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Comparing the Clinical Approaches of Christian Social Workers and Secular Social Workers

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### GLOSSARY

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<th>Term</th>
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<tr>
<td>Biblical Counseling</td>
<td>Counseling that is centered on Jesus Christ, operates within the worldview of the Bible, and is intended to produce conviction of sin, the joyous reception of Jesus Christ, and renewal of life; biblical counseling rejects theory, concepts, and practices based in secular psychology (Powlison, 1988)</td>
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<tr>
<td>Christian Social Worker</td>
<td>Social worker who identifies professionally to others as a “Christian Social Worker”; the Christian social worker may or may not work in a practice setting that has a religious affiliation. A Christian Social Worker may hold religious beliefs to be true, value religion highly, and counsel a religious client but may not do religious counseling, which deals with religious values and beliefs explicitly (Worthington, Kurusu, McCullough, &amp; Sandage, 1996)</td>
</tr>
<tr>
<td>Secular.Liberal Social Worker</td>
<td>A social worker whose religious beliefs are not a featured characteristic of his or her professional identity</td>
</tr>
<tr>
<td>Social Worker who is Christian</td>
<td>A social worker who personally identifies as Christian and who may, or may not, draw from his/her faith in clinical practice, but for whom faith is not an orienting component of clinical practice</td>
</tr>
<tr>
<td>Clinical Treatment Approach</td>
<td>Inclusive of all aspects of treatment process, including: choice of clinical theory; information obtained in assessment; identification and conceptualization of presenting problem; treatment goals; and treatment interventions</td>
</tr>
<tr>
<td>Religion</td>
<td>A social institution that consists of beliefs, practices, and shared rituals that provide a meaning system for its adherents. In religion, community is present (Gumz, Wall, &amp; Grossman, 2003)</td>
</tr>
<tr>
<td>Religious Counseling</td>
<td>Counseling that uses the content associated with an organized religion (e.g. discussions of sin, guilt, confession, forgiveness, and repentance; attendance at religious services; and religious duties) to address clinical issues, counseling that uses explicit discussion of the impact of a person’s actions on his or her religious beliefs or values or the impact of a person’s religious beliefs and values on his or her actions, or counseling done in an explicitly religious context where consideration of religious issues might be normally expected to occur (Worthington, Kurusu, McCullough, &amp; Sandage, 1996)</td>
</tr>
<tr>
<td>Religious Affiliation of Practice Setting</td>
<td>Whether or not the participant’s place of employment is secular or is connected to a religious organization</td>
</tr>
<tr>
<td>Religious Person</td>
<td>One that holds some religious beliefs and values religion to some degree; the degree of religiosity can vary across a wide spectrum (Worthington, Kurusu, McCullough, &amp; Sandage, 1996)</td>
</tr>
<tr>
<td>Spirituality</td>
<td>Individuals’ search for meaning, purpose, and values in their lives, interpersonally, and with transcendent being. Spirituality may or may not have a sense of community (Gumz, Wall, &amp; Grossman, 2003)</td>
</tr>
<tr>
<td>Spiritual Person</td>
<td>One who believes in, values, or is devoted to some higher power than what exists in the corporeal world (Worthington, Kurusu, McCullough, &amp; Sandage, 1996)</td>
</tr>
<tr>
<td>Spiritually-Derived Interventions</td>
<td>Spiritually or religiously based in-session practitioner techniques or behaviors; Sheridan (2004) identified 24 such interventions in her Spiritually-Derived Interventions Checklist (SDIC). Refer to Appendix H for SDIC.</td>
</tr>
</tbody>
</table>
CHAPTER ONE

INTRODUCTION

The relationship between religion and the profession of social work is long standing and has been alternately embraced and challenged (Trattner, 1989; Canda & Furman, 1999; Sallee, 2004). While there has been research that supports the value of attending to religious and spiritual beliefs, there has been evidence that some social workers, including both clinicians and those in academia, maintain negative attitudes toward the interface of religion and social work practice (Canda, Nakashima, & Furman, 2004; Ressler & Hodge, 2003; Hodge, 2002; Ressler & Hodge, 2005; Thyer & Myers, 2009). This study was designed to build upon previous research exploring the interface of religion and social work and to provide added relevant data about how social workers are responding to religion and spirituality in clinical practice.

Statement of the Problem

Like religious studies, the field of social work is by nature interdisciplinary. Social work, however, grapples still with the highly divergent ideals of its founders. This hundred-year-old legacy, as Sharon Freedberg notes, consists equally of ‘religious stewardship, scientific professionalism, and political idealism’ (Freedberg, 1986, p. 95). Such conflicting ideals have resulted, moreover, in a history of struggles ‘within, between, and among the Judaeo-Christian value base from which the profession evolved; on the scientific value of the ‘medical model’ and of Freudian theory; and on the political social context of ideology and mission.’ Such divergent motivations also help explain the current heated debates over how, or whether, social work should engage spirituality and religion (Praglin, 2004, p. 69)
American social work has been entwined with religion since its inception. Throughout its history, including the present day, overlapping values between social work and various world-religions have led many social workers to enter the profession as a direct result of their religious faith (Trattner, 1989; Fram & Miller-Cribbs, 2008; Moss, 2012). Yet the profession has wrestled so fervently with this relationship. Researchers throughout the last decade have uncovered negative attitudes within the profession toward the interface of religion and social work practice. Streets (2009) described social workers as cautious and concerned about the integration of religious beliefs into the field. Canda, Nakashima, and Furman (2004) reported that some social workers believe the integration of religion and spirituality into social work practice or education conflicts with the NASW Code of Ethics and social work’s mission.

Others have expressed concern that social workers’ negative attitudes have led to oppression and discrimination against conservative Christian social workers by their religiously liberal counterparts (Ressler & Hodge, 2003; Hodge, 2002; Ressler & Hodge, 2005). Thyer and Myers (2009) cited religious discrimination within academic social work as an ongoing problem and a failure within the profession to promote social justice. Canda, Nakashima, and Furman’s (2004) survey of social workers detected comments that might reflect religious discrimination, and they explained that the recurrent citing of Christian activities as examples of the inappropriate use of religiously based activities might reflect an underlying bias held by some social workers. Although studies “indicate that few providers engage in proselytization” (Tangenberg, 2005), it appears that
concerns about the potential for misuse of religious and spiritual beliefs in practice are prevalent.

The tension that exists within the field of social work around its interface with religion may be fueled, in part, by perceptions that the treatment provided by Christian social workers and secular social workers will be fundamentally different (secular social workers may fear that these fundamental differences cannot be reconciled with social work’s principles of self-determination and client-oriented interventions; Christian social workers may be concerned that secular social workers’ aversion to religion/spirituality results in the neglect of this important aspect within the lives of clients). See Table 1 for concerns secular and Christian social workers may have about each other.

Table 1. Concerns Held by Secular and Christian Social Workers about Each Other

<table>
<thead>
<tr>
<th>Concerns Held by Secular Social Workers about Christian Social Workers</th>
<th>Concerns Held by Christian Social Workers about Secular Social Workers</th>
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<tbody>
<tr>
<td>Clinical treatment provided by Christian social workers will be fundamentally different</td>
<td>Clinical treatment provided by secular social workers will be fundamentally different</td>
</tr>
<tr>
<td>Rigidity, dogmatism, and judgmentalism of religions are worrisome (Canda &amp; Furman, 2010)</td>
<td>Secular social workers neglect religious/spiritual aspect of clients’ lives, when &quot;evidence shows that s/r [spirituality/religion] are crucial for understanding many clients and their cultures&quot; (Canda &amp; Furman, 2010)</td>
</tr>
<tr>
<td>Christian social workers might use the clinician-client power differential to engage in proselytization</td>
<td>Secular social workers might use the clinician-client power differential to pathologize spiritual/religious beliefs</td>
</tr>
<tr>
<td>Religious values supersede professional social work principles of self-determination and client-oriented interventions</td>
<td>Secular social workers are inadequately trained to respond to spirituality and religion when they are a component of the client’s presenting problem</td>
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One way this tension can be addressed is through further exploration of the clinical approaches of these two groups. This study seeks to undertake this exploration with the following key research questions: How do the clinical treatment approaches of NACSW members and NASW members differ: does identical clinical material presented to these two different audiences lead to different treatment interventions? Is there a set of clinical skills that social work practitioners expect from Christian social workers and not secular social workers?

**Significance**

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, signed into law by President Bill Clinton, introduced Charitable Choice, a legislative provision designed to encourage states to involve faith-based organizations as providers of welfare services (Cnaan & Boddie, 2002). In 2001, President George W. Bush created the White House Office of Faith-Based and Community Initiatives with the goal of expanding the use of faith-based groups in the provision of publicly funded social services. These efforts were viewed by many as divisive and controversial, and they drew attention and criticism from health care professionals, civil liberty groups, and members of the faith community (Wright, 2009; Gibelman & Gelman, 2002; Gibelman & Gelman, 2003). Researchers Cnann, Boddie, and Danzig (2005) stressed that a “rift between social work and religion really exists” and suggested that this could be problematic as more and more public services are contracted out to religious providers.

Over a decade later, the interest in creating government partnerships with religious providers remained; in 2009, President Barack Obama established the White
House Office of Faith-Based and Neighborhood Partnerships. While the path of the faith-based initiative has shifted under the new leadership, President Obama’s commitment to strengthening faith-based groups is evident. The American Recovery and Reinvestment Act of 2009 (ARRA), signed into law by President Obama, included the Strengthening Communities Fund which has made $50 million worth of grants available for two programs that provide support to both secular nonprofit and faith-based social service providers (Wright, 2009).

Stewart (2009) stated that tensions between social work values and traditional Christian values are “inescapable” (p.38). Belcher, Fandetti, and Cole (2004) echoed this sentiment by asserting that those who maintain there is compatibility between conservative Christian values and the goals of the social welfare state are “grossly misinterpreting the theology of conservative Christianity” (p. 274). While some may argue that social workers have legitimate reasons to be concerned about, if not oppose, the interface of religion and social work, the continuation of faith-based funding within Obama’s presidency has made it clear that the relationship between religion/spirituality and social work will continue to move forward. It is important for social workers to understand how this relationship can affect the field on a macro level, such as the impact of faith-based initiatives that rely on conservative Christian values, as well as the dynamics this relationship introduces on a micro level, which is the focus of this study. For example, analysis of participants’ responses might provide insight as to whether employment in a religious-affiliated agency or attendance of a sectarian university has a
relationship with how social workers approach religion and/or spirituality in clinical practice.

