Jensen, J., & Bergin, A. (1988). Mental health values of professional therapists: A national interdisciplinary survey. *Professional Psychology: Research and Practice, 19*(3), 290–297. https://doi.org/10.1037/0735-7028.19.3.290

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*(4), 409–419. https://doi.org/10.1037/0022-0167.50.4.409

Jouriles, E. N., Rancher, C., Mahoney, A., Kurth, C., Cook, K., & McDonald, R. (2020). Divine spiritual struggles and psychological adjustment among adolescents who have been sexually abused. *Psychology of Violence, 10*(3), 334–343. https://doi.org/10.1037/vio0000274

Kass, J., Friedman, R., Leserman, J., Zuttermeister, P., & Benson, H. (1991). Health outcomes and a new index of spiritual experience. *Journal for the Scientific Study of Religion, 30*(2), 203–211. https://doi.org/10.2307/1387214

Kelly, E. W. (1995). Counselor values: a national survey. *Journal of Counseling & Development*, *73*(6), 648–653. https://doi.org/10.1002/j.1556-6676.1995.tb01810.x

Keum, B. T., Morales Dixon, K., Kivlighan Jr., D. M., Hill, C. E., & Gelso, C. J. (2020). Do therapists improve in their ability to assess clients' satisfaction? A truth and bias model. *Journal of Counseling Psychology*, Advance online publication. https://doi.org/10.1037/cou0000525

Kim, E., & Kang, M. (2018). The effects of client–counselor racial matching on therapeutic outcome. *Asia Pacific Education Review*, *19*(1), 103–110. https://doi.org/10.1007/s12564-018-9518-9

Kivlighan, D. M., Jr., & Marmarosh, C. L. (2018). Counselors' attachment anxiety and avoidance and the congruence in clients' and therapists' working alliance ratings. *Psychotherapy Research*, *28*(4), 571–580. https://doi.org/10.1080/10503307.2016.1198875

Koenig, H. G. (1997). *Is religion good for your health?: The effects of religion on physical and mental health*. Psychology Press.

Koenig, H. G., & Büssing, A. (2010). The Duke University Religion Index (DUREL): a five-item measure for use in epidemiological studies. *Religions*, *1*(1), 78–85. https://doi.org/10.3390/rel1010078

Koenig HG, McCullough M, Larson DB. (2001) *Handbook of religion and health: A century of research reviewed*. Oxford University Press.

Koenig, H. G., Meador, K., & Parkerson, G. (1997). Religion index for psychiatric research. *American Journal of Psychiatry*, *154*(6), 885b–8886. https://doi.org/10.1176/ajp.154.6.885b

Kosmin, B. A., & Keysar, A. (2009). American religious identification survey (ARIS). Trinity College.

Krumrei, E. J., Mahoney, A., & Pargament, K. I. (2009). Divorce and the divine: The role of spirituality in adjustment to divorce. *Journal of Marriage and Family*, *71*(2), 373–383. https://doi.org/10.1111/j.1741-3737.2009.00605.x

Lambert, M. J. (2013). *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (6th ed.). Wiley.

Langeland, J. M., Anderson, M. L., Bischof, G. H., & Will, B. (2010). Spiritual and religious considerations of Michigan Counseling Association members. *Michigan Journal of Counseling: Research, Theory, and Practice*, *37*(1), 16–24. https://doi.org/10.22237/mijoc/1267401720

Larsen, K. M. (2011). How Spiritual Are Social Workers? An Exploration of Social Work Practitioners' Personal Spiritual Beliefs, Attitudes, and Practices. *Journal of Religion &*

Spirituality in Social Work: Social Thought, *30*(1), 17–33. https://doi.org/10.1080/15426432.2011.542713

Lent, R. W., Hill, C. E., & Hoffman, M. A. (2003). Development and validation of the counselor activity self-efficacy scales. *Journal of Counseling Psychology*, 50(1), 97–108. https://doi.org/10.1037/0022-0167.50.1.97

