Spiritual/Religious Issues in Therapy at a Community Mental Health Clinic

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Spiritual/Religious Issues in Therapy at a Community Mental Health Clinic

by

Courtney E. McConnell

Presented to the Faculty of the
Graduate Department of Clinical Psychology
George Fox University
in partial fulfillment
of the requirements for the degree of
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in Clinical Psychology

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Spiritual/Religious Issues in Therapy at a Community Mental Health Clinic

by

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Graduate Department of Clinical Psychology

George Fox University

as a Dissertation for the PsyD degree

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Abstract

The purpose of this dissertation is to explore the growing area of spirituality and religion in counseling. The American public values religion; and the American Psychological Association (APA) acknowledges religion/spirituality as a vital area of diversity. With APA calling for specialized training in religious diversity, it is important to consider what religious/spiritual issues arise in a community counseling setting. This study was designed to determine whether clients or therapists raise religious issues, and whether clients who self-identify as religiously affiliated spend more time discussing religious/spiritual topics in session. In addition, researchers hoped to learn about what religious content was brought into therapy, and when in the course of short-term therapy spiritual issues arise. Data were gathered from archived session tapes from a community mental health clinic, located at a university that is known in the community to have a strong religious identity. The participants ($N = 15$) had a mean age of 48.9 years, 60% of them were female and 93.3% self-identified as White; half of them requested faith integrated into their therapy ($N = 8$). Two session tapes per client were reviewed to look for religious content. Additional demographic data, Session Rating Scales, Outcome Rating Scales and a post-hoc
client attitudes questionnaire were collected to provide additional information. The results showed that 80% of clients self reported a religious affiliation and 80% of clients discussed some religious/spiritual content in at least one observed session. These conversations were more frequent in early sessions and were typically initiated by the client. While there was not a statistically significant difference in the amount of time spent discussing spiritual content based on whether clients requested spiritual integration, there was a significant correlation between these factors and a large effect size. The most common content to arise included that surrounding church/faith community, religious texts, and rituals such as prayer. These findings suggest that spiritual issues are commonly brought up by clients and provide some insight into these concerns.
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Chapter 1
Introduction

Most Americans report that religion is important to them. In 2008, 65% of Americans reported that religion was an important part of their daily lives (Newport, 2009). There is significant variability in the prevalence of religious beliefs across states, with rates ranging between 42% in Vermont to 85% in Mississippi of polled residents endorsing religion as being important in their lives. The overall nationwide average is 65% of residents saying that religion is important in their daily lives. A study of perceptions of important topics to treatment found that spiritual/religious beliefs and practices to be 2 of the top 10 areas identified by clinicians and clients (Miovic et al., 2006). Other areas important to discuss in treatment included family, friends, work, finance, fitness, education, hobbies, and sexuality. Thus, clients feel that religion/spirituality is one of many salient issues to address in psychotherapy.

When considering the effectiveness of religious interventions, or the impact of client spirituality on treatment, it is necessary to define what constitutes religious/spiritual content. Other researchers have used a variety of operational definitions of spirituality and religion (Aten & Worthington, Jr., 2009). Many of them have focused on the differences between organized religion and an individually centered sense of spirituality (Knox, Catlin, Casper & Schlosser, 2005). For the purpose of this study, it is more relevant to consider the commonalities of these concepts, namely that they both involve searching for a connection with the sacred (Hill &
Pargament, 2003). The sacred may include God, transcendence and any other concepts that are set apart from the ordinary. In this paper, the terms religion and spirituality will be used interchangeably, because traditionally these concepts have been measured utilizing the same global indices (Weisman de Mamani, Tuchman & Duarte, 2010).

**Current Developments in APA**

In the past few years, the American Psychological Association has formally acknowledged the importance of addressing religious issues in therapy, as well as having spoken out against discrimination based on religion. The Resolution on Religious, Religion-Based and/or Religion Derived Prejudice, adopted by the APA, described the profound impact that religious/spiritual beliefs can have on individual’s lives, and the fact that spiritual concerns are under-addressed in the field of psychology (2007). Also, despite past reluctance to explore this area, the American Psychological Association asserted that addressing religious issues is a vital part of conducting culturally-sensitive research, counseling and psychological assessment.

**Christian Association for Psychological Studies (CAPS)** is a professional association of Christian mental health providers, who, “exist to encourage understanding of the relationship between Christianity and the behavioral sciences at both the clinical/counseling and the theoretical/research levels” (CAPS, 2013, About Us: Who We Are, para. 2).

**Training In Religious/Spiritual Therapy**

While the importance of addressing spirituality in therapy has become widely recognized, there are relatively few spiritual training opportunities for doctoral psychology students. A recent study by Vogel, McMinn, Peterson and Gathercoal identified religion and spirituality as diversity factors that graduate students, faculty, interns and internship training directors felt were among
those that graduate training was least effective in teaching (2013). Russell and Yarhouse (2006) found that only 35% of the APA internship sites they surveyed offered spiritual/religious didactic training. About 90% of internship training directors reported that spirituality/religion were addressed in clinical supervision, the majority of the time in direct relationship to spiritual content brought up by clients in session. This mode of addressing spirituality was confirmed by another study in which psychology trainees and trainers both reported that trainees most often learn about religion/spirituality through direct clinical experiences with clients and in supervision (Vogel et al., 2013). The second most common mode of learning about spirituality was through peer interactions. They suggested that this represents a more reactive model of learning in contrast to more proactive didactic training or graduate coursework.

However, a survey of practicing psychologists showed that 51% disagreed with religious/spiritual training being taught predominately through clinical supervision, instead suggesting that it should be a part of other aspects of graduate training as well (Crook-Lyon et al., 2012). In fact, 76% said that they felt spirituality and religion were not adequately addressed in current psychology graduate training. When considering the potential implications of this lack of training in spiritual/religious intervention, researchers suggest that clinicians could run the risk of alienating clients with religious concerns or imposing their own religious biases on their clients (Hage, 2006). Most psychologists report that they do not routinely assess for spirituality or include it in treatment planning. Therapists who are not trained in spiritual interventions may not know to utilize interventions, such as prayer, which could be beneficial to clients.

Surprisingly, despite recent movement toward diversity training within psychology, about 68% of APA internship directors reported they expect that formal religious and spiritual training
will never be offered within their program (Russell & Yarhouse, 2006). It seems that psychology training programs overall may be slow to incorporate spiritual and religious training elements. One potential factor influencing this fact is a lack of professor/staff interest in spirituality, as over 73% of APA internship directors reported that none of their staff members’ predominate area of interest was spirituality.