Growing appreciation for the value of attending to the religious and/or spiritual dimension of clients’ lives has led to the increased inclusion of this dimension in the assessment process; this movement has been emphasized by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which now requires the administration of a spiritual assessment (Hodge, 2006). Despite the expectation that religious and/or spiritual factors be incorporated into the clinical experience, there have been mixed reports regarding the training social workers have received to prepare them for competence in this area (Furman, Benson, Canda, & Grimwood, 2005; Moss, 2012; Barker, 2013; Mulder, 2014). One of the challenges of assessing competence in this area is the limited professional dialogue and lack of professional consensus about what constitutes an adequate spiritual assessment. JCAHO does not specify what needs to be included in a spiritual assessment but rather relies on each organization to define the content and scope of their spiritual assessments (Joint Commission: The Source, 2005).

In addition to the primary question of whether there is a set of clinical skills expected from Christian social workers and not secular social workers, this study asks: How do Christian social workers view their training and clinical skills relative to identifying and responding to client problems of a religious and/or spiritual nature or client problems with a religious and/or spiritual component? What clinical issues prompt a referral to a faith-based provider (Christian social worker, pastoral counselor, priest, pastor, chaplain, rabbi)?
These questions are meant to provide an opportunity to comment on how social work education addresses, and/or might address in the future, the subjects of religion and spirituality. The Code of Ethics of the National Association of Social Workers identifies “Cultural Competence and Social Diversity” as one of social workers’ ethical responsibilities to clients, and religion is cited as one of the multiple aspects of social diversity. It could be argued that the topic of religion and/or spirituality would benefit from more attention and instruction than it’s afforded within a broad review of diversity that includes also race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, immigration status, and mental or physical disability. However, it's important to consider, at the very least, the minimum amount of training on religion and/or spirituality social work education needs to provide to produce ethical clinicians. These questions will also contribute to professional dialogue regarding the extent to which clinical social workers are expected to address religion and/or spirituality as a component of basic clinical competency and where they draw their professional boundaries and, instead, provide referrals to faith-based providers.

Finally, social work, as a profession that has concentrated its efforts on addressing discrimination, oppression, and social injustice, has an ethical obligation to attend to those who claim mistreatment and discrimination from within. In order to effectively respond to these concerns we must first increase our understanding of the dynamics that underlie them. This study, which seeks to investigate the ways in which religious and spiritual beliefs are currently interfacing with clinical social work practice, can make a valuable contribution to dialogue on this issue. Exploration of the clinical approaches of
Christian social workers and secular social workers provides the opportunity to address
misperceptions held by each of these groups about each other as well as further our
understanding of the ways in which religious beliefs and secular beliefs currently impact
clinical practice.

**Research Design**

This multiple methods study makes use of a survey questionnaire and focus group
discussion to investigate the clinical practices of both Christian social workers and
secular social workers. This study draws participants from the North American
Association of Christians in Social Work (NACSW) and the National Association of
Social Workers (NASW) membership lists. These groups have been chosen based on the
assumption that membership to these associations is a reflection of how one
professionally self-identifies. Further, this study is interested in the integration of
religious beliefs and practice, and a study of NACSW members found that their primary
reason for joining NACSW was “to receive help in integrating their faith in practice”
(Ortiz & Kuhlmann, 1988).
CHAPTER TWO
REVIEW OF THE LITERATURE

This chapter provides a detailed context for the proposed study. The historical relationship between religion and the profession of social work will be reviewed. Previous research that has informed our understanding of the interface of religion and the profession of social work will be highlighted. Research findings that this study seeks to expand upon will be identified.

The basic tenets and programs of any social welfare system reflect the values of the society in which the system functions. Like all other social institutions, social welfare systems do not arise in a vacuum; they stem from the customs, statues, and practices of the past. Therefore, one cannot understand current efforts to help the needy without first comprehending the foundations on which they were built. And since the practice of assisting people in need as we know it in America did not originate in this country but was transplanted from the Old World to the New during the colonial period, we must go back in time, perhaps even to antiquity, to begin our study of American social welfare (Trattner, 1999, p.1).

In his comprehensive text *From Poor Law to Welfare State*, Trattner (1989) explained how the profession social work orienting values have appeared throughout many cultures and practices of the past. He detailed how values such as service and social justice are linked with these historical cultures and have been heavily influenced by the theory and practice of charity found within the world religions of Buddhism, Judaism, and Christianity. Lee (2005) echoed this sentiment: “The roots of social services for the care of the poor, the sick, the dispossessed, the mentally ill, and many other types of vulnerable people, of course, stemmed from the outwardly charged missions of the early
church (*diakonia*)” (p. 139). Throughout history, dating back to ancient Babylonia, people have been tasked with responding to the needs of the least among us, and many have had their efforts influenced, if not informed, by their faith.

**History of American Social Work**

Authors Canda and Furman have offered a framework for reviewing the relationship between spirituality and American social work. In the first edition of their text *Spiritual Diversity in Social Work Practice*, Canda and Furman (1999) described the relationship between spirituality and social work in America within the framework of three historical phases: the first phase included the colonial period through the early twentieth century; the second phase stretched from the mid-twentieth century through the 1970s; and the third phase covered the 1980s through mid-1990s. In the second edition of their text, published 11 years later, Canda and Furman (2010) updated their framework to include two additional historical phases: “Indigenous Social Welfare” and “Transcending Boundaries”.


Canda and Furman (2010) recognized the presence and influence of spirituality in America prior to its colonization and redefined the first phase of their framework as “Indigenous Social Welfare.” This historical phase covered “tens of thousands of years during which Indigenous cultures in North America (as everywhere else) had distinctive spirituality based on patterns of helping, healing, and mutual support extending to social welfare and respect for the earth” (p. 109). Canda and Furman urged modern day social workers to “hold Indigenous ways of helping with special esteem and appreciation” and
noted, in fact, that social workers in the twenty-first century have been rediscovering many insights offered by indigenous worldviews (p. 111).

History of American Social Work: Sectarian Origins

The second phase of Canda and Furman’s (2010) framework, the colonial period through the early twentieth century, was labeled “Sectarian Origins” emphasizing the role religion played in the dawn of the social work profession. During this phase, Christian and Jewish sectarian professional services dominated the provision of social services, and both voluntary and governmental social welfare services were directly impacted by theological ideas of charity, justice, and communal responsibility.

Colonists of the New World faced the age-old problem of poverty and need, and early American colonists, in closely knit communities, relied on the support of neighbors during times of struggle and misfortune. According to Trattner (1989):

…for seventeenth-century Americans need was in the order of things, a natural and inevitable part of the human condition. The poor, mere pawns in a divinely destined universe and hence not responsible for their condition, were always present – in America as elsewhere. This, however, was not a necessary evil, but rather a blessing, a God-given opportunity for men to do good – to serve society and their Creator (p. 16).

Trattner explained, however, that the social and economic forces associated with immigration intermingled with rival applications of theological ideas to shift and shape society’s views on the poor and their subsequent welfare practices. As the number of persons in need grew, American patterns of assisting the poor followed the laws and activities of the Old World’s Elizabethan Poor Laws of 1601 (Sallee, 2004). Town parishes were commonly “charged with the responsibility of caring for the poor,” (Trattner, 1989, p. 17) and religious people experienced increased tension between their
view that it was an obligation and “blessing” to care for those in need and “their Calvinistic ideas about the virtue of hard work and the sin of idleness” (p. 21).

The growing sentiment that most destitution was the result of individual and moral causes created fertile grounds for the Charity Organization Society movement to take root in the late 1870s. The Charity Organization Society movement focused on “the betterment of individuals or families, one by one” (Sallee, 2004, p.28). The movement used charity workers, known as “friendly visitors,” to gather information on relief applicants. Charity workers were expected to have specific skills, and the first training course for them was provided by the New York Charity Association in 1898 (Sallee, 2004). Charity workers used their training to interact with relief applicants and maintain detailed registries that could be used in the process of sorting out the “worthy” from the “unworthy.” According to Trattner (1989), the Charity Organization Society movement “rested upon a series of preconceived moral judgments and presuppositions about the poor…that attributed poverty and distress to personal defects and evil acts” (p. 89).

In the late 1880s, the Settlement House Movement offered a different route for responding to poverty in America. Those who joined the Settlement House Movement regarded themselves as social reformers and their efforts focused on the social and economic conditions that propelled poverty. Men and women, many of them college graduates in their 20s, relocated to impoverished neighborhoods to live interdependently with those in poverty. Trattner (1989) noted that religious beliefs played an important role in the Settlement House Movement:

…most residents took their religion seriously, and religious feeling was an important factor in the conversion to settlement work and social reform. Jane
Addams, in describing her own motivating ‘impulse to share the lives of the poor,’ spoke for many when she indicated that it can from a desire ‘to make social service...express the spirit of Christ’”(p. 156).

While the Organized Charity Societies and the Settlement House movement were “in many ways the very antithesis of each other,” they shared a common goal: to respond to the needs of the poor and oppressed who were living in the neglected and marginalized sectors of society (Trattner, 1989, p.150). Further, both “had a religious tone to them” and “emphasized sacrifice and human fellowship” (p. 150). Their similarities enabled them to cooperate and, in the early twentieth century, the two entities began to merge into “social work” (Trattner, 1989).