Levy, K. N., Kivity, Y., Johnson, B. N., & Gooch, C. V. (2018). Adult attachment as a predictor and moderator of psychotherapy outcome: A meta-analysis. *Journal of clinical psychology*, *74*(11), 1996–2013. https://doi.org/10.1002/jclp.22685

Martinez, J. S., Smith, T. B., & Barlow, S. H. (2007). Spiritual interventions in psychotherapy: Evaluations by highly religious clients. *Journal of Clinical Psychology*, *63*(10), 943–960. https://doi.org/10.1002/jclp.20399

McClure, R. F., & Livingston, R. B. (2000). Religious values of counselors, psychologists, and college students. *TCA Journal*, *28*(2), 78–85. https://doi.org/10.1080/15564223.2000.12034569

McConnell, K. M., Pargament, K. I., Ellison, C. G., Flannelly, K. J. (2006) Examining the links between spiritual struggles and symptoms of psychopathology in a national sample. *Journal of Clinical Psychology, 62*(12), 1469-84. https://doi.org/10.1002/jclp.20325.

McCormick, W. H., Carrol, T. D., Sims, B. M., & Currier, J. (2017) Adverse childhood experiences, religious/spiritual struggles, and mental health symptoms: Examination of mediation models. *Mental Health, Religion & Culture, 20*(10), 1042-1054, https://doi.org/10.1080/13674676.2018.1440544

McVittie, C., & Tiliopoulos, N. (2007). When 2–3% really matters: The (un)importance of religiosity in psychotherapy. *Mental Health, Religion & Culture*, *10*(5), 515–526. https://doi.org/10.1080/13674670601005471

Meisenhelder, J. B., & Chandler, E. N. (2001). Frequency of prayer and functional health in Presbyterian pastors. *Journal for the Scientific Study of Religion*, 40(2), 323–330. https://doi.org/10.1111/0021-8294.00059

Miller, E. D. (2004). The development and validation of a new measure of spirituality. *North America Journal of Psychology, 6*(3), 423–430.

Mohr, S., & Philippe, Huguelet, P. (2014). The wishes of outpatients with severe mental disorders to discuss spiritual and religious issues in their psychiatric care. *International Journal of Psychiatry in Clinical Practice, 18*(4)*,* https://doi.org.10.3109/13651501.2014.902071.

Moradi, B., & Budge, S. L. (2018). Engaging in LGBQ+ affirmative psychotherapies with all clients: Defining themes and practices. *Journal of clinical psychology*, *74*(11), 2028–2042. https://doi.org/10.1002/jclp.22687

Moreira-Almeida, A., Neto, F.L., & Koenig, H. G. (2006). Religiousness and mental health: A review. *Brazilian Journal of Psychiatry*, *28*(3), 242–250. https://dx.doi.org/10.1590/S1516-44462006005000006

Munder, T., Flückiger, C., Leichsenring, F., Abbass, A. A., Hilsenroth, M. J., Luyten, P., Rabung, S., Steinert, C., Wampold, B. E. (2018). Is psychotherapy effective? A re-analysis of treatments for depression. *Epidemiology and Psychiatric Sciences*, *28*(3), 268–274. https://doi.org/10.1017/S2045796018000355

Murphy, M. J., Faulkner, R. A., & Behrens, C. (2004). The effect of therapist–client racial similarity on client satisfaction and therapist evaluation of treatment. *Contemporary Family Therapy,* 26(3), 279–292. https://doi.org/10.1023/B:COFT.0000037915.95303.28

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy, 55*(4), 303–315. http://dx.doi.org/10.1037/pst0000193

Norcross, J. C., & Wampold, B. E. (2010). What works for whom: Tailoring psychotherapy to the person. *Journal of Clinical Psychology*, *67*(2), 127–132. https://doi.org/10.1002/jclp.20764

Orlinsky, D. E., Ambuhl, H., Rønnestad, M. H., Davis, J. D., Gerin, P., Davis, M. Willutzki, U., Botermans, J., Dazord, A., Cierpka, M., Aapro, N., Buchheim, P., Bae, S., Davidson, C., Jorgensen, E., Ekaterina, J., Kalmykova, E., Meyerberg, J., Northcut, T . . . SPR collaborative research network (1999). The development of psychotherapists: Concepts, questions, and methods of a collaborative international study. *Psychotherapy Research, 9*, 127–153. https://doi.org/10.1080/10503309912331332651

Orlinsky, D.E., & Smith, D. P. (1995). *Religious experience profile*. [Unpublished questionnaire] Committee on Human Development, University of Chicago.