**Review of Spiritual Treatment Outcomes**

Because there is little training on religious/spiritual issues in graduate school, many psychologists are unaware of the impact of religious/spiritual issues in therapy on therapy outcomes. Religious involvement has been shown in some cases to enhance the effectiveness of psychological treatment. For instance, a study of a cognitive behavioral group treatment program for panic disorder showed that individuals who rated religion as “very important” improved more than other participants in terms of reduced general symptoms, anxiety and scores on the Perceived Stress Scales at 12 month follow-up (Bowen, Baetz & D’Arcy, 2006). This finding suggests that religious beliefs can be an important factor in the effectiveness of evidence-based practices in psychotherapy.

While considering client spirituality as a factor in treatment outcomes, it is also important to evaluate spiritual and religious treatment models in terms of their effectiveness, to ensure that psychologists are providing evidence-based treatment. The area of research on religious and spiritual psychological treatment is relatively young, but there are several studies that suggest spiritual interventions can be a part of effective means of treatment. A meta-analysis of 31 research studies involving spiritual/religious interventions concluded that these types of treatments were effective (Smith, Bartz & Richards, 2007). The 22 studies in this review, which
compared spiritual and secular interventions, demonstrated that both types of intervention were about equally powerful. The authors noted that client outcomes did not differ based on age or gender suggesting that spiritual approaches may be generalizable across different populations, though the meta-analysis involved predominately Christian and Muslim clientele. Further, in considering outcome measurement, Smith et al. (2007) found that measures of overall well-being seemed more sensitive to the impact of religious interventions than measures of specific mental health symptoms. These findings demonstrate that religious and spiritual interventions may be just as effective as secular interventions, and suggest that spiritual interventions have a similar level of effectiveness across client age and gender.

Hook, et al. (2010) also completed a review of studies predominately utilizing spirituality incorporated into secular treatment models. They found relatively few studies of religious/spiritual treatment and most with small sample sizes, which complicated their ability to evaluate the effectiveness of the treatments studied. Overall, their results suggested that including a religious component into an existing empirically validated secular treatment model produced a spiritually inclusive treatment, which was as effective as the original secular treatment. Thus, their research seems to indicate that involving spirituality does not diminish the effectiveness of research-based treatments. As such, evidence-based treatments with a spiritual component may be able to provide the same benefit as the secular therapy while also attending to clients’ spiritual needs. Further research in this area is needed to determine whether incorporating spirituality makes a meaningful difference in some aspect of treatment outcomes or in the clients’ subjective experience of treatment.
Some therapists have used only spiritual interventions without a secular research-based therapy component, which have yielded mixed results. While it is not to say that such interventions could not be effective, there is a lack of research to support such therapeutic methods. Hathaway (2011) suggests that this type of therapy brings up several potential ethical concerns. This is especially true if clients are not made aware of other potential treatment options that are empirically supported, or that spiritual treatment alone is currently considered experimental in nature.

**Clinical Implications**

Since the majority of Americans still identify themselves as religious/spiritual, what are the practical implications of this knowledge for clinical psychologists? The American Psychological Association is promoting stronger consideration of religious/spiritual issues, however, there is limited current research in which these recommendations have been put into practice. Richards and Bergin (2005) wrote about the importance of religious/spiritual assessment as a part of therapy. They suggested that spiritual/religious assessment should be part of a multilevel, multisystemic assessment of a client’s overall functioning, that begins during the intake session. However, they comment that most therapists do not routinely include religious assessment into their work with clients. While more in-depth assessment of spirituality is certainly useful, Gorsuch and McPherson (1989), isolated reliable single item measures which can be used assess extrinsic and intrinsic spirituality. Such individual items may be useful, for instance, in settings where spirituality is not typically a primary concern. These items can act as a screening tool, which indicate when further exploration may be relevant.

**Patient Attitudes and Concerns**
Limited research has been conducted on the prevalence of distress in the general population related to spiritual/religious concerns. In large study of 5,472 private and public college students, approximately 44% reported between a little bit and an extreme level of current distress related to religious or spiritual concerns (Johnson & Hayes, 2003). More specifically, 12% endorsed a moderate amount of distress, 8% reported quite a bit and 6% reported an extreme amount of distress related to religious or spiritual issues. In this study, about half of the sample had sought help from a university counseling center. Those with at least a moderate level of religious/spiritual distress were more likely than other clients to also experience distress related to sexual concerns, relationships with peers, concerns about being punished for their sins and confusion about their beliefs.

Related research on religious issues in therapy suggests that clients who are currently in therapy feel it is appropriate to discuss spirituality with their therapist. Rose, Westefeld and Ansley (2001) surveyed clients from a variety of setting including a university counseling center, a psychology training center, a private practice, Lutheran Social Service center, and two community mental health clinics. Of clients surveyed, 63% indicated that they felt discussing religious issues in therapy was appropriate. When asked whether they wanted to discuss religious issues within their own therapy, 55% of the sample responded positively. Interestingly, in this study, whether or not clients wished to discuss spirituality in therapy had a relatively weak relationship to the self-reported presence or absence of spiritual problems in their lives. While this study included a relatively small number of participants per counseling setting, it suggests that across settings the majority of clients believe spiritual discussions are important and would like to incorporate spirituality into their personal therapy.
In a college counseling setting, a survey of therapists found that 90% were able to identify a recent client whose issues related to spirituality/religion (Kellems, Hill, Crook-Lyon & Freitas, 2010). These clients were described as entering counseling with a variety of presenting problems including emotional distress, questioning their values, academic stress, adjustment difficulties and body image issues. Of the 200 client cases that therapists responded about, the four most common ways that clients’ religious/spiritual issues were evidenced in therapy included incongruence between beliefs and sexual behavior, abandonment of family of origin’s religious traditions, use of religion as a source of strength, and exploring or defining the client’s religious beliefs. The results of this study provide some information regarding the prevalence of religious concerns and some associated presenting problems. However, many of the findings reflect concerns that are generally more prevalent in college student populations and many not provide much insight into spirituality in a community mental health setting.

A descriptive study of spiritual discussions that psychotherapy clients had with non-religiously affiliated therapists, yielded a more diverse sample with a mean age of 43.4 years (Knox et al., 2005). The participants (N=12) described a wide range of presenting problems including depression, anxiety, family-of-origin issues, trauma and grief. Clients identified specific instances in which religious conversations in therapy had been helpful. Participants described the helpful topics raised as including personal struggles with existential concerns, support received from a religious/spiritual community and the client’s use of religious/spiritual belief or practice as part of therapy. These helpful conversations were brought up either by the client, or mutually by the client and therapist, and lead to clients feeling satisfied with therapy. Conversely, when the participants discussed specific unhelpful spiritual conversations in therapy,
the issues were raised by therapist 50% of the time, and clients the other 50%. The participants explained that the conversations became unhelpful when they felt the therapist had passed judgment or imposed their personal religious beliefs onto the clients.