**History of American Social Work: Professionalization and Secularization**

A variety of factors converged at the start of the twentieth century to direct the path of the social work profession. Population changes led many professional classes, including social workers, to move out of the cities and into the suburbs. Settlements struggled to attract social workers who sought other employment opportunities, and the presence of social settlements began to dwindle. Then, in 1915, Abraham Flexner presented at the National Conference of Charities and Corrections. Flexner, who was a persuasive advocate for scientific knowledge and its advancement in the medical field, declared that social work lacked the qualities essential to be defined as a profession (Sallee, 2004). Flexner’s presentation, followed by the publication of *Social Diagnosis*, the “first true textbook on social work,” in 1917 (p. 31), led social workers to shift their focus away from social reform and embrace the “scientific” approach of casework (Trattner, 1989). Casework, with its emphasis on personal deficits and psychological
impediments, was then cemented as a leading theory of practice by Freud’s presence in the mental hygiene movement of the 1920s. According to Trattner (1989), social workers “became preoccupied with professionalization” (p. 167) and this made them “naturally receptive to Freud,” who “provided them with both a theoretical base and a scientific method of treatment that until that time had been lacking” (p. 237).

In an effort to compete with other established and esteemed professions, social work embedded itself in the task of professionalization and the pursuit of practice approaches that could be researched and reproduced with the scientific method. Canda and Furman (2010) marked this as the third phase of their framework and explained:

“...as social work professionalized in competition with and along with medicine and law, secular humanistic and scientific perspectives, such as socialism, social functionalism, Freudianism, and behaviorism became more influential than theology. It was hoped that these scientific views would provide a more reliable base for practice (p. 112). During this phase of professionalism, increased involvement of federal and state governments in social welfare introduced concerns about the separation of church and state within the field of social work (Canda & Furman, 2010). This dynamic, in turn, increased professional skepticism of religiously based social work and “many social workers grew wary of the tendency of some religious providers of services to engage in moralistic judgementalism, blaming the victim, proselytization, and exclusivism” (p. 89).

This phase of Canda and Furman’s (2010) framework lasted from the 1920s through the 1970s. During this time, the profession’s responsiveness to societal change was reflected in the shifting areas of knowledge and functioning in which social workers were expected to be proficient (Rothman, 2009). Medical advances that occurred during this era broadened the sphere of social work from “psychosocial” to “biospsychosocial”
(Rothman, 2009); social workers were expected to take physical factors into account during the process of defining problems and developing interventions. Social work’s field of knowledge expanded again during this era in response to the social revolution of the 1960s. Rothman (2009) notes:

…social workers embraced the acceptance of, and respect for, diversity that became government policy with the Civil Rights movements of the 1960s. Cultural competence and diversity competence became an integral part of professional skills and social work education. Social work’s field of knowledge became biopsychosociocultural” (p. 167).

In addition to the civil rights changes of the 1960s, women’s rights, gay and lesbian rights, and students’ rights were advocated; social workers were prompted to reconsider their focus on casework, and social reform goals reemerged (Sallee, 2004).

This was a time in social work’s history when there was disintegration between the field of social work and religion; however the influence of religious and nonreligious spiritual perspectives were not wholly absent. Sectarian private social service agencies, including Catholic Social Services, Lutheran Social Services, Jewish Family Services, and the Salvation Army, continued to provide social work services, and nonsectarian spiritual perspectives, such as 12 step programs, grew in influence (Canda and Furman, 2010). Yet it was not until the next phase of social work’s history that religion and spirituality reemerged as an important sphere of human experience to consider within professional social work.

**History of American Social Work: Resurgence of Interest in Spirituality**

The 1980s ushered in the fourth phase of Canda and Furman’s (2010) framework. During this phase, which lasted through the mid-1990s, a number of significant political
and social events occurred. The election of President Ronald Reagan marked the onset of the “war on the welfare state” (Trattner, 1989; Sallee, 2004). Reagan, whose sentiments about welfare recipients echoed the Calvanistic values of the Colonial Period, argued that the “cheats” and “free loaders…should be forced back into the labor market” (p. 328). Rather than receive aid from the government, Reagan asserted that private foundations, churches, and charitable organizations should provide for those in need. In response, the American Roman Catholic bishops

…called poverty in America a ‘social and moral scandal that must not be ignored,’ and stated that ‘works of charity cannot and should not have to substitute for humane public policy. Society’s responsibility to alleviate poverty must…be carried out through the government acting as the agent of the common good’ (p. 337).

Ultimately, “Reagan’s assault on social welfare programs would last nearly a decade and effectively restrict eligibility for public assistance to the poorest of Americans” (Sallee, 2004, p. 15). Welfare reform that harkened back to the Poor Laws continued after Reagan, however, with The Personal Responsibility and Work Opportunity Reconciliation Act of 1996. This Act further reinforced the “traditional value of individualism and work” by placing time limits for financial assistance and additional emphasis on requiring employment (Sallee, 2004, p. 15).

Social movements that gained traction in the 1960s and 1970s experienced pushback from fundamentalist religious groups during this phase. The women’s rights movement of the 1960s and early 1970s, with regards to the social issue of abortion, had emphasized the right of women to control their bodies and their lives, and, in response, “Advocacy groups founded in the late 1970s and early 1980s by members of conservative religious organizations, such as Focus on the Family and Concerned Women for
America, made opposition to abortion one of their founding principles” (Hoffman & Johnson, 2005, p. 164). According to McConkey (2001), during this phase, “religious polarization” on issues related to “family values”, including gender roles, child rearing techniques, homosexuality, and premarital sex, in addition to abortion, occurred among political and religious elites as well as ordinary citizens (p. 151). In reference to this time frame, Fram and Miller-Cribbs (2008) stated, “The American population has become increasingly conservative in recent years, with political ideology being driven by religious affiliation and ‘family values’ on issues such as abortion and gay rights” (p. 883). This phase concluded with the presidency of George W. Bush who, with his 2001 election, moved evangelical Christianity from the margins of politics into the White House and solidified the presence of the religious right in the national spotlight.

Social work was responsive to the political and social changes of the 1980s and 1990s. The profession experienced a revival of interest in religion and spirituality (Sheridan, 2004) and the reemergence of attention to religion and spirituality in social work education (Cnaan, Boddie, & Danzig, 2005). During this time, there was a swift and steady increase of faith-related research publications (Canda & Furman, 1999), an expansion of Catholic Charities, Jewish Family and Children Services, and the Salvation Army, and religious social services “began to hire BSWs and MSWs as a matter of course” (Cnaan, Boddie, & Danzig, 2005, p. 98). With regards to this phase, and the next, Rothman (2009) asserted:

At least four major forces have combined at this time in our history to spur a new interest in spiritual matters: the Internet’s enabling of instant global communication, the influence and impact of Asian immigrants and Eastern religions, the popularity of ‘New Age’ spiritual practices, and the popularization
of evangelical and fundamentalist religions. These have fostered an increased openness to discussing religious and spiritual practices and beliefs... (p. 166)

History of American Social Work: Transcending Boundaries

Canda and Furman’s (2010) phase “Transcending Boundaries” was cited as the final, and current, phase of their framework. The authors described this phase, starting in the mid-1990s, as a time when the trend of attending to religion and spirituality in social work continued to accelerate. There was a growth of transpersonal and ecophilosophical views in social work publications, increased engagement in interdisciplinary research, and social workers participated in the development of global perspectives on spirituality and social work (Canda, 2008). Transcending Boundaries has been a time when, as Senreich (2013) noted, “textbooks focusing exclusively on the intersection of spirituality and social work have become fairly commonplace” (p. 548), and social workers have worked in earnest to fine-tune their lexicon for discussing religion and spirituality (Streets, 2009). According to Cascio (1999),

Care has been taken in the social work literature to differentiate between the two often misinterpreted terms. Although these words are frequently used interchangeably, religion and spirituality do, indeed, have different meanings. Briefly stated, the term religion is typically used to describe formal adherence to a belief system... Spirituality, on the other hand, is exclusively an intrinsic phenomenon (p. 130).

As the interest in religion and spirituality in social work swelled and gained momentum, the profession, once again, needed to expand the sphere in which it functioned. Rothman (2009) explained:

With the resurgence of interest in religious and spiritual issues at the turn of the century, the religion and spirituality dialogue in social work, never absent, became a more clearly recognized force. Religious wars abroad and terrorism at home seemed to encourage a concern that religious differences may engender
separation, wars, and hatred. Spirituality, on the other hand, retained a universal, adaptable, amorphous quality that had the potential to unite, rather than divide, people. As social workers adopted a more holistic stance and a clear focus on addressing the needs of the “whole person,” religion, faith, spirituality, and the beliefs and practices that accompany these became a focus of interest. Possibly because of its potential for inclusiveness, the term “spirituality” was adopted, and social work’s domain has become biopsychosociocultural-spiritual (p. 167).

A distinguishing feature of the Transcending Boundaries phase has been “the formal recognition of spirituality in U.S. social work education standards” – in 1995, the American Council on Social Work Education (CSWE) included religion as one of the dimensions of human diversity that social work education needed to address (Canda & Furman, 2010, p. 113). The CSWE did not provide specific directives on how social work programs were to include this topic, and programs displayed significant variation in their efforts to meet the requirement. Many programs included content on religion and spirituality as a component of diversity in introductory courses (Cnaan, Boddie, & Danzig, 2005; Senreich, 2013). Others devoted more time and attention to the topic; in 2004, 57 spirituality elective courses were offered by American MSW programs throughout the country (Russel, 2006), and, in 2005, 75 dual degree programs were offering courses in spirituality and religion (Moss, 2012).

The rise of dual degree programs has been another feature of the Transcending Boundaries phase. Lee (2005) reported,

…it was in the mid 1990s when a push to widen the scope of dual degree programs came by a wave of students who were interested in combining social work practice skills and credentials with theological calling and spiritual discipline, thus increasing a holistic orientation for career and personal advancements” (p. 38).
The existence of dual degree programs has called for renewed and ongoing discourse about the differences that exist between religion and social work that impact their integration and create tensions for those who seek personal integration of religion and social work. Social work and religion present with different perspectives and theoretical bases in understanding human nature, commitment to diversity, sources of healing, sanctions for services, and role distinctions that lead social workers to “struggle in the process of reconciling the differing roles and paradoxes in beliefs” (Lee, 2005, p. 149). Streets (2009) asserted, “There are indeed inherent tensions between what social work and religion bring in response to human needs” (p. 190), and he echoed Lee’s observation by noting that faithful social work practitioners “quietly struggle to balance their personal faith with some of the ethical and value expectations of the social work profession (p. 186). Streets explained, for example, that social work supports self-determination “even when the client’s choice many not comply with the expectations and aims of social work,” but religious approaches “direct or prescribe” how a person should proceed (p. 190).