Oxhandler, H., Polson, E., Moffatt, K., & Achenbaum, W. (2017). The religious and spiritual beliefs and practices among practitioners across five helping professions. *Religions*, *8*(11), 237. https://doi.org/10.3390/rel8110237

Pew Research Center. (2012, October 9). "Nones" on the rise. Retrieved May 20, 2020, from https://www.pewforum.org/2012/10/09/nones-on-the-rise/#_ftn6

Pew Research Center. (2017, September 6). More Americans now say they're spiritual but not religious. Retrieved October 11, 2019, from https://www.pewresearch.org/fact-tank/2017/09/06/more-americans-now-say-theyre-spiritual-but-not-religious/

Pew Research Center. (2018a, September 19). Religious landscape study. Retrieved September 24, 2019, from https://www.pewforum.org/religious-landscape-study/frequency-of-feeling-spiritual-peace-and-wellbeing/

Pew Research Center. (2018b, September 19). The spiritual but not religious - Religion in America: U.S. religious data, demographics and statistics. Retrieved May 20, 2020, from https://www.pewforum.org/religious-landscape-study/religious-denomination/spiritual-but-not-religious/

Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (Eds.). (2010). *Handbook of multicultural counseling*. Sage Publications.

Post, B. C., & Wade, N. G. (2009). Religion and spirituality in psychotherapy: a practice-friendly review of research. *Journal of Clinical Psychology*, *65*(2), 131–146. https://doi.org/10.1002/jclp.20563

Prest, L. A., Russel, R., & D'Souza, H. (1999). Spirituality and religion in training, practice and personal development. *Journal of Family Therapy*, *21*(1), 60–77. https://doi.org/10.1111/1467-6427.00104

Raney, A., Cox, D., & Jones, R. P. (2017, November). Searching for spirituality in the U.S: A new look at the spiritual but not religious. Retrieved November 9, 2019, from https://www.prri.org/research/religiosity-and-spirituality-in-america/

Rohrbaugh, J., & Jessor, R. (1975). Religiosity in youth: a personal control against deviant behavior? *Journal of Personality, 43*(1), 136–155. https://doi.org/10.1111/j.1467-6494.1975.tb00577.x

Rose, E. M., Westefeld, J. S., & Ansely, T. N. (2001). Spiritual issues in counseling: clients' beliefs and preferences. *Journal of Counseling Psychology, 48*(1), 61–71. https://doi.org/10.1037/0022-0167.48.1.61

Rosmarin, D. H., Forester, B. P., Shassian, D. M., Webb, C. A., & Björgvinsson, T. (2015). Interest in spiritually integrated psychotherapy among acute psychiatric patients. *Journal of Consulting and Clinical Psychology, 83*(6), 1149–1153. https://doi.org/10.1037/ccp0000046

Rosmarin, D. H., Green, D., Pirutinsky, S., & McKay, D. (2013). Attitudes toward spirituality/religion among members of the Association for Behavioral and Cognitive Therapies. *Professional Psychology: Research and Practice*, *44*(6), 424–433. https://doi.org/10.1037/a0035218

Santos, H. C., Varnum, M. E. W., & Grossmann, I. (2017). Global Increases in Individualism. *Psychological Science*, *28*(9), 1228–1239. https://doi.org/10.1177/0956797617700622

Sedikides, C. (2010). Why does religiosity persist? *Personality and Social Psychology Review*, *14*(1), 3–6. https://doi.org/10.1177/1088868309352323

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. https://doi.org/10.1111/1468-5906.00129