**Current Study**

While the research that has been conducted previously on religious/spiritual issues provides some insight into the nature of religious problems in therapy, more research is needed to expand upon this knowledge base. At this point, it is not clear what percentage of patients in a community mental health setting would like for their faith to be integrated into treatment, or what spiritual issues might arise in this context. The purpose of this study is to provide clinicians with valuable information about spiritual/religious issues that arise in a community mental health clinic. The proposed research is unique in that it will investigate spirituality in the context of a short-term therapy model, at a clinic that is affiliated with a religious university. This setting will provide the opportunity for clients to bring up spiritual issues, within a low cost clinic that is accessible to a wide range of clientele.
Chapter 2

Method

Participants

The data for this study were selected from archived session tapes of 15 clients of the George Fox University Behavioral Health Clinic (BHC). From June 2012 to January 2013, 171 clients received therapy through the BHC, thus the 15 clients in this study would represent 8.7% of the clientele served during that period (George Fox University, 2013). Participants were predominately female (N = 9 female, 6 male) and almost exclusively identified as White (N=14). The median age was 48.9 years (SD = 13.15), with participants ranging in age from 24 to 65 years. Session tapes were selected on the basis that the clients recorded were over the age of 18, and completed at least five sessions of individual therapy. To maintain consistency across participant experiences, only new intake clients who had not previously sought treatment at the BHC were included. Individuals for whom English is a not first language were not eligible for this study.

Instruments

Demographics record. Demographic information for participants was collected through a review of their chart at the Behavioral Health Clinic. Information gathered included gender, age, ethnicity, self-reported spirituality, presenting problem, diagnosis, and session cost based on a sliding fee scale (see Appendix A).
Session evaluation log. Each psychotherapy session included in this study was reviewed using an evaluation log. (See Appendix B) The purpose of this form was to document whether spiritual content was present, and whether the client or therapist brought up this content. In addition, this form gathered information about the spiritual topics discussed using the codebook (see Appendix C) and the amount of time in the session that was spent on spiritual matters.

Session Rating Scale. This a very brief self-report measure of the therapeutic relationship developed by Duncan et al. (2003). This scale is used at the conclusion of each session so that the therapist receives feedback about the client’s experience, and they can use this information to enhance the therapeutic alliance. For the purposes of this study, the SRS data was used as a measure of the clients’ experience each session. Studies on the SRS (Miller, Duncan, Sorrell, & Brown, 2004) show an average concurrent validity of \( r = .48 \) when compared to the HAQ-II. Internal consistency and test-retest reliability range from \( r = .88 \) to \( r = .96 \), and from \( r = .50 \) to \( r = .74 \), respectively. Although the test-retest reliability of the measures seems to be lower than desired, this is to be expected from tests which measure fluctuating phenomena (Miller et al., 2004).

Outcome Rating Scale. This very brief outcome measure was created for ease of use by clinicians to measure weakly changes in clients’ perceived outcomes throughout the course of therapy. This scale is comprised of four different scales including clients’ individual, interpersonal, social and overall wellbeing, which clients mark on a continuum of low to high. In the current study, the ORS was used as measure of clients’ self-reported outcome regarding their well-being throughout the course of treatment. Bringhurst, Watson, Miller, & Duncan (2006) compared scores on the ORS to the much longer Outcome Questionnaire 24, 2nd version.
They found a moderate level of concurrent validity with correlation coefficients ranging from $r = .53$ to $.69$ over four repeated administrations over time. They found the overall internal consistency of the ORS was Cronbach’s alpha = .97, and suggest that the high degree of internal consistency is likely due to the fact that the four dimensions measured are strongly related, providing an overall measure of distress versus measuring distinct constructs. The test-retest reliability of the ORS in this study was reported as coefficient alpha = .97.

**Faith Attitudes Post-Treatment Survey.** The clients were sent a survey created specifically for this study to collect information about clients’ personal attitudes about faith in relation to their counseling experience (see Appendix D). This brief survey was comprised of Likert-type scale items concerning the clients’ comfort with and the perceived helpfulness of discussing religion/spirituality in therapy. This measure also included clients’ perceptions of whether religion/spirituality was related to the problem that they came to counseling to address.

**Procedure**

Since data were gathered from archived session tapes, the participants experienced the typical counseling process utilized by the BHC. The BHC is a community mental health clinic staffed by doctoral students studying clinical psychology, who are supervised by a licensed psychologist. A sliding fee scale, based on client income, determines the cost of sessions at the BHC.

During the first session, participants were presented with the standard informed consent used by the BHC for all of their clients. This form includes consent for videotaping sessions as well as a release to use de-identified client information for research purposes. The remainder of the first meeting includes a semi-structured intake interview used to gather information about
current functioning as well as social, familial and occupational history. Counseling sessions were held individually, and clients met with the same doctoral psychology student for each fifty-minute session. During subsequent sessions, counselors worked with clients on their presenting problems using short-term cognitive behavioral techniques. At the end of each session, participants filled out the Session Rating Scale (SRS), which is standard protocol for all BHC clients.

All counseling sessions conducted at the Behavioral Health Center are recorded for educational purposes, using a closed circuit recording system that is hardwired into the counseling rooms. These video files are archived electronically on a secure computer server, which is overseen by the Director of the Behavioral Health Clinic. The client file review was completed at the Behavioral Health Clinic using the Demographic Record Form to collect data that is routinely kept in client records.

A sampling of 30 session tapes was chosen from 15 different clients. To ensure an even sampling from different points in the therapy for each participant, one tape falling between the 1st and 4th therapy session, and the other falling between the 5th and 8th session was randomly selected based on tape availability. Clients were selected based on availability of tapes, and their self-reported desired to have spirituality incorporated into their counseling (N = 8) or not (N = 7).
Chapter 3

Results

Demographic Information

Participants in this study were diverse in their presenting problems, diagnosis, and referral sources. Some of the presenting concerns that led participants to seek counseling included unemployment, substance use, relationship difficulties, suicidality, and court mandate. When considering primary diagnoses, Mood Disorders were most prevalent ($N = 8$), followed by Anxiety Disorders ($N = 5$), a V-Code of Relational Problem ($N = 2$), Substance Abuse ($N = 1$), Bereavement ($N = 1$) and Adjustment Disorder ($N = 1$). Clients were referred to the BHC through a variety of avenues, including direct referral from the Behavioral Health Consultants who perform risk assessments at the local Emergency Room, and from the Behavioral Health practitioners who provide limited solution focused therapy within the medical setting. Other clients were referred for counseling by friends, their pastor or primary care doctor or by the County Court.