**Research on Religion and Spirituality in Social Work**

Canda and Furman (2010) cited an increase in empirical research on religion and spirituality in social work as another trend of the Transcending Boundaries phase. Researchers seeking to explore the interface of religion, spirituality, and social work have approached the topic from numerous angles, and their inquiries have illuminated tensions and divisions among members of the social work profession. While there has been research that supports the value of attending to religious and spiritual beliefs in social
work practice, there has been evidence that some social workers, including both clinicians and those in academia, maintain negative attitudes toward the interface of religion and social work (Canda, Nakashima, & Furman, 2004; Ressler & Hodge, 2003; Hodge, 2002; Ressler & Hodge, 2005; Thyer & Myers, 2009). Moss (2012) reported that “Evidence across several state universities…suggests that these topics still arouse considerable disquiet among faculty colleagues” (p. 597), and Streets (2009) described social workers as still cautious and concerned about the integration of religious beliefs into the field.

Respondents who took part in a national qualitative survey about religion and spirituality in social work stressed the importance of remaining nonjudgmental and respecting client self-determination when using religious or spiritual interventions in practice (Canda, Nakashima, and Furman, 2004). They further underscored the importance of adhering to the NASW Code of Ethics and emphasized the need for “avoiding demeaning criticisms of clients’ religious beliefs” and “refraining from efforts to evangelize or convert clients to one’s own religion” (p. 31). Some asserted that the very integration of religion and spirituality into social work practice conflicts with the NASW Code of Ethics and social work’s mission. They expressed opposition to self-disclosure of social workers’ religious beliefs in clinical practice and opposition to the inclusion of content on religion and spirituality in social work education. Canda and Furman (2010) present a summary of concerns about studying religion and spirituality in social work as well as their responses to these concerns in a table entitled, “Resolving the
Debate about Studying Religion and Spirituality (R/S) in Social Work” (p. 7). This table is presented in its entirety in Appendix I (Table 1.1).

Although studies “indicate that few providers engage in proselytization” (Tangenberg, 2005), it appears that concerns about the potential for misuse of religious and spiritual beliefs in practice, which surfaced in the mid-twentieth century, remain. According to Krieglstein (2006), “The old fear of proselytizing is still evident in the discussion…” (p. 24). Some have expressed concern that social workers’ negative attitudes have led to oppression and discrimination against conservative Christian social workers by their religiously liberal counterparts (Ressler & Hodge, 2003; Hodge, 2002; Ressler & Hodge, 2005; Thyer & Myers, 2009). Thyer and Myers (2009) reported, “over the years we have gained the impression that religiously oriented social workers remain somehow legitimate targets for ridicule, attack, and discrimination from some members within our own profession” (p. 147). They cited religious discrimination within academic social work is an ongoing problem and detailed examples such as admissions committees looking unfavorably upon applicants who report religious motivations for wanting to enter the field and students being “ridiculed or angrily attacked by fellow students and sometimes even by faculty” (p. 145) when their religious beliefs inform their opinions on social issues such as abortion rights and gay rights. Thyer and Myers (2009) viewed this religious discrimination within academic social work as a failure within the profession to promote social justice.

Canda, Nakashima, and Furman (2004) reported that their survey of social workers detected “comments that might reflect religious discrimination” (p. 34). They
explained that the recurrent citing of Christian activities as examples of the inappropriate use of religiously based activities might reflect an underlying bias held by some social workers. Barker (2013) reported, “…Christian social workers, including students, practitioners, and faculty, have perceived hostile and discriminatory attitudes and actions toward them by other social workers” (p. 5). Researchers Ressler and Hodge have explored the experiences of conservative Christian social workers in the profession and report that they have been subjected to professional oppression and discrimination (Ressler & Hodge, 2003; Hodge, 2002; Ressler & Hodge, 2005). One conservative Christian social worker who shared her narrative “indicated that she knew of no conservative Christian who had not experienced discrimination at some time (Ressler & Hodge, 2003, p. 136). One respondent reported that there was a lack of education and understanding about conservative Christians within the profession, another stated that conservative Christians were understood but rejected by their colleagues, and another “described the way he was treated as like a ‘skunk at a garden party’” (p. 135).

Ressler and Hodge (2005) used New Class theory and Epistemological theory to predict discriminatory patterns amongst social workers. Guided by their theory, they posited that conservative Christian social workers pose a threat to religiously liberal social workers’ economic self-interests. They hypothesized that the liberal majority, in response to the threat, seek to oppress the viewpoints of the conservative minority. The researchers’ choice of theory can be understood against the socio-political backdrop that took shape in 2000. The political campaigning and presidential election of George W. Bush increased the amount of attention given to faith-based initiatives. In early 2004, in a
speech given on the 75th anniversary of Rev. Martin Luther King’s birth, President Bush called for an end to discrimination against those affiliated with religious institutions. He stated, “The government should not fear faith-based programs…we ought to fund faith-based programs” (Bureau of International Information Programs, U.S. Department of State, 2004). Approximately one year later, in their published report, Ressler and Hodge (2005) asserted that their study affirmed their concerns: “many people and institutions in the profession are thought to be failing to provide an atmosphere free from religious oppression” (p. 71).

It is possible that economic self-interests motivate religiously liberal social workers’ responses to conservative Christian social workers. It is equally possible that different motivators exist. Religions often have explicit or implicit positions on many issues addressed by social workers. Poverty, for example, has been linked to morality to varying degrees throughout history, with reflections of this relationship present in current social welfare policies. There are still those who contend that “welfare payments and bureaucratic support for poor people are ineffective, and that the only way to provide real aid to people who are poor is through religious transformation that changes lives and instills responsibility, discipline, and work ethics” (Cnaan & Boddie, 2002, p. 227-228)

Other issues on which both religion and social work maintain perspectives include: crime; substance use; mental illness; sexuality; conception and contraception; abortion; marriage and divorce. In President George W. Bush’s 2004 speech, in which he called for an end to “discrimination” against those affiliated with religious institutions, he shared his view on the etiology and treatment of substance dependence:
Many of the problems that are facing our society are problems of the heart. Addiction in the problem of the heart...I was a drinker. I quit drinking because I changed my heart. I guess I was a one-man faith-based program. Problems that face our society are oftentimes problems that require something greater than just a government program or a government counselor to solve. Intractable problems, problems that seem impossible to solve can be solved...it requires a willingness to understand the origin of miracle. Miracles happen as a result of the love of the Almighty... (Bureau of International Information Programs, U.S. Department of State, 2004).

Those who view alcohol dependence as a “problem of the heart” would likely promote treatment interventions that would differ from those who subscribe to a medical model of substance dependence. A study of religious and social work values of MSW students found that “students who were highly religious as defined by the study chose religious values over those of social work when making a decision in practice situations where their social work and religious values either agreed or conflicted with one another” (Streets, 2009, p.189). The tension that exists within the field of social work around its interface with religion may be fueled, in part, by perceptions that the treatment provided by Christian social workers and secular social workers will be fundamentally different. Secular social workers may believe that, for Christian social workers, religious values supersede professional social work ethics and values.

Christian social workers, on the other hand, may be concerned that secular social workers’ aversion to religion/spirituality results in the neglect of this important aspect within the lives of clients. According to Sullivan (2009), “Even where the centrality of religious/spiritual matters in a consumer’s life is recognized and pinpointed as a primary source of problems or a potential resource to address their goals, many professionals prefer taking a ‘hands-off’ approach” (p. 93). Further, those who are not averse to
addressing religious/spiritual matters in clinical practice may struggle to recognize when clients present with such matters. Practitioners have reported inadequate training in schools of social work to deal with religious and spiritual factors (Furman, Benson, Canda, & Grimwood, 2005; Mulder, 2014). It has been demonstrated that those seeking clinical services are generally more religious than professionals providing services, and Sullivan (2009) speculates that “this alone may reduce the natural sensitivity of helpers to the importance of religion/spirituality in the clients they serve” (p. 91).

Multiple researchers have explored individual factors that impact social workers’ responses to the interface of religious beliefs and social work practice (Heyman, Buchanan, Marlowe, & Sealy, 2006; Canda, Nakashima, & Furman, 2004; Sheridan, Bullis, Adcock, Berlin, & Miller, 1992; Sheridan, 2004; Stewart, Koeske, & Koeske, 2006). The behavior of personal participation in religious or spiritual services has been positively correlated with the use of spiritually-derived interventions (see Appendix H) in social work practice (Sheridan, 2004; Stewart, Koeske, & Koeske, 2006). Additionally, a positive attitude toward the inclusion of spiritually-derived interventions has been related to their increased use (Sheridan, 2004). Heyman, Buchanan, Marlowe, and Sealy (2006) found social workers’ attitudes toward the role of religion and spirituality in social work practice were positively correlated with personal spiritual participation and having taken coursework in spirituality. In contrast, it was found that number of years in the field showed a negative correlation to one’s attitude toward the role of religion and spirituality in social work; the researchers suggested that an agency practice of not embracing the
inclusion of religion and spirituality could negatively impact clinicians’ attitudes toward these matters (Heyman, et. al., 2006).

Social work is not the only secular professional arena in which the role of religion and spirituality has been questioned, criticized, and studied. Doka (2011) noted, “Many health professionals have little specialized training in spirituality” (p. 107), and Praglin (2004) reported, “…social work mirrors a multitude of helping professions which in the past decade have actively sought to integrate spiritual perspectives into their knowledge base” (p, 68). Catanzaro and McMullen (2001) report that at the end of the Nineteenth Century American nurse educators adopted a secular model that initiated the “schism between religion and nursing education’s concern for the moral and spiritual development of the student “(p. 221). While there has been increased interest in the integration of spirituality and religion (Barker, 2013; Catanzaro & McMullen, 2001), there remains a “spiritual vacuum” in nursing education (Catanzaro & McMullen, 2001, p. 225).