Shafranske, E. P., & Cummings, J. P. (2013). Religious and spiritual beliefs, affiliations, and practices of psychologists. In K. I. Pargament, A. Mahoney, & E. P. Shafranske

(Eds.), *APA handbook of psychology, religion, and spirituality (Vol. 2): An applied psychology of religion and spirituality* (pp. 23–41). American Psychological Association. https://doi.org/10.1037/14046-002

Shafranske, E. P., & Malony, H. N. (1990). Clinical psychologists' religious and spiritual orientations and their practice of psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *27*(1), 72–78. https://doi.org/10.1037/0033-3204.27.1.72

Shafranske, E. P., & Pargament, K. I. (2010). Religious and spiritual attitudes and practices of clinical and counseling psychologists and graduate students in clinical and counseling Psychology. (As cited in Shafranske & Cummings 2013).

Sheridan, M. J., Bullis, R. K., Adcock, C. R., Berlin, S. D., & Miller, P. C. (1992). Practitioners' personal and professional attitudes and behaviors toward religion and spirituality: Issues for education and practice. *Journal of Social Work Education*, *28*(2), 190–203. https://doi.org/10.1080/10437797.1992.10778772

Shumway, B., & Waldo, M. (2012). Client's religiosity and expected working alliance with theistic psychotherapists. *Psychology of Religion and Spirituality*, *4*(2), 85–92. https://doi.org/10.1037/a0025675

Slife, B., Scott, L., & McDonald, A. (2016). The clash of theism and liberal individualism in psychotherapy: A case illustration. *Open Theology, 2*(1). https://doi.org/10.1515/opth-2016-0047

Smith, D. P., & Orlinsky, D. E. (2004). Religious and spiritual experience among psychotherapists. *Psychotherapy: Theory, Research, Practice, Training*, *41*(2), 144–151. https://doi.org/10.1037/0033-3204.41.2.144

Smith, T. W., Marsden, P., Hout, M., & Kim, J. (2014). *General social surveys, 1972–2014 cumulative file*. Chicago: National Opinion Research Center at the University of Chicago.

Snyder, C. R. (2002). Hope theory: Rainbows in the mind. *Psychological Inquiry*, 13(4), 249–275. https://doi.org/10.1207/s15327965pli1304_01

Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S. A., Irving, L. M., Sigmon, S. T., Yoshinobu, L., Gibb, J., Langelle, C., & Harney, P. (1991). The will and the ways: Development and validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology, 60*(4),570–585. https://doi.org/10.1037/0022-3514.60.4.570

Soto, A., Smith, T. B., Griner, D., Domenech Rodríguez, M., & Bernal, G. (2018). Cultural adaptations and therapist multicultural competence: Two meta-analytic reviews. *Journal of clinical psychology*, *74*(11), 1907–1923. https://doi.org/10.1002/jclp.22679

Stanley, M. A., Bush, A. L., Camp, M. E., Jameson, J. P., Phillips, L. L., Barber, C. R., Zeno, D., Lomax, J. W., & Cully, J. A. (2011) Older adults' preferences for religion/spirituality in treatment for anxiety and depression. *Aging & Mental Health, 15*(3), 334-343, https://doi.org/10.1080/13607863.2010.519326

Stolte, J. (2021). Measurement and social desirability response bias in experimental vignette research: A test of Fazio's mode theory. PsyArXiv. https://doi.org/10.31234/osf.io/xp9tb

Swift, J. K., Callahan, J. L., Cooper, M., & Parkin, S. R. (2018a). The impact of accommodating client preference in psychotherapy: A meta-analysis. *Journal of clinical psychology*, *74*(11), 1924–1937.https://doi.org/10.1002/jclp.22680

Swift, J. K., Derthick, A. O., & Tompkins, K. A. (2018b). The relationship between trainee therapists' and clients' initial expectations and actual treatment duration and outcomes. *Practice Innovations, 3*(2), 84–93. https://doi.org/10.1037/pri0000065

Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology, 80*(4), 547–559. https://doi.org/10.1037/a0028226

Tompkins, K. A., & Swift, J. K. (2015). Psychotherapy process and outcome research. *The Encyclopedia of Clinical Psychology*, 1–7. https://doi.org/10.1002/9781118625392.wbecp33

Trusty, W., Swift, J., Dimmick, A., Winkle, J., Penix, E., (2019). *Religious Microaggressions in Psychotherapy: Impact on Process and Outcome with Religious Clients.* Poster presented at American Psychological Association national convention, Chicago, IL.