Almost half of the participants were currently employed ($N = 6$). Data was collected on household income for the sliding fee scale, with the majority of participants falling in the under $15,000 per year range ($N = 10$), and the remaining falling between $15,000-30,000 per year ($N = 2$), $30,000-45,000 per year ($N = 2$) and greater than 45,000 per year ($N = 1$).
Religious Affiliation/Faith Rating

While only half of clients requested to integrate faith into sessions, 80% \((N = 12)\) of the participants reported having a religious affiliation. Specifically, 53.3% \((N = 8)\) of participants identified as Protestant Christian, 13.3% as Catholic \((N = 2)\), 6.7% as Jehovah’s Witness \((N = 1)\), and 26.67% \((N = 4)\) as not religious. Of those who reported belonging to a religious group, 66.7% \((N = 8)\) wanted spirituality in their counseling, while the participants who reported that they have no faith \((N = 2)\) did not want faith incorporated, and one did not respond. On a Likert-type scale of the importance of faith in one’s life, with 1 being *Not at all, I have no religion* to 5 being *Extremely important, it is the center of my life*, clients rated their faith on average as very important \((M = 4.14, SD = 1)\). Higher faith ratings were related to clients wanting faith integrated in their therapy \((r = .70, p < .05)\), See Table 1. There was a significant difference in the ratings of the importance of faith for participants who did \((M = 4.64, SD = .62)\) and did not \((M = 3.25, SD = .96)\) want faith discussed in their sessions, \(t(9) = 2.95, p = .02\).

Faith Attitudes

A post-hoc questionnaire was used to assess attitudes about the helpfulness, comfort and relevance of discussing faith in therapy. The total response rate for this survey was 53.3% \((N = 8)\). There was a significant difference in the ratings of helpfulness of discussing spirituality in session for those who did \((M = 4.67, SD = .52)\) and did not \((M = 3.00, SD = .00)\) want faith discussed in their sessions, Welch’s \(t(5) = 7.91, p = .001\). This indicates that individuals who wanted faith incorporated in their counseling viewed discussing faith as more helpful \((r = .46)\). Clients who had talked more about religion in their therapy also rated religious discussion as
Table 1

**Correlations Between Client and Therapist Factors**

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<td>Client Requests Faith Integration</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>SRS Total for Late Session</td>
<td>.53*</td>
<td>.02</td>
<td>-.43</td>
<td>.28</td>
<td>-.18</td>
<td>.67</td>
<td>.47</td>
<td>-.32</td>
<td>-.21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SRS Relationship Score Late Session</td>
<td>.47*</td>
<td>.12</td>
<td>-.47</td>
<td>.09</td>
<td>-.13</td>
<td>.72</td>
<td>.61</td>
<td>-.24</td>
<td>-.22</td>
<td>.93*</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Total Client Initiations</td>
<td>.93*</td>
<td>.59*</td>
<td>-.52*</td>
<td>-.09</td>
<td>.59*</td>
<td>.19</td>
<td>.05</td>
<td>.17</td>
<td>.14</td>
<td>.46</td>
<td>.43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Therapist Initiations</td>
<td>.83*</td>
<td>.35*</td>
<td>-.41*</td>
<td>-.02</td>
<td>.27</td>
<td>.23</td>
<td>-.25</td>
<td>.16</td>
<td>.23</td>
<td>.42</td>
<td>.24</td>
<td>.76*</td>
<td></td>
</tr>
<tr>
<td>Discussing Spirituality Helpful</td>
<td>.32*</td>
<td>.46*</td>
<td>.23</td>
<td>-.33</td>
<td>.41*</td>
<td>-.08</td>
<td>-.01</td>
<td>.11</td>
<td>-.05</td>
<td>.14</td>
<td>.18</td>
<td>.39</td>
<td>.09</td>
</tr>
<tr>
<td>Spirituality Related to Presenting Problem</td>
<td>.44*</td>
<td>.33*</td>
<td>-.30*</td>
<td>.33</td>
<td>.51*</td>
<td>.59</td>
<td>.60</td>
<td>-.15</td>
<td>.12</td>
<td>.87</td>
<td>.90</td>
<td>.50*</td>
<td>.32</td>
</tr>
</tbody>
</table>

*Note. *p < .05.*
more helpful post hoc \((r = .32)\). People with higher faith ratings also reported discussing faith as more helpful \((r = .41)\) and more related to their presenting problem \((r = .50)\).

When asked if spirituality was related to the problem they came in for, clients who said yes were more likely to have said they wanted faith to be a part of their sessions \((r = .33)\). They also tended to have spent more time talking about religion/spirituality during counseling \((r = .44)\). Interestingly, younger clients were also more likely to indicate that the presenting problem was related to spirituality \((r = -.30)\).

There was also a significant difference in participants’ rating of whether discussing spirituality was intrusive, based on whether they did \((M = 1.67, SD = .82)\) and did not \((M = 3.50, SD = .71)\) want faith discussed in their counseling, \(t(6) = -2.81, p = .03\). Thus, individuals who did not report wanting to discuss faith felt that doing so would be more intrusive.

**Faith Discussed**

One of the research questions to be addressed in this study was whether people actually discuss religion or spirituality in counseling sessions. We hypothesized that the participant’s level of comfort and tendency to discuss spirituality might be affected by how long they had been in therapy, so we analyzed religious discussion in Early sessions (sessions 1-4) and Late sessions (sessions 5-8). We found that 66.7\% \((N = 10)\) of the participants actually discussed religion in an early session, while 73.3\% \((N = 11)\) of them spoke about it in the later session. People’s intentions to discuss faith issues and their actual discussions were related for early sessions, \(X^2(1) = 3.35, p = .07\), and for later sessions, \(X^2(1) = 1.76, p = .19\), though neither relationship was statistically significant, likely due to limited sample size.
Time Discussed

A 2x2 analysis of variance (ANOVA) was used to determine whether the number of minutes spent discussing religious issues in session differed as a function of whether the session was early or late, and whether the client did or did not self-reported a desire to include spiritual issues in therapy. The mean number of minutes spent discussing religious issues is shown in Table 2 for each of these four conditions.

Table 2

<table>
<thead>
<tr>
<th>Client Requested Faith In</th>
<th>Sessions</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Session</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8</td>
<td>7.50</td>
<td>7.98</td>
<td></td>
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<tr>
<td>No</td>
<td>7</td>
<td>1.00</td>
<td>1.53</td>
<td></td>
</tr>
<tr>
<td>Late Session</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8</td>
<td>6.38</td>
<td>9.12</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>1.14</td>
<td>1.46</td>
<td></td>
</tr>
</tbody>
</table>

Note. Client request was determined based on intake information. The Mean, in minutes, is reported per one counseling session approximately 50 minutes in length.