Researchers Cnann, Boddie, and Danzig (2005) stressed that there was a rift between social work and religion and suggested that this could be problematic as more and more public services are contracted out to religious providers. Graff (2007) noted that the funding of faith-based initiatives “present social workers with challenges related to issues of religion and spirituality” (p. 243). The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, signed into law by President Bill Clinton, introduced Charitable Choice, a legislative provision designed to encourage states to involve faith-based organizations as providers of welfare services (Cnaan & Boddie,
In 2001, President George W. Bush created the White House Office of Faith-Based and Community Initiatives with the goal of expanding the use of faith-based groups in the provision of publicly funded social services. These efforts were viewed by many as divisive and controversial, and they drew attention and criticism from health care professionals, civil liberty groups, and members of the faith community (Wright, 2009; Gibelman & Gelman, 2002; Gibelman & Gelman, 2003).

Over a decade later, however, an interest in creating government partnerships with religious providers remained; in 2009, President Barack Obama established the White House Office of Faith-Based and Neighborhood Partnerships. Indeed, as Cnaan and Boddie (2002) noted, “The belief that churches can address welfare better than the government and the secular social services system is not limited to Republican and conservative thinkers” (p. 228). While the path of the faith-based initiative shifted under the new leadership, President Obama’s commitment to strengthening faith-based groups was evident. The American Recovery and Reinvestment Act of 2009 (ARRA), signed into law by President Obama, included the Strengthening Communities Fund which made $50 million worth of grants available for two programs that provided support to both secular nonprofit and faith-based social service providers (Wright, 2009).

Stewart (2009) stated that tensions between social work values and traditional Christian values are “inescapable” (p.38). Belcher, Fandetti, and Cole (2004) echoed this sentiment and added that “the profession of social work is correct in its wariness of faith-based initiatives” (p. 274). While some may argue that social workers have legitimate reasons to be concerned about, if not oppose, the interface of religion and social work,
faith-based funding within multiple presidencies has made it clear that the faith-based initiative will continue to move forward, and the profession of social work needs to understand how it will move forward along with it. This study, which seeks to investigate the ways in which religious and spiritual attitudes, assumptions, practices, and cognitions are currently interfacing with clinical social work practice, can make a valuable contribution to dialogue on this issue.

Additionally, social work, as a profession that has concentrated its efforts on addressing discrimination, oppression, and social injustice, has an ethical obligation to attend to those who claim mistreatment and discrimination from within. In order to effectively respond to these concerns we must first increase our understanding of the dynamics that underlie them. This study seeks to increase our understanding of these dynamics through a number of research questions. The first research question: How do the clinical treatment approaches of NACSW members and NASW members differ: does identical clinical material presented to these two different audiences lead to different treatment interventions? In addition to the possibility of addressing misperceptions held by these groups about each other, responses to this question can further our understanding of the ways in which religious beliefs and secular beliefs currently impact clinical practice.

Additional research questions include: How do Christian Social Workers and Secular Social Workers view their training and clinical skills relative to identifying and responding to client problems of a religious and/or spiritual nature or client problems with a religious and/or spiritual component? Is there a set of clinical skills expected from
Christian social workers and not secular social workers? What clinical issues prompt a referral to a faith-based provider (Christian Social Worker, pastoral counselor, priest, pastor, chaplain, rabbi)? These questions are meant to provide an opportunity to comment on how social work education has addressed and/or might address in the future, the subjects of religion and spirituality. Growing appreciation for the value of attending to the religious and/or spiritual dimension of clients’ lives has led to the increased inclusion of this dimension in the assessment process; this movement has been emphasized by the Joint Commission on Accreditation of Healthcare Organizations, which now requires the administration of a spiritual assessment (Hodge, 2006). Despite the expectation that religious and/or spiritual factors be incorporated into the clinical experience, there have been mixed reports regarding the training social workers have received to prepare them for competence in this area.
CHAPTER THREE

METHODOLOGY

Chapter three provides a thorough overview of the methodology used in this study. The chapter begins with a review of the study’s design and procedures and then includes subsequent sections addressing sample, measures, and data analysis.

Design and Procedures

This multiple methods study made use of survey questionnaires and focus groups to investigate the clinical practices of both Christian social workers and secular social workers. With Loyola University Chicago’s Institutional Review Board’s approval, the first phase of this two-phase study involved the use of a mailed letter (Appendix A) to samples of NASW Illinois members and NACSW members. In total, 2000 subjects were sent a mailed letter inviting them to complete an online Opinio questionnaire (Appendix B) time-tested to take approximately 15 minutes to complete. In addition to providing a general overview of the study, the letter included instructions on how to access the online questionnaire. NASW Illinois members were directed to one Opinio questionnaire and NACSW members were directed to an identical version of the Opinio questionnaire; subjects were directed to two different sites to complete identical questionnaires to enable this researcher to track from which membership group submitted questionnaires were sent. Immediately upon accessing the online questionnaire, participants were prompted to provide their informed consent (Appendix F). Approximately one week following the
mailing of the initial letter a postcard thank you/reminder was sent to all subjects (Appendix C). This postcard served as a thank you for those who had responded and a reminder for those who had not.

According to Dillman (2007) most participants who answer questionnaires will do so within one week, and the postcard follow-up one week later has been shown to be an effective method of increasing response rate. Dillman (2007) asserts that “multiple contacts have been shown to be more effective than any other technique for increasing response to surveys by mail…recent research confirms that this is also true for surveys by e-mail” (p. 149). A study that compared response rates of mail and web-based surveys found that a reminder mail notification was able to increase response rates for a web-based survey (Kaplowitz, Hadlock, & Levine, 2004).

While the methods researched in these prior studies were not an exact match to the mixed-mode method of this study, wherein initial contact was made through mail and a web-based response was requested, they demonstrated the value of a second contact as well as indicated that contact via mail can increase responses via the web. Many different factors have been shown to influence survey response rates, and it was hard to anticipate how these factors would converge to impact the response rate to the questionnaire for this study. Yegidis & Weinbach (2002) reported that a typical response rate for data collection instruments mailed to strangers and using at least one follow-up request is 30 to 40 percent; unfortunately the response rate for this survey was considerably lower. The response rate for the NASW-IL group was 9.14%, and the NACSW group had a response rate of 12.19%.
It is possible that the subject matter of the research study was a deterrent to some participants; this would provide an explanation for the higher response rate of the NACSW group. It is also possible that the format of initiating contact via mail and requesting a web-based response has a natural tendency to produce lower response rates than those predicted by Yegidis and Weinbach. Regardless, it is likely that additional contacts would have improved the response rate; however, that was not a financially viable option for this study.

The questionnaire was primarily used to address the research question: How do the clinical treatment approaches of NACSW members and NASW Illinois members differ: does identical clinical material presented to these two different audiences lead to different treatment conceptualizations and interventions? This question was approached through the use of 2 clinical vignettes and related question sets (Appendix B). Demographic data was collected and participants were asked to complete the Role of Religion and Spirituality in Practice Scale (RRSP) and the Religiosity Measure instrument.

At the conclusion of each questionnaire there was an imbedded e-mail link invited participants to call up their e-mail to submit their contact information to volunteer for focus group discussion (Appendix D). The e-mail links imbedded at the end of the questionnaires were different, which enabled this researcher to track from which membership group participants submitted their contact information belong. Nine participants volunteered for the Secular focus group and 6 participants volunteered for the Christian focus group. Participants were informed that their contact information was sent
separate from their submitted questionnaire – ensuring that their questionnaire submission remained anonymous – however their membership group was identifiable. Participants were also informed that the focus group discussion would address additional questions about the interface of religion and clinical practice in social work. They were informed of the desire to keep groups homogenous around the variable of religion, and those who volunteered were asked to self-select placement in either a Christian or Secular group.

Informed by literature that advocates for the use of smaller groups when covering emotionally charged topics, the decision was made to limit the size of the focus groups (Morgan, 1996). In coordinating the focus groups, the intent was to construct groups that included no less than 3 participants and no more than 8 participants. Based on participant availability, efforts to coordinate dates/times for focus group sessions resulted in the scheduling of 4 participants for the Secular focus group and 4 participants for the Christian focus group. Subsequently, two of 2 of the 4 scheduled participants presented for the Secular focus group session and 3 of the 4 scheduled participants presented for the Christian focus group session.

The two discussions occurred at the Loyola University Chicago campus and were facilitated by this researcher. Focus group participants were asked to provide their informed consent (Appendix G) prior to engaging in focus group discussions. Discussions lasted 1.5 hours, included light refreshments (e.g. bottled water, coffee, bagels), and participants were offered reduced parking fees through ticket validation. To facilitate safe and open dialogue around the topic of religious beliefs, the focus groups
were kept homogenous with regards to participants’ religious self-identification as Christian or secular in their social work practice. Focus group participants were provided with informed consent documentation upon arrival for focus group discussion. They were given the opportunity to decline or consent to participation (Appendix G), and it was explained that those who consented free to withdraw from focus group discussion at any time without penalty.

A systematic comparison of survey and focus group results reported that “the biggest difference found between the methods was the ability of the focus groups to produce more in-depth information on the topic at hand” (Morgan, 1996, p. 137). Through the use of focus group discussion, this researcher sought to expand upon and add to the data collected through the online questionnaire. The focus groups were used to address research questions: How do Christian Social Workers and Secular Social Workers view their training and clinical skills relative to identifying and responding to client problems of a religious and/or spiritual nature or client problems with a religious and/or spiritual component? Is there a set of clinical skills expected from Christian social workers and not secular social workers? What clinical issues prompt a referral to a faith-based provider (Christian Social Worker, pastoral counselor, priest, pastor, chaplain, rabbi)? These broad research questions are approached through 16 questions organized by treatment, training, assessment, and concluding questions (Appendix E).

Focus group discussion was audio-taped to aid this researcher in accurately capturing information shared by participants. The confidentiality of participants was protected throughout the study; participants were instructed to not identify themselves by
name when speaking or refer to other participants by name. While the content of the focus group discussion was important to capture, this researcher did not seek to link content with subjects’ identities. This researcher secured the services of a transcription professional with a confidentiality policy, and all audio recordings, as well as data obtained through the online questionnaire process, were secured in a locked cabinet and deleted/destroyed upon completion of the research.