Vervaeke, G. A., Vertommen, H., & Storms, G. (1997). Client and therapist values in relation to drop-out. *Clinical Psychology & Psychotherapy: An International Journal of Theory and Practice*, *4*(1), 1-6. https://doi.org/10.1002/(SICI)1099-0879(199703)4:1<1::AID-CPP97>3.0.CO;2-W

Weinstein, C. M., Parker, J., & Archer, J. (2002). College counselor attitudes toward spiritual and religious issues and practices in counseling. *Journal of College Counseling*, *5*(2), 164–174. https://doi.org/10.1002/j.2161-1882.2002.tb00218.x

Weisz, J. R., Weiss, B., Alicke, M. D., & Klotz, M. L. (1987). Effectiveness of psychotherapy with children and adolescents: A meta-analysis for clinicians. *Journal of Consulting and Clinical Psychology, 55*(4), 542–549. https://doi.org/10.1037/0022-006X.55.4.542

Wilks, S. E. (2006). Intrinsic spirituality among Alzheimer's caretakers: A pathway to resiliency. *Advances in Social Work*, *7*(1), 67–89. https://doi.org/10.18060/121

Worthington, E. L., Hook, J. N., Davis, D. E., & McDaniel, M. A. (2010). Religion and spirituality. *Journal of Clinical Psychology*, *67*(2), 204–214. https://doi.org/10.1002/jclp.20760

Worthington Jr., E. L., Wade, N. G., Hight, T. L., Ripley, J. S., McCullough, M. E., Berry, J. W., Schmitt, M. M., Berry, J. T., Bursley, K. H., & O'Connor, L. (2003). The Religious Commitment Inventory–10: Development, refinement, and validation of a brief scale for research and counseling. *Journal of Counseling Psychology*, *50*(1), 84–96. https://doi.org/10.1037/0022-0167.50.1.84

Wortmann, J. H., Park, C. L., & Edmondson, D. (2011). Trauma and PTSD symptoms: Does spiritual struggle mediate the link?. *Psychological Trauma: Theory, Research, Practice and Policy*, *3*(4), 442–452. https://doi.org/10.1037/a0021413

Wright, A. J., & Stern, S. (2016). The role of spirituality in sexual minority identity. *Psychology of Sexual Orientation and Gender Diversity, 3*(1), 71–79. https://doi.org/10.1037/sgd0000139

Ying, Y.-W. (2019). Religiosity, spirituality, mindfulness, and mental health in social work students. *Critical Social Work*, *10*(1). https://doi.org/10.22329/csw.v10i1.5803

Yoder, J., Bovard-Johns, R.M. (2017) Religiosity and therapeutic alliance among youth who commit sexual crimes. *Child Youth Care Forum 46*(1)*,* 119–135. https://doi.org/10.1007/s10566-016-9371-0

Zhai, J. E., Ellison, C. G., Stokes, C. E., & Glenn, N. D. (2008). “Spiritual, but Not Religious”: The Impact of Parental Divorce on the Religious and Spiritual Identities of Young Adults in the United States. *Review of Religious Research*, *49*(4), 379–394.

Zinnbauer, B., Pargament, K., & Scott, A. (2001). The emerging meanings of religiousness and spirituality: Problems and prospects. *Journal of Personality, 67*(6), 889 - 919. https://doi.org/s10.1111/1467-6494.00077.