The assumptions of the repeated measures ANOVA were met. There was no difference in the number of minutes spent discussing religious issues in session as a function of the client’s desire to include religious issues, $F(1,13) = 4.52$, $p = .053$, however, it should be noted that the effect size for this factor is large, $\eta^2 = .26$ (Cohen, 1992). This means that the effect of the clients’ willingness to include religious issues in session probably would be statistically significant if the sample size had been larger. There was a significant correlation between clients wanting faith in their therapy and the total minutes spent discussing spirituality in their sessions.
A higher faith rating was also significantly related to clients’ having talked about faith for more minutes ($r = .46$). Finally, younger clients spent more minutes talking about faith in session than older clients ($r = -.45$).

There was no difference in the number of minutes spent discussing religious issues in session as a function of the whether the sessions were early of late, $F(1,13) = 0.07, p = .79, \eta^2 = .006$, and the interaction was not significant, $F(1,13)= .12, p = .73, \eta^2 = .009$, therefore the analysis was repeated collapsing over early and late sessions. The mean total minutes for participants who said they did and did not want to discuss faith is shown in table 3.

**Table 3**

<table>
<thead>
<tr>
<th>Client Requested Faith In Sessions</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>8</td>
<td>13.88</td>
<td>14.45</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>2.14</td>
<td>1.77</td>
</tr>
</tbody>
</table>

*Note.* Mean in minutes represents the average amount of time spent discussing faith issues across two therapy sessions approximately 50 minutes in length each.

The assumption of equal variances was not met, Levene’s $F (1, 13) = 10.74, p = .006$, so a Brown-Forsyth ANOVA was conducted. There was no difference in the number of minutes spent discussing religious issues in session as a function of the client’s desire to include religious issues, Brown-Forsyth $F(1, 7.24)= 5.2, p = .056$, however, it should be noted that the effect size for this factor is large, $\eta^2 = .27$.

**Client Satisfaction**

A 2x2 ANOVA showed that overall Session Rating Scale (SRS) scores did not differ based on whether clients stated that they wanted to or did not want to incorporate faith into their
sessions $f(1,11) = 0.20, p = .67$. Similarly, SRS scores did not differ as a function of whether participants actually did or did not discuss spiritual issues in session $f(1,11) = 1.34, p = .31$. However, clients who had higher scores on the SRS total and SRS relationship subscale in late sessions talked about religion/spirituality for more minutes ($r = .53, .47$). This suggests that clients who were more satisfied with the therapeutic relationship in larger sessions may have felt more comfortable discussing their faith.

There was also no significant difference in overall Outcome Rating Scale scores based on whether clients wanted to or actually discussed faith in session $f(1,11) = .182, p = .68, \eta^2 = .02$. These findings were consistent across early and late session data. This finding suggests that clients were equally satisfied with their counseling sessions whether they wanted to discuss spirituality or not, and whether or not they actually discussed it.

**Initiations of Spiritual Discussion**

Another of the original research questions focused on the initiation of spiritual conversation in therapy. Overall, religious issues were brought up significantly more often across both client and therapist if the client had indicated they wanted spirituality in their sessions $f(1,12) = 5.46, p = .04, \eta^2 = .30$. Clients with higher faith ratings and younger clients were more likely to initiate spiritual/religious discussion in session ($r = .59, -.52; p < .05$). The therapists of younger clients also tended to initiate more often ($r = -.41, p < .05$).

There was a significant interaction between spiritual conversation initiations, whether the initiation occurred in an early versus late session, and if the initiator was a client or therapist $f(1,12) = 19.22, p = .001, \eta^2 = .60$, see figure 1. Clients tended to initiate more spiritual conversations overall, but initiated less frequently in later sessions. While therapists initiated
spiritual conversations less often overall, their initiations increased in the later sessions (see Figure 1).

![Figure 1](image.png)

*Figure 1. Average number of spiritual conversation initiations by client and therapist, in early versus late sessions.*

There was also a significant relationship between whether the client wanted religious integration and whether the client or therapist initiated spiritual conversation, $f(1,12) = 7.33, p = .018$, $\eta^2 = .36$. Both clients and therapists initiate more often when the client wanted faith integration than when they didn’t ($r = .59, .35; p < .05$). Though the client initiated those conversations with much greater frequency, see Figure 2. However, clients and therapists were more similar in the frequency of initiating spiritual conversation when clients did not request spirituality in their counseling.
Spiritual Topics Discussed

In examining the subject matter of spirituality in therapy, sessions were coded based on the content category as described in the codebook, and duration of religious discussions. Figure 3 represents the number of initiations of spiritual discussion across early and late sessions for all clients. The results suggest that the most commonly brought up spiritual topics include the faith community or church ($N = 13$), spiritual texts ($N = 11$) and spiritual rituals ($N = 7$), including prayer and meditation.

We also examined how long various spiritual content was discussed in counseling sessions. Figure 4 shows the total number of minutes each topic was addressed. While the most frequently raised topics also generally took more time for discussion, there were some subtle
Figure 3. The frequency of spiritual conversation initiations by content category. Initiations were collapsed across initiator and early versus late session and combined for all participants, this represents data from 30 sessions total.

**differences.** Spiritual texts received the most discussion based on time in total minutes ($TM = 35$), while involvement in a faith community came next ($TM = 19$), followed by spiritual rituals ($TM = 13$).
Figure 4. The duration of spiritual conversations by content category. Conversations were collapsed across initiator and early versus late session and combined for all participants, and represents data from 30 sessions total. Discussions lasting up to one minute, were coded as one minute.
Chapter 4

Discussion

This study was meant to provide useful information for clinicians on the prevalence and content of religious/spiritual connect brought up during therapy in a community mental health setting. Although only 53.3% of participants requested that faith issues be incorporated in their sessions at intake, 80% discussed some religious content in at least one of the two observed sessions. This is consistent with previous research suggesting that clients feel that therapy is an appropriate place to explore their religious beliefs and concerns (Knox, Catlin, Casper & Schlosser, 2005).

Religious/Spiritual Rating

The results suggest that using a rating scale to assess the importance of religion in a client’s life provides helpful information to the therapist. Higher scores on this single item were related to an increased likelihood that clients would want religious integration in session. Those who rated their faith as more important to them also spent more time discussing spiritual topics. This finding is consistent with Gorsuch and McPherson’s assertion that this single-item measure could be used as an assessment to provide meaningful information about client spirituality (1989). This study also suggests that such a measure not only provides information about client religiosity, but is related to both their desire for religious/spiritual discussion in therapy and the
content of their sessions. Thus, a religious assessment does not have to be lengthy or detail oriented to be meaningful and clinically relevant.