Sample

In total 2000 subjects, 1000 NASW Illinois members and 1000 NACSW members, were invited to participate in the first phase of this study, and 91 NASW-IL participants and 120 NACSW participants completed the questionnaire. The decision to select only NASW-IL members as subjects rather than conduct a larger survey of NASW members nationwide was made, in part, due to financial limitations of this researcher; there was a fee associated with access to members’ names. NASW Illinois allowed rental of membership mailing labels at a rate of $.15 per label for NASW Illinois members and $.20 per label for nonmembers. Those interested in purchasing labels from NASW Illinois’ membership database were directed to specify a membership category. Category selection includes NASW Illinois district, city, county, and field of practice (e.g., aging, child/family welfare, mental health, school social work). This researcher chose to specify Mental Health as the field of practice, with the expectation that it would yield a sample of participants prepared to respond to clinical material.

At the time of this study, the number of NASW Illinois members specializing in the field of Mental Health was listed at 1,100, however the exact number of members can
vary on a monthly basis. NASW Illinois requires purchase of the entire requested category; therefore, approximately 1,100 name labels were purchased. Of the 1,100 name labels purchased, the first 1000 were selected as the sample of NASW Illinois members to receive a mailing inviting participation in the study. 1000 NACSW members, including the selective inclusion of 119 Illinois based members, received a mailing as well. NACSW listed its total membership as 1,297, and this researcher requested all names/contact information. After the identification and inclusion of all Illinois based members, the first 1000 of the remaining listed names were selected.

Focus group participants were drawn from those who volunteered at the conclusion of the first phase of this study. Focus group participants were not reimbursed for their time or for any travel expenses they incurred, and this researcher appreciated that this might have inhibited many questionnaire participants from volunteering for focus group discussion. Focus group discussion was held on Loyola University Chicago’s campus, and the decision to select only Illinois based NASW members and to selectively include all of the Illinois based NACSW members was made, in part, to pursue clinicians whose geographical location would be conducive to participating in the focus groups. To facilitate safe and open dialogue around the topic of religious beliefs, the focus groups were kept homogenous with regards to participants’ religious self-identification as Christian or secular in their social work practice. Participants were informed of the desire to keep groups homogenous and were prompted to self-select a group for placement.
Measures

The first phase of this study involved completion of a web-based Opinio questionnaire (Appendix B). Participants were asked to provide demographic data as well as information about their current place of employment and previous training in integrating spiritual/religious concept into the clinical practice of social work. Participants were then presented with two case vignettes and related question sets. The case vignettes were designed to provide participants with an opportunity to respond to client problems with a religious and/or spiritual component. The first case vignette portrayed a 27-year-old woman named Anna who was raised Lutheran and was planning her wedding to a man who was raised Catholic; in the efforts to plan their wedding their difference in religious backgrounds had become a source of tension in their relationship. Anna felt that she is seeing a “whole new side” of her fiancé and planning their wedding had become associated with feelings of anger and anxiety. The second case vignette presented Tom, a 57-year-old who has been irritable and moody. Tom and his wife left their church within the past year and they had a recently engaged daughter. Tom had been questioning the purpose of his life and experiencing unresolved feelings regarding the loss of his parents.

The same set of eleven questions followed the two case vignettes and both quantitative and qualitative measures were employed. Four of the questions were presented to participants as 7-point Likert items; participants were asked to rate the seriousness of the presenting problem, rate the level of impairment of the identified client’s functioning, and rate both the client’s level of motivation and prognosis for
therapy. Participants were also asked to cite the anticipated number of treatment sessions
needed and respond to two closed-ended multiple choice questions regarding
recommended treatment modality and choice of clinical theory. Participants were asked
to provide qualitative data through a number of open questions, including: What would
you identify as the primary presenting problems in this case? What additional assessment
information is needed to create a plan for moving forward with this client? What clinical
interventions might you use with this client? Would there be any spiritual interventions or
resources that you would consider for this client?

Following the questionnaire’s vignettes, participants were asked to complete the
Role of Religion and Spirituality in Practice Scale (RRSP) (Sheridan, 2000). The RRSP
was developed to measure professional attitudes toward the role of religion and
spirituality in social work practice. It is an 18-item measure that asks respondents to rate
each item on a 5-point scale that ranges from strongly disagree to strongly agree. The
RRSP differentiates between spirituality and religion and presents respondents with
questions about the presence of spirituality and religion in clinical practice, assessment,
and education. RRSP scores can range from 18 to 90, with higher RRSP scores indicating
more positive attitudes toward the role of religion and spirituality in practice. A previous
study of a random sample of 204 licensed clinical social workers in a mid-Atlantic state
produced a mean RRSP score of 69.88, with a range of 36 to 90 (Sheridan, 2000). This
researcher anticipated a similar mean score for this study’s NASW-IL group, and a higher
mean RRSP score for the NACSW respondents, and that is exactly what occurred. The
average score for the NASW-IL group was 66.95 (SD = 12.14), and the average score for the NACSW group was 78.40 (SD = 7.311).

Initial evidence demonstrated it to be a reliable and valid research instrument (Sheridan, 2000). It has been tested with a number of populations, including social work faculty, social work graduate students, and social work practitioners. In each study, reliability was tested using Cronbach’s alpha and scores ranged from .82 to .88. Additionally, both convergent and divergent construct validity was tested by examining relationship of scale scores to responses to other variables that theoretically should or should not show a significant relationship; analysis showed support for anticipated relationships at the minimum of p < .05 significance level (Sheridan, 2000).

The RRSP was chosen for inclusion in this study’s questionnaire as a tool for assessing that sampling methods were successful in obtaining two groups of social workers that differed on their degree of religiosity. The RRSP measure was impacted in this study as a result of researcher error. The measure is comprised of 18 items but only 17 items were submitted for inclusion in the questionnaire. Despite this error, which will be accounted for as a limitation of this study, the measure showed good reliability for all those for whom a score could be calculated (n = 194, alpha .89), good reliability for the NASW-IL sample (n = 85, alpha .88), and acceptable reliability for the NACSW sample (n = 109, alpha .79). Further, there was good evidence for unidimensionality in the full sample.

The Religiosity Measure (Hill & Wood, 1999) was developed to evaluate the impact of religion on the respondent’s secular life and is intended to be applicable to
religiosity in general (no particular religious affiliation is assumed). The 8-item multiple-choice instrument covers four dimensions of religiosity (ritual, consequential, ideological, and experiential) and is scored from least religiosity to greatest religiosity. The Religiosity Measure has a score range of 0 to 32, with higher scores indicating greater religiosity. The Religiosity Measure has been demonstrated to have high internal consistency, with cronbach coefficient alphas over .90, and good construct, internal, and discriminant validity (Hill & Wood, 1999).

This Religiosity Measure was used to explore the relationship between one’s degree of religiosity and his or her professional attitude and approach to the practice of clinical social work. Subsequent to administration of the survey, during the course of scoring participant responses to the Religiosity Measure, it was discovered that the Religiosity Measure was misprinted in the comprehensive Measures of Religiosity (1999) text. Specifically, two items of the eight-item multiple-choice instrument included only four of what should have been five possible response options. The Religiosity Measure was designed to yield an overall score between 0 (least religiosity) and 32 (greatest religiosity); the measure’s misprint within this study meant that the instrument could yield an overall score between 0 and 30. Despite this error, which will be accounted for as a limitation of this study, basic psychometrics indicated that the Religiosity Measure showed good reliability for all those for whom a score could be calculated (n = 196, alpha .94) and good reliability for the NASW-IL sample (n = 85, alpha .95). While the measure showed poor reliability for the NACSW sample (n = 111, alpha .47), and this limitation will be reviewed in the Discussion chapter, the measure yielded a statistically significant
difference in means between the NACSW group and the NASW-IL group. The NACSW group scored significantly higher with a mean score of 27.91 (SD = 3.00), and the NASW-IL group had a mean score of 15.27 (SD = 10.64).

Focus group questions used in the second phase of the study were constructed to pursue the following research questions: How do Christian Social Workers and Secular Social Workers view their training and clinical skills relative to identifying and responding to client problems of a religious and/or spiritual nature or client problems with a religious and/or spiritual component? Is there a set of clinical skills expected from Christian social workers and not secular social workers? What clinical issues prompt a referral to a faith-based provider (Christian Social Worker, pastoral counselor, priest, pastor, chaplain, rabbi)? These broad questions are approached through 16 questions that explore the areas of treatment, training, and assessment in clinical social work (Appendix E). Participants’ responses to these questions provided additional insight into the professional attitudes and clinical approaches of Christian social workers and secular social workers.

Data Analysis

Data analysis included descriptive statistics about the participants as well as statistical analyses of the participants’ responses, NASW and NACSW, to the vignettes. The primary goal was to better understand the characteristics of clinical practice that differentiate those who identify as Christian social workers and those who identify as secular social workers. To obtain more detailed information about participants and their level of responses addressing the areas of inquiry in this study, statistical procedures were
used to detect any significant differences in level or type of responses between groups of participants.

Participants’ responses to the survey’s case vignettes were analyzed to address the research question, how do the clinical treatment approaches of NACSW members and NASW members differ: does identical clinical material presented to these two different audiences lead to different treatment interventions? The question sets following the case vignettes pursued quantitative data as well as simple qualitative data. A series of chi square tests were employed to assess whether there were significant differences between how Christian social workers and secular social workers responded to the case vignettes. A detailed write up of participant responses is provided in the Results chapter.

The audio recordings of focus group conversation were transcribed verbatim by a professional transcriptionist. This researcher reviewed the transcripts and listened to the tapes, looking and listening for emerging themes or patterns; attending to whether several people within a focus group repeated or made very similar statements or whether, when someone in a group made a statement, others demonstrated verbal agreement. The use of ATLAS.ti, a computer assisted qualitative data analysis program, was employed to assist with content analysis, a specific technique that takes qualitative data and transforms it into quantitative data. ATLAS.ti sped up the coding process as well as provided a variety of options for exploring relationships in the data. This process helped with zeroing in on themes that emerged most during the focus groups; this researcher was interested in the themes of each individual focus group and how they compared with each other. A detailed description of focus group content is provided in the Results chapter.
CHAPTER FOUR

RESULTS

Chapter four details the results of the multiple methods study. This chapter begins with a presentation of the quantitative and qualitative data collected through the online Opinio questionnaire and concludes with an overview of the qualitative data collected through the focus group discussions.