Appendix I: Clinical Vignettes

Clinical Vignette (Including R/S Factors)

Bethany Jones is a 35-year-old elementary school teacher who is married with no children. She describes her husband as supportive and indicates that she also has a strong social support network of friends. Additionally, she is heavily involved in her religious community and reports that her personal religious and spiritual beliefs are very important to her. Although she generally copes fairly well with stressors in her life, over the past two months she has experienced feelings of depression and an overall lack of energy that have lasted most of the day, nearly every day. Prior to this, she was able to find a significant amount of meaning and fulfillment in interacting with her students, but she reports that lately she dreads the idea of going into work. She also reports difficulty in concentrating and staying on task while at work. Bethany indicated that she used to enjoy gardening and going on walks, but lately she has found very little pleasure from those activities too. She further indicates that over the past 6-weeks she has gained about 15 pounds, due to what she labeled as comfort eating. She also reports feelings of constant fatigue and a desire to stay in bed the entire day. She has no family history of mental illness and denies suicidal ideation and psychotic symptoms. During the initial interview she participated well, but revealed that she had some doubts about how effective therapy can be in her situation. She primarily would like therapy to focus on her recent feelings of a lack of fulfillment and joy in life and she suggested that some level of religious integration might be helpful in treatment.

Clinical Vignette (Without R/S Factors)

Bethany Jones is a 35-year-old elementary school teacher who is married with no children. She describes her husband as supportive and indicates that she also has a strong social support network of friends. She is heavily involved in her local community and states that

community involvement is very important to her. Although she generally copes fairly well with stressors in her life, over the past two months she has experienced feelings of depression and an overall lack of energy that have lasted most of the day, nearly every day. Prior to this, she was able to find a significant amount of meaning and fulfillment in interacting with her students, but she reports that lately she dreads the idea of going into work. She also reports difficulty in concentrating and staying on task while at work. Bethany indicated that she used to enjoy gardening and going on walks, but lately she has found very little pleasure from those activities too. She further indicates that over the past 6-weeks she has gained about 15 pounds, due to what she labeled as comfort eating. She also reports feelings of constant fatigue and a desire to stay in bed the entire day. She has no family history of mental illness and denies suicidal ideation and psychotic symptoms. During the initial interview she participated well but revealed that she had some doubts about how effective therapy can be in her situation. She primarily would like therapy to focus on her recent feelings of a lack of fulfillment and joy in life.

Appendix II: Survey Items and Measures

Therapist Hope for Clients (THCS) Original Items (Bartholomew et al. 2020)

Instructions: Please think carefully about your experience with your individual client as you respond to each of the following items. If you find yourself wanting more information to answer a given question, do your best to respond to the item based on your existing experiences with the client (i.e., if you have seen your client for just one session, do your best to respond to the items based upon your expectations for the client given your existing clinical experience with her or him). Using the eight-point scale below, indicate the number that best describes you for each item.

1. I am motivated to help this client resolve their concerns through counseling.
2. I believe my client is aware of what she or he wants to accomplish through counseling.
3. My work with this client is energizing to me.
4. I believe my client experiences the impact of counseling most days outside of sessions.
5. I can identify many ways for my client to use counseling to reach clinical goals.
6. Even in times when my client is stuck, I energetically pursue our work together.
7. Even when we are stuck, I am confident my client remains motivated to pursue their goals.
8. My client's goals for counseling are easily identified.
9. I sustain active participation with this client in counseling.
10. I know what my client wants to work on in counseling.

Therapist Hope for Clients (THCS) Adapted Items

1. I am motivated to help this client resolve their concerns through counseling.
2. I believe this client is aware of what he or she wants to accomplish through counseling.
3. I believe my future work with this client would be energizing to me.
4. When in therapy, I believe this client will experience the impact of therapy most days outside of sessions.
5. I can identify many ways for this client to use counseling to reach clinical goals.
6. Even in times when my client is stuck, I energetically pursue our work together.
7. Even in times when this client will be stuck, I will energetically pursue our work together.
8. I will easily be able to identify this client's goals.
9. I believe I will be able to sustain active participation with this client in counseling.
10. I know what this client wants to work on in counseling.

Pew Research Foundation Survey Items (2018a)

Please rate the following items from 0 (seldom) to 4 (daily)

1. How frequently do you attend religious services?
2. How frequently do you pray?
3. How frequently do you experience feelings of spiritual peace and well-being?