**Client Characteristics and Behavior**

Interestingly, younger clients in our study initiated more discussion about faith and spent more minutes discussing it than older clients. However, this study was conducted in a rural area in a clinic that was affiliated with Christian college. Thus, it seems that this particular setting may have been one reason for this finding. Younger adults are less religious, but also more spiritual. For the purpose of this study, we focus on the similarities between spirituality and religiosity instead of differentiating between the two. Most often, religion is regarded as more structured, dogmatic and ritualized belief system, while spirituality relates to a personal understanding and relationship to the sacred. This finding likely reflects the increased spirituality of young people.

The results also suggested that people were just as likely to discuss religion in early counseling sessions as later ones. This finding was in contrast to our initial hypothesis that clients would be more comfortable in the therapeutic relationship and therefore more likely to discuss spiritual matters in later counseling sessions. It is clinically useful to know that, at least in this particular study, clients were willing to talk about their faith from the beginning of counseling. In fact, clients initiated spiritual conversations more often in earlier counseling sessions. This may be because in earlier sessions as the therapist and clients are getting to know each other. Clients in our study initiated the majority of spiritual conversations, which is consistent with previous research based on clients’ self report of who initiated helpful spiritual conversations (Knox et al., 2005). This suggests that therapists are likely to follow their clients’
lead when it relates to spiritual/religious discussion. Overall, it seems that this may be due both to the therapist’s desire to be respectful of clients and not bring up spirituality if it might cause discomfort. This could also be reflective of therapists’ feelings of uncertainty about how or when to integrate clients’ faith into therapy, even when clients explicitly request it.

While the number of minutes spent talking about faith did not differ significantly for clients who did and did not express a desire to include spirituality in their counseling, they were correlated and the effect size was large. With a larger sample size, we anticipate that this relationship would have been statistically significant. Thus, the question whether clients want to incorporate faith could potentially be used to predict their actual amount of discussion in therapy.

**Training Implications of Spiritual Content**

The content of religious discussions that we observed most frequently related to the client’s faith community, reading of spiritual texts, and engagement in spiritual rituals. Among these categories, the most time was spent discussing spiritual texts. It seemed that clients valued the discussion of spiritual writings with a therapist. Within the session, clients often seemed to be working to apply the message of the text to their own personal experiences, and to make sense of their lives in relation to their beliefs. These findings have definite implications for the preparation of therapists to respond to concerns of clients and incorporate spirituality in their treatment. Training in religiously affiliated doctoral programs likely provide increased exposure to religious and spiritual concerns through coursework and didactics, while Vogel et al. (2013) found that the majority of current training occurs through supervision and peer informants.

With few formal opportunities for spiritually related instruction in graduate psychology training, clinicians may be in a difficult situation, based on the tenants of the APA Ethics Code
On one hand, the code asserts that psychologists must be aware of and respectful toward aspects of diversity including religion, and consider such factors in their work with these individuals. However, psychologists are also ethically bound to practice within the scope of their knowledge and training. Psychologists should not practice spiritual/religious treatment without proper training, “yet this does not mean that psychologists should be content to simply avoid this domain indefinitely” (Hathaway, 2011).

Discussion of a client’s faith community may be similar to that other social support networks in that this is a source of emotional support and social connections. However, religious groups vary greatly in their established hierarchy, values and beliefs. The practice of spiritual disciplines, such as prayer and meditation, can be done to fill a variety of client needs and purposes, which may depend partially on factors including the client’s presenting problem and religious/spiritual background. The emphasis on spiritual texts in therapy sessions is likely to create the most challenge for therapists who are nonreligious or of a different faith tradition than their clients. Thus, training for therapists should include familiarization with the content and themes of major religious texts, as it seems likely that therapists will likely encounter clients discussing these texts. Hathaway and Ripley (2009) have generated specific preliminary guidelines for ethical religious/spiritual assessment, intervention and cultural practice. These guidelines state that psychologists should, “make reasonable efforts to become familiar with the varieties of spirituality and religion present in their client population.” However, the results of the current study suggest that psychologists would specifically benefit from learning about spiritual practices, texts and organizations relevant to their practice.
Client Satisfaction and Outcomes

While we hypothesized that religious and spiritual discussion might impact client satisfaction and outcome ratings, there were no significant differences in satisfaction or outcomes for clients who did and did not request to or actually discuss faith in their sessions. Nor were there differences in satisfaction or outcomes for clients who did and did not actually discuss faith in their sessions. The lack of difference in outcome is consistent with past research on evidence-based treatments which incorporate a spiritual/religious component. The therapy provided at the clinic where data was collected was rooted in an evidenced-based cognitive behavioral framework. Thus, our results supported the findings of Hook et al. (2010), that a research-based treatment with religious inclusion was equally effective as the secular research based treatment alone. So adding a religious/spiritual component to treatment did not impact clients’ overall satisfaction or perception of their outcome, but did provide a religiously sensitive counseling experience. Higher session ratings overall and specifically in the category of relationship were related to more minutes spent talking about spirituality. This suggests that clients may feel more free to discuss spirituality when they feel the therapeutic relationship is stronger. Further research would be needed to determine if a lack of spiritual inclusion in therapy with clients who request it has any impact on their perceived outcome.

Limitations

While this study can provide useful information on religious/spiritual content in therapy, the results are limited in their ability to generalize to the population at large. Though this study has a small sample size, about 80% of participants self-reported a religious affiliation, which is consistent with the 79.9% of US citizens who identify as religious (Kosmin & Keysar, 2009).
This suggests that despite a limited N and somewhat rural location, the individuals we sampled were extremely similar in frequency of religious affiliation to the general public. In particular, the lack of ethnic and religious diversity in the client sample are factors that narrow the scope of this study. Additional research with greater diversity would be necessary to determine whether the results we found apply within other setting and across client groups. Also, studies focused on therapists’ practice of spiritual integration in session and their attitudes about integration would provide additional clarification of the current findings, especially related to an overall lack of therapists initiating spiritual discussion.