Questionnaire Results

One thousand letters inviting NASW-IL subjects to complete an online Opinio questionnaire were mailed via first class USPS postage. However, five letters were routed return to sender which left 995 legitimate invitations to NASW-IL subjects for this study. 125 NASW-IL subjects responded to the invitation by initiating an online Opinio questionnaire, and 91 of those who initiated the questionnaire completed it. This yielded a response rate for NASW-IL subjects of 9.14%. One thousand letters of invitation were also mailed to NACSW subjects, sixteen of which were routed return to sender. This left 984 legitimate invitations to NACSW subjects for this study. A total of 185 NACSW subjects responded to the invitation by initiating an online Opinio questionnaire, and 120 of those who initiated the questionnaire completed it. This yielded a response rate for NACSW subjects of 12.19%.

Questionnaire Results: Demographic Data

Table 2 provides information on the demographic characteristics of the NASW-IL
and NACSW members who completed the questionnaire. Both samples had more female participants than male. The NASW-IL sample was 60.70% female and the NACSW sample was 67.30% female. The participants ranged in age from 22 to 83 years, and there was a significant difference in the mean age of NASW-IL participants (M = 52.57, SD = 14.96) and NACSW participants (M = 46.05, SD = 13.16); t(200) = 3.24, p = .001. With regards to race/ethnicity of participants, non-Hispanic white participants constituted the majority of both samples. The NASW-IL sample had 96.51% of its participants identify as non-Hispanic white, and 87.50% of the NACSW participants identified as non-Hispanic white. This demographic difference was statistically significant; \( \chi^2(1, N = 198) = 4.82, p = .03 \).

Table 2. General Demographic Data

<table>
<thead>
<tr>
<th></th>
<th>NASW-IL Participants</th>
<th>NACSW Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>39.30%, n = 35</td>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
<td>60.70%, n = 54</td>
<td>Female</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>52.57, n = 89</td>
<td>Average</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>91.21%, n = 83</td>
<td>White</td>
</tr>
<tr>
<td>Minority Identification</td>
<td>3.30%, n = 3</td>
<td>Minority Identification</td>
</tr>
<tr>
<td>No Answer</td>
<td>5.49%, n = 5</td>
<td>No Answer</td>
</tr>
</tbody>
</table>

Note. ^a t(200) = 3.24, p = .001. ^b \( \chi^2(1, N = 198) = 4.82, p = .03 \)

In addition to sex, age, and race/ethnicity, participants were asked to provide data about their educational background, employment, and religious involvement, and this information is provided in Tables 3 and 4. The two samples were similar with regards to attendance of a secular universities for their social work degrees: 75.56% of NASW-IL participants and 76.72% of NACSW participants attended secular universities. Similarly,
the majority of participants in both samples did not have additional degrees or recognition denoting advanced study of ministry or theology (e.g., Master in Divinity, Master in Pastoral Counseling, Other Ordination). The samples did differ with regards to their participation in both credited and non-credited courses focused on integrating spiritual/religious concepts into social work practice. NASW-IL had 10.23% of its participants report that they had taken a credited class on integrating spiritual/religious concepts into social work practice, while 33.33% of NACSW reported that they had taken a credited class. This difference was statistically significant $\chi^2(1, N = 199) = 33.49$, $p < .001$. Similarly, only 10.11% of NASW-IL participants reported that they had taken specialized non-credit training in integrating spiritual/religious concepts into their practice of social work, and 48.31% of NACSW participants reported that they had done this. Again, this difference was statistically significant $\chi^2(1, N = 200) = 17.53$, $p < .001$.
Table 3. Education, Employment, and Professional Identification

<table>
<thead>
<tr>
<th></th>
<th>NASW-IL Participants</th>
<th>NACSW Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attend Sectarian University</td>
<td>Yes 24.44%, n = 22</td>
<td>Yes 23.28%, n = 27</td>
</tr>
<tr>
<td></td>
<td>No 75.56%, n = 68</td>
<td>No 76.72%, n = 89</td>
</tr>
<tr>
<td>Additional Degrees</td>
<td>M.Div 4.40%, n = 3</td>
<td>M.Div 3.33%, n = 4</td>
</tr>
<tr>
<td></td>
<td>Pastoral Coun. 0%, n = 0</td>
<td>Pastoral Coun. 0.83%, n = 1</td>
</tr>
<tr>
<td></td>
<td>Other Ordination 4.40%, n = 3</td>
<td>Other Ordination 11.67%, n = 14</td>
</tr>
<tr>
<td></td>
<td>NA 72.53%, n = 66</td>
<td>NA 69.17%, n = 83</td>
</tr>
<tr>
<td></td>
<td>No Answer 28.79%, n = 19</td>
<td>No Answer 15.00%, n = 18</td>
</tr>
<tr>
<td>Credited Class Religion</td>
<td>Yes 10.23%, n = 9</td>
<td>Yes 33.33%, n = 40</td>
</tr>
<tr>
<td></td>
<td>No 89.77%, n = 79</td>
<td>No 66.67%, n = 80</td>
</tr>
<tr>
<td>Non-credit Training Religion</td>
<td>Yes 9.89%, n = 9</td>
<td>Yes 47.50%, n = 57</td>
</tr>
<tr>
<td></td>
<td>No 87.91%, n = 80</td>
<td>No 50.83%, n = 61</td>
</tr>
<tr>
<td>Current Place Employment</td>
<td>College/Univ 12.09%, n = 11</td>
<td>College/Univ 24.17%, n = 29</td>
</tr>
<tr>
<td></td>
<td>Hospital 6.60%, n = 6</td>
<td>Hospital 9.17%, n = 11</td>
</tr>
<tr>
<td></td>
<td>Private Practice 41.76%, n = 38</td>
<td>Private Practice 20.83%, n = 25</td>
</tr>
<tr>
<td></td>
<td>Religious-based 3.30%, n = 3</td>
<td>Religious-based 10.83%, n = 13</td>
</tr>
<tr>
<td></td>
<td>Com mental hlth 19.78%, n = 18</td>
<td>Com mental hlth 7.50%, n = 9</td>
</tr>
<tr>
<td></td>
<td>Other 30.77%, n = 28</td>
<td>Other 61.67%, n = 74</td>
</tr>
<tr>
<td>Hours/Week with Clients</td>
<td>0-10 hrs 33.33%, n = 29</td>
<td>0-10 hrs 51.78%, n = 58</td>
</tr>
<tr>
<td></td>
<td>11+ hrs 66.67%, n = 48</td>
<td>11+ hrs 48.21%, n = 54</td>
</tr>
<tr>
<td>Member of NACSW</td>
<td>Yes 5.50%, n = 6</td>
<td>Yes 94.5%, n = 104</td>
</tr>
<tr>
<td></td>
<td>No 90.2%, n = 83</td>
<td>No 9.8% n = 9</td>
</tr>
</tbody>
</table>

Note. $^a$χ² (1, N = 199) = 33.49, p < .001. $^b$χ² (1, N = 200) = 17.53, p < .001. $^c$χ² (1, N = 199) = 6.48, p = .009. $^d$χ² (1, N = 202) = 146.04, p < .001.

Participants were asked to indicate their current place(s) of employment as well as the approximate number of hours spent each week with clients. There was a significant difference between the groups with regards to time spent in direct practice with client; χ²(1, N = 199) = 6.48, p = .009. Nearly two-thirds (66.67%) of NASW-IL participants reported eleven or more hours each week with clients, and the settings cited with greatest frequency were: 1) Private Practice (36.54%); 2) Secular Community Mental Health Agency (17.31%); 3) College/University (10.58%); and 4) Hospital (5.77%). Nearly half (48.21%) of NACSW participants reported spending eleven or more hours each week.
with clients, and the settings cited with greatest frequency were: 1) College/University (18.01%); 2) Private Practice (15.53%); 3) Religious-based or affiliated agency (8.07%); and 4) Hospital (6.83%). Of the top four most frequently cited employment sites, NASW-IL members and NACSW members overlapped in 3 of the 4 areas.

The NASW-IL and NACSW samples differed with regards to their involvement in a church/religious community (Table 4). All NACSW participants (100%) cited their current religious affiliation as Christian, while 42.70% of the NASW-IL participants reported their current religious affiliation as Christian. This difference was statistically significant; $\chi^2(2, N = 200) = 85.38, p < .001$. Further, 96.49% of the NASCW participants reported current membership to a church/religious community; in contrast, 44.94% of NASW-IL participants reported current membership to a church/religious community. This difference was also statistically significant $\chi^2(1, N = 202) = 68.27, p < .001$.

Table 4. Religious Affiliation

<table>
<thead>
<tr>
<th>Childhood Religious Affiliation</th>
<th>NASW-IL Participants</th>
<th>NACSW Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>80.90%, n = 72</td>
<td>Christian</td>
</tr>
<tr>
<td>Other</td>
<td>12.40%, n = 11</td>
<td>Other</td>
</tr>
<tr>
<td>Unaffiliated</td>
<td>6.70%, n = 6</td>
<td>Unaffiliated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Religious Affiliation</th>
<th>NASW-IL Participants</th>
<th>NACSW Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>42.70%, n = 38</td>
<td>Christian</td>
</tr>
<tr>
<td>Other</td>
<td>27.00%, n = 24</td>
<td>Other</td>
</tr>
<tr>
<td>Unaffiliated</td>
<td>30.30%, n = 27</td>
<td>Unaffiliated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Currently Belong to Church</th>
<th>NASW-IL Participants</th>
<th>NACSW Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>44.94%, n = 40</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>55.06%, n = 49</td>
<td>No</td>
</tr>
</tbody>
</table>

Note. $^a\chi^2(2, N = 200) = 12.31, p = .002$. $^b\chi^2(2, N = 200) = 85.38, p = < .001$. $^c\chi^2(1, N = 202) = 68.27, p < .001$
Questionnaire Results: Standardized Measures

The Religiosity Measure and RRSP scale were successful in demonstrating that the NACSW and NASW-IL groups were significantly different in degree of religiosity. The NACSW participants’ scores were significantly higher. The average score for NACSW participants on this Religiosity Measure was 27.91 (SD = 3.00), and the average score for NASW-IL participants on this scale was 15.27 (SD = 10.64). This difference in means between the two groups was statistically significant; t(99.02) = -12.04, p < .001. Further, the average score for NACSW participants on the RRSP scale was 78.40 (SD = 7.31), and the average score for NASW-IL participants on this scale was 66.95 (SD = 12.14). This difference in means between the two groups was significant; t(192) = -8.14, p < .001.