Please rate the following items from 1 (very religious/spiritual) to 4 (very religious/spiritual)

4. Do you consider yourself to be a religious person?
5. Do you consider yourself to be a spiritual person?

Additional Items From Past Research

Please rate the truthfulness of the following statements from 1 (not at all true) to 5 (very true)

1. "Spiritual beliefs very important to me" (Bilgrave & Deluty, 2002; Francis, 2011).
2. "I was raised in a particular religion" (Hodge, 2002; Prest et al., 1999; Shafranske & Malony, 1990).
3. "I am currently affiliated with a religious organization" (Dwyer, 2008; Francis, 2011; Kelly, 1995; Rosmarin et al., 2013; Shafranske & Malony, 1990; Ying, 2009).

Items From Bergin and Jensen (1990)

Please rate the truthfulness of the following statements on a scale of 1 (strongly disagree) to 5 (strongly agree)

1. I try hard to live my life according to my religious beliefs.
2. My whole approach to life is based on my religion.
3. I seek a spiritual understanding of the universe and one's place in it.
4. I actively participate in my religious affiliation.

Religious Commitment Inventory–10 (Worthington et al., 2003)

RCI-10

Instructions: Read each of the following statements. Using the scale to the right, CIRCLE the response that best describes how true each statement is for you.

	Not at all true of me 1	**Somewhat** true of me 2	**Moderately** true of me 3	**Mostly** true of me 4	**Totally** true of me 5

1.	I often read books and magazines about my faith.	1	2	3	4	5
2.	I make financial contributions to my religious organization.	1	2	3	4	5
3.	I spend time trying to grow in understanding of my faith.	1	2	3	4	5
4.	Religion is especially important to me because it answers many questions about the meaning of life.	1	2	3	4	5
5.	My religious beliefs lie behind my whole approach to life.	1	2	3	4	5
6.	I enjoy spending time with others of my religious affiliation.	1	2	3	4	5
7.	Religious beliefs influence all my dealings in life.	1	2	3	4	5
8.	It is important to me to spend periods of time in private religious thought and reflection.	1	2	3	4	5
9.	I enjoy working in the activities of my religious affiliation.	1	2	3	4	5
10.	I keep well informed about my local religious group and have some influence in its decisions.	1	2	3	4	5

Intrinsic Spirituality Scale (Hodge, 2003)

For the following six questions, *spirituality* is defined as one's relationship to God, or whatever you perceive to be Ultimate Transcendence.

The questions use a sentence completion format to measure various attributes associated with spirituality. An incomplete sentence fragment is provided, followed directly below by two phrases that are linked to a scale ranging from 0 to 10. The phrases, which complete the sentence fragment, anchor each end of the scale. The 0 to 10 range provides you with a continuum on which to reply, with 0 corresponding to absence or zero amount of the attribute, while 10 corresponds to the maximum amount of the attribute. In other words, the end points represent extreme values, while five corresponds to a medium, or moderate, amount of the attribute. Please circle the *number* along the continuum that best reflects your initial feeling.

1. In terms of the questions I have about life, my spirituality answers

no questions										**absolutely all my questions**
0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	***10***

2. Growing spiritually is

more important than anything else in my life										**of no importance to me**
10	*9*	*8*	*7*	*6*	*5*	*4*	*3*	*2*	*1*	***0***

3. When I am faced with an important decision, my spirituality

plays absolutely no role										**is always the overriding consideration**
0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	***10***

4. Spirituality is

the master motive of my life, directing every other aspect of my life										**not part of my life**
10	*9*	*8*	*7*	*6*	*5*	*4*	*3*	*2*	*1*	***0***

5. When I think of the things that help me to grow and mature as a person, my spirituality

has no effect on my personal growth										**is absolutely the most important factor in my personal growth**
0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	***10***

6. My spiritual beliefs affect

absolutely every aspect of my life										**no aspect of my life**
10	*9*	*8*	*7*	*6*	*5*	*4*	*3*	*2*	*1*	***0***