**Conclusion**

This exploratory study was meant to provide information for clinicians about the prevalence and content of spiritual discussions in therapy. The results indicated that the majority of clients in a community mental health clinic affiliated with a religious university did talk about spiritual/religious issues in counseling. Clients were more likely than therapists to initiate spiritual discussion. Those who said they wanted to discuss spirituality talked about it for more minutes, and those who talked about spirituality more also rated this discussion as more helpful. The most commonly addressed spiritual topics included clients’ faith community, reading spiritual texts, and rituals such as prayer or meditation. It is important for clinicians to understand what religious content is likely to come up in session so that they are prepared to address these concerns. Additional, larger scale studies are needed to further investigate the role of spiritual discussion in evidence based therapy, and the potential effect on clients’ perceptions of the therapeutic relationship.
References


George Fox University (2013, September). *George Fox Behavioral Health Clinic: Director’s report to the advisory board*. Newberg, OR: Joel A. Gregor.


Appendix A

Demographics Record

Chart Review Form

Participant ID: ______________

Gender: M F

Age: ____________

Ethnicity:
   1) Non-Hispanic White
   2) Latino/Hispanic
   3) African American
   4) Asian/Pacific Islander
   5) Native American
   6) Other: ________________________________

Presenting Problem:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Diagnoses:
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Self-Reported Religious Affiliation (intake form question):
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Fee Per Session: ______________
### Appendix B

#### Session Evaluation Log

<table>
<thead>
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<th>Incidence</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Start Time</td>
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</tr>
<tr>
<td>Content Code</td>
<td></td>
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<tr>
<td>Duration</td>
<td></td>
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</tr>
</tbody>
</table>

Initiator: Client = 1, Therapist = 2
## Appendix C

### Religious/Spiritual Content Codebook

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<th>Code</th>
<th>Category</th>
<th>Example(s)</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Personal beliefs on existence of God/Spiritual World</td>
<td>The existence of God, belief in the power or presence of God</td>
</tr>
<tr>
<td>2</td>
<td>Nature/Character of God</td>
<td>Existence of God, God described as loving, angry, a teacher, father, counselor, all knowing</td>
</tr>
<tr>
<td>3</td>
<td>Rituals to connect with a higher power</td>
<td>Prayer, Meditation</td>
</tr>
<tr>
<td>4</td>
<td>Faith community/church</td>
<td>Religious services, Youth group, Bible study group, Religious classes, Relationship with Pastor, Spiritual Director</td>
</tr>
<tr>
<td>5</td>
<td>Spiritual documents/devotionals</td>
<td>Reading devotionals individually or with a partner; Reading the Bible, Koran, Torah or any other religious text</td>
</tr>
<tr>
<td>6</td>
<td>Sin and consequences, Grace</td>
<td>Evil, the Devil, sinfulness</td>
</tr>
<tr>
<td>7</td>
<td>Providence/fate/predestination</td>
<td>Free will, God’s plan or purpose, “things happen for a reason”</td>
</tr>
<tr>
<td>8</td>
<td>Ministry</td>
<td>Evangelism, Missionary work, Outreach</td>
</tr>
<tr>
<td>9</td>
<td>Death/finality</td>
<td>Afterlife, Heaven, Mortality</td>
</tr>
<tr>
<td>10</td>
<td>Hope</td>
<td>Redemption, Overcoming adversity</td>
</tr>
<tr>
<td>11</td>
<td>Forgiveness</td>
<td>God’s forgiveness of sin, the importance of forgiving others, receiving forgiveness</td>
</tr>
<tr>
<td>12</td>
<td>Nature of people, Anthropology</td>
<td>Human motives for doing things, human nature, personal relationship to god</td>
</tr>
<tr>
<td>13</td>
<td>Experiential Connection with God</td>
<td>Religious visions</td>
</tr>
</tbody>
</table>
Appendix D

Faith Attitudes Post Treatment Survey

George Fox Behavioral Health Clinic Survey

Thank you for choosing the George Fox Behavioral Health Clinic to meet your counseling needs. We hope that you had a great experience and found our services helpful. In order to help us better understand and serve our clients, we would appreciate it if you would take a moment to answer these questions and mail this survey back to us in the stamped envelope provided. Thank you in advance for completing this survey; we have enclosed $2.00 in cash because we know your time is valuable.

1. What is your religious affiliation: _______________________________

2. How important is your religion to you?

   1 2 3 4 5
   Not at all, Somewhat Extremely
   I have no important, it is the
   religion center of my life

3. Did you feel it was (or would have been) helpful to discuss spirituality with your counselor?

   1 2 3 4 5
   Very Somewhat Neither Very
   Unhelpful Unhelpful helpful helpful
   Unhelpful Unhelpful

4. Did you feel it was (or would have been) intrusive or uncomfortable for your counselor to ask you about your spirituality?

   1 2 3 4 5
   Very Somewhat Neither Very
   comfortable comfortable helpful uncomfortable
   uncomfortable
5. Do you feel that spirituality was related to the problem that you came to counseling for?

   YES or NO
Appendix E

Curriculum Vitae

Courtney Elizabeth McConnell
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253-732-7848
cmcconnell08@georgefox.edu

EDUCATION

2008 – Present  George Fox University
Graduate Department of Clinical Psychology: APA Accredited
Newberg, Oregon
Degree:  Master of Arts, April, 2010
          Doctorate of Psychology (anticipated), April, 2014
GPA:      3.81

2005 – 2008  Western Washington University
Bellingham, Washington
Degree:  Bachelor of Arts, Psychology
GPA:      3.88

2003 – 2005  Tacoma Community College
Tacoma, Washington
GPA:       3.91

AWARDS and SCHOLARSHIPS

2007   Adams-Woodring Scholarship
        Department of Psychology
        Western Washington University

2005 – 2007  President’s List Honor Roll
        Western Washington University

SUPERVISED CLINICAL EXPERIENCE

2013 – 2014  Radford University Student Counseling Services
Radford, VA
& Center for Assessment and Psychological Services
• Individual psychotherapy with college and graduate students with a range of presenting problems including Mood Disorders, Anxiety, Eating Disorders, and Adjustment Disorders
• Comprehensive assessment of Learning Disabilities and ADHD
• Coordination of care with psychiatrist
Supervisors: David Hamilton, PhD; Valarie Leake, PhD

2012 – 2013  **George Fox University Health and Counseling Center**  
Newberg, OR
• Individual psychotherapy with a range of presenting problems such as Bipolar Disorder, Eating Disorders, Depression and Adjustment Disorders
• Comprehensive assessment of cognitive functioning and personality
• Coordination of care with multidisciplinary healthcare providers
Supervisor: William C. Buhrow Jr., PsyD

2010 – 2011  **Warner Pacific College Career and Life Counseling Center**  
Portland, OR
• Individual psychotherapy with college students including treatment for Anxiety, PTSD, Adjustment Disorders and Bereavement
• Group therapy with ethnically diverse, low SES students focused on the transition to college
• Drug and alcohol abuse counseling
• Comprehensive assessment of learning disabilities, ADHD and PTSD
Supervisor: Denise Lopez Haugen, PsyD