Questionnaire Results: Vignette I

After participants were asked to provide demographic information, they were introduced to the vignette portion of the survey. The vignettes and related question sets were purposed to pursue the question of whether identical clinical material presented to NASW-IL members and NACSW members would lead to different or similar treatment conceptualizations and interventions. Participants were presented with 2 clinical vignettes and related question sets that asked them to identify and rate the severity of presenting problem(s), recommend a treatment modality and clinical theory, and hypothesize both on the number of sessions needed and the client’s prognosis for therapy.

Vignette I

The first case vignette portrayed a 27-year-old woman named Anna:
Anna, a 27 year old female, reports feeling over-stressed in her life right now. She and Jeff, her boyfriend of 4 years, have begun to plan their wedding after a long engagement. Anna explains that she’s been frustrated by Jeff’s lack of involvement in the planning process, and she’s concerned that the tasks she’s delegated to him won’t get done. Further, they’ve been arguing over where to hold the wedding ceremony and who will perform it. Anna explains that she was raised Lutheran and Jeff was raised Catholic and, while this difference in religious backgrounds has not previously been an issue, it is currently a major source of tension in their relationship. Anna would like to have a religious ceremony but has felt pressured to convert to Catholicism in order to be married in the church Jeff’s family attends. Anna explains that Jeff’s family has offered to help fund the wedding, but only if they get married in their church. In addition, Jeff, who initially argued in favor of a civil ceremony, has begun pushing for a Catholic ceremony in an effort to please his parents and avoid conflict with them. Anna explains that Jeff has traditionally been very flexible and willing to compromise, and she now feels that she is seeing a “whole new side” of him. She tearfully remarks that planning their wedding has become associated with feelings of anger and anxiety instead of the feelings of joy and excitement she was anticipating.

Responses to the presenting problem of Vignette I. Participants were asked to identify the primary presenting problem(s) in the case and were provided space within the online survey to enter their unique, open-ended responses. Participant responses ranged in length from one word to multiple sentences; many participants indicated the presence of a constellation of presenting problems. ATLAS.ti was used to assist with the process of analyzing all open-ended responses and identifying themes. Analysis began with an initial review of all participant responses to establish familiarity with the content. The liberal application of codes began with the second review of participant responses. Subsequent reviews of the data were used to complete a careful refining process that involved both collapsing and expanding codes as clear themes emerged. See
Appendix J for examples of participant responses and the application of the coding process.

Through the coding process, five presenting problems emerged as predominant with regards to the frequency as reported by participants: 1) Anxiety/Stress; 2) Communication Issues; 3) Conflict Resolution and Decision Making; 4) Family of Origin Issues and Differentiation; and 5) Religious/Spiritual Component. These presenting problems were cited by a minimum of 10% of either participant group. Appendix L has examples of participant responses that were coded as referencing each of these presenting problems, and Table 5 provides a listing of the frequency with which these presenting problems were reported by participants. Each presenting problem was isolated and identified as “yes” mentioned or “no” not mentioned, and the observed frequencies were inputted into an interactive calculation tool for chi-square tests of goodness of fit and independence (Preacher, 2001). Through this process it was found that NASW-IL participants and NACSW participants identified three of the five presenting problems at statistically significant differences in frequency: Anxiety/Stress; Conflict Resolution and Decision Making; and Religious or Spiritual Component.
Table 5. Presenting Problems: Vignette I

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>NASW-IL</th>
<th>NACSW</th>
<th>Test Statistic</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety/Stress</td>
<td>31.87%, N = 29</td>
<td>18.33%, N = 22</td>
<td>$\chi^2 = 5.17$</td>
<td>0.023*</td>
</tr>
<tr>
<td>Communication Issues</td>
<td>20.88%, N = 19</td>
<td>30%, N = 36</td>
<td>$\chi^2 = 2.23$</td>
<td>0.135</td>
</tr>
<tr>
<td>Conflict Resolution and Decision Making</td>
<td>58.24%, N = 53</td>
<td>38.33%, N = 46</td>
<td>$\chi^2 = 8.24$</td>
<td>0.004*</td>
</tr>
<tr>
<td>Family of Origin and Differentiation</td>
<td>36.26%, N = 33</td>
<td>40%, N = 48</td>
<td>$\chi^2 = 0.305$</td>
<td>0.581</td>
</tr>
<tr>
<td>Religious or Spiritual Component</td>
<td>35.16%, N = 32</td>
<td>52.50%, N = 63</td>
<td>$\chi^2 = 6.28$</td>
<td>0.012*</td>
</tr>
</tbody>
</table>

Note: *p < .05

Responses to Vignette I: Degree of Seriousness and Treatment Modality.

Following identification of the vignette’s presenting problem(s), participants were asked to rate the presenting problem(s) degree of seriousness and indicate a recommended treatment modality. To rate the degree of seriousness participants were provided with a 7-point scale wherein 1 indicated “not serious” and 7 indicated “very serious”. 85.55% of NASW-IL participants and 88.89% of NACSW participants rated the client’s presenting problem(s) as a 4 or above, indicating that they considered the problem to be, at least, somewhat to moderately serious. There were no participants in either group who rated the client’s presenting problem(s) at the level 1 minimum on the scale. Thus, both groups agreed on the seriousness of the problem.

Table 6 details the treatment modalities recommended by participants. Participants were provided with a list of treatment modalities and were asked to indicate which they would recommend for the vignette’s client; participants were not limited in the number of modalities they could choose. The majority of both NASW-IL participants...
and NACSW participants identified couple’s therapy as a recommended treatment modality; 62.02% of NASW-IL participants chose this modality and 67.28% of NACSW participants chose this modality. Individual therapy was identified as a recommended treatment modality by 28.68% of NASW-IL participants and 23.46% of NACSW participants. Family therapy, identified by 5.43% of NASW-IL participants and 4.32% of NACSW participants, was the third most frequently recommended treatment modality. Thus, both groups appear to be in agreement of choice of treatment modalities.

Table 6. Recommended Treatment Modality: Vignette I

<table>
<thead>
<tr>
<th>Treatment Modality</th>
<th>NASW-IL Relative Frequency</th>
<th>NACSW Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Therapy</td>
<td>28.68%</td>
<td>23.46%</td>
</tr>
<tr>
<td>Couple’s Therapy</td>
<td>62.02%</td>
<td>67.28%</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>5.43%</td>
<td>4.32%</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>0.78%</td>
<td>-</td>
</tr>
<tr>
<td>Psychiatric Assessment</td>
<td>0.78%</td>
<td>1.23%</td>
</tr>
<tr>
<td>No Treatment Necessary</td>
<td>0.78%</td>
<td>-</td>
</tr>
<tr>
<td>Referral to Other Provider/Service</td>
<td>1.55%</td>
<td>3.70%</td>
</tr>
</tbody>
</table>

Responses to Vignette I: Additional Assessment Information. Participants were asked to provide their own text responses to the question: “What additional assessment information would you request to create a plan for moving forward with this client?” Participants provided 189 unique responses to this question, the majority of which consisted of requests for additional information that fell within one of the
following assessment areas: Conflict Management Skills; Premarital Inventory; Couple’s Relationship History; Mental Health History/Assessment; Religious or Spiritual Beliefs; or Family/Social History. Each of these assessment areas was cited by a minimum of 10% of at least one of the two participant groups. Table 7 provides an overview of the identified assessment areas and the frequency with which they were referenced by the two participant groups.

Table 7. Additional Assessment Requests: Vignette I

<table>
<thead>
<tr>
<th>Additional Assessment Information Needed</th>
<th>NASW-IL</th>
<th>NACSW</th>
<th>Test Statistic</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict Management Skills</td>
<td>28.57%</td>
<td>21.67%</td>
<td>( \chi^2 = 1.33 )</td>
<td>0.25</td>
</tr>
<tr>
<td>Premarital Inventory</td>
<td>1.10%</td>
<td>13.33%</td>
<td>Fisher’s exact test</td>
<td>0.001*</td>
</tr>
<tr>
<td>Couple’s Relationship History</td>
<td>23.08%</td>
<td>20.83%</td>
<td>( \chi^2 = 0.15 )</td>
<td>0.70</td>
</tr>
<tr>
<td>Mental Health History/Assessment</td>
<td>13.19%</td>
<td>6.67%</td>
<td>( \chi^2 = 2.56 )</td>
<td>0.11</td>
</tr>
<tr>
<td>Religious or Spiritual Beliefs</td>
<td>51.65%</td>
<td>50.83%</td>
<td>( \chi^2 = 0.01 )</td>
<td>0.91</td>
</tr>
<tr>
<td>Family/Social History</td>
<td>50.55%</td>
<td>45.83%</td>
<td>( \chi^2 = 0.46 )</td>
<td>0.50</td>
</tr>
</tbody>
</table>

Note: *p < .05

**Significant difference in response to Vignette I: Additional assessment requests**

For Premarital Inventory. To determine whether the differences in frequencies between these two groups were statistically significant, observed frequencies were inputted into an interactive calculation tool for chi-square tests of goodness of fit and independence (Preacher, 2001); Fisher’s exact test was used to analyze frequencies that were too small to be appropriately analyzed with the chi-square test. As shown in Table 7, Premarital Inventory was the only assessment area that NASW-IL participants and NACSW
participants referenced at statistically significant different frequencies. It was referenced by 13.33% of NACSW participants and was the 5th most frequently referenced assessment area by this group, but it was only referenced by one NASW-IL participant. A premarital inventory is a tool or set of instruments, frequently used during premarital counseling, to prompt discussion on important and sometimes sensitive issues. Many participants cited specific premarital inventory tools in their response, including FOCCUS and PREPARE/ENRICH. Appendix M has examples of participant responses that were coded for referencing the assessment area of Premarital Inventory as well as the other identified assessment areas.

**Responses to