2010 – 2011  **Oregon Health & Science University Family Medicine at Richmond**  
Portland, OR
• Individual psychotherapy for clients with complex medical presentation with presenting concerns including PTSD, Anxiety, Borderline Intellectual Functioning and Depression
• Psycho-education focused on behavioral health to increase treatment compliance and positive health behaviors
• Collaborative care consultation to optimize multifaceted intervention for clients
• Comprehensive assessment of intellectual functioning and ADHD
Supervisor: Tamara Hoogestraat, PsyD

2009 – 2010  **George Fox University Rural School District Consortium**  
Yamhill, OR
• Individual psychotherapy with children ages 6 to 18, with presenting concerns including Autism Spectrum Disorders, Anxiety, Depression, and Trauma
• Intensive group therapy intervention for students with Autism Spectrum Disorders and intellectual or physical disabilities
• Consultation and liaison for Individualized Education Plans
• Comprehensive assessment of cognitive, academic, memory and psychological functioning

Supervisors: Elizabeth Hamilton, PhD; Gene Bundy, LCSW

PROFESSIONAL AFFILIATIONS

2006 – Present

American Psychological Association, Student Affiliate
Washington State Psychological Association, Student Affiliate
Western Psychological Association, Student Member

PUBLICATIONS


PRESENTATIONS


TEACHING EXPERIENCE

Graduate Student Guest Lecturer
• Undergraduate Psychology Department, George Fox University Newberg, OR
  Presentation on the applications of cognitive assessment, highlighting a complex assessment case study from my practicum experience in a general psychology class

• Social Sciences Department, Chemeketa Community College McMinnville, OR
  Presentation on facets of employee motivation and the benefits of team building in an industrial/organizational psychology class

RESEARCH EXPERIENCE

2010 – present  Doctoral Dissertation
Spiritual/Religious Issues in Therapy at a Community Mental Health Clinic
George Fox University
• Preliminary Oral Exam completed April, 2011: full pass
• Project approved by Human Subjects Review Board
• Data collection in progress
Chairperson: Kathleen Gathercoal, PhD

2008 – present  Research Vertical Team Member
George Fox University
• Contributed to the formulation and refinement of other members’ dissertation research projects
• Collaborated in conducting supplemental group research, primarily focused on gender equality in academia and the relationship between cost of psychological services and client satisfaction
Supervisor: Kathleen Gathercoal, PhD

2006 – 2008  Research Team Member
Understanding Love Relationships: research into current measures/models of love, and the effects of peak experiences and stress in heterosexual and same sex relationship dynamics
Western Washington University
• Recruited participants and analyzed data for a year-long nationwide study of the application of marital protective factors to co-habiting heterosexual and homosexual relationships
• Composed a literature review and preformed data entry for a meta-analysis comparing the psychometric properties of widely used measures of love.
• Collaborated in the formulation of a relationship implicit associations test of relationship quality, ran participants through preliminary study assessing its validity and reliability
• Ran participant couples through a game-playing exercise to assess the impact of task interest level and difficulty on couple interactions and subsequent self-reported feelings of love

Supervisor: James Graham, PhD

2007 – 2008

Research Team Member

Predictors of student success in clinical, counseling and school psychology graduate programs.
Western Washington University

• Compiled outcome data including EPPP scores and ABPP designations to assess graduate student success by graduate program and degree type
• Collaborated in writing the proposal for APA submission, creating and presenting poster

Supervisor: James Graham, PhD

2008

Research Team Member

Juror sensitivity to eyewitness identification evidence in criminal court cases.
Western Washington University

• Participated in data entry and ran participants through a simulated jury experience evaluating the credibility of eyewitness testimony based upon the race of the eyewitness and defendant, event duration, and adherence to line-up protocol by police

Supervisor: Jennifer Devenport, PhD

2007

Undergraduate Thesis

College students’ attitudes about condom use in the context of social desirability and gender.
Western Washington University

• Formulated research question concerning the effect of gender and social desirability on college student’s reported beliefs about condom use
• Collaborated with a small group to compose a literature review, recruit participants, analyzed data, and present results

Supervisor: Todd Haskell, PhD
ACADEMIC SERVICE

2010 – 2011

Executive Council Member, Student Council Vice President
Elected to Graduate Department of Clinical Psychology student council leadership
- Coordinated APA membership renewal process for all students
- Led meetings and student activities such as community service

2009 – 2010

Executive Council Member, Student Council Secretary
Elected to Graduate Department of Clinical Psychology student council leadership
- Set the agenda for student council meetings
- Collaborated in planning spring banquet
- Coordinated library improvements

2008 – 2009

Student Council Representative
Elected to Graduate Department of Clinical Psychology student council leadership
- Involved in planning new student orientation
- Facilitated library resource improvement

2008 – 2012

George Fox University Serve Day Participant
Worked with other students to maintain and improve the Juliette’s House Child Abuse Assessment Center facility as a service to the local community.

RELEVANT ASSESSMENT TRAINING AND EXPERIENCE

- 16 Personality Factors (16PF)
- Beck Depression Inventory, Second Edition (BDI-II)
- Behavioral Assessment System for Children – 2nd Edition (BASC-2)
- Brown Attention-Deficit Disorder Scale
- Conners Comprehensive Behavior Rating Scales (Conners CBRS)
- Gilliam’s Asperger Disorder Scale (GADS)
- Gray Oral Reading Test – 4th Edition (GORT4)
- House-Tree-Person Test (HTP)
- Millon Clinical Multiaxial Inventory – 3rd Edition (MCMI-III)
- Minnesota Multiphasic Personality Inventory – 2nd Edition (MMPI-II)
- Peabody Picture Vocabulary Test – 4th Edition (PPVT-IV)
- Personality Assessment Inventory (PAI)
- Roberts’ Apperception Test for Children (RATC)
- Rorschach Inkblot Test
- Rotter Incomplete Sentence Blank (RISB)
Thematic Apperception Test (TAT)
Wechsler Adult Intelligence Scale – 4th Edition (WAIS-IV)
Wechsler Individual Achievement Test – 2nd Edition (WIAT-III)
Wechsler Intelligence Scale for Children – 4th Edition (WISC-IV)
Wide Range Achievement Test – 3rd Edition (WRAT3)
Wide Range Assessment of Memory & Learning – 2nd Edition (WRAML-2)
Wide Range Intelligence Test (WRIT)
Woodcock Johnson Test of Cognitive Abilities – 3rd Edition (WJ-III COG)
Woodcock Johnson Test of Academic Achievement – 3rd Edition (WJ-III ACH)

REFERENCES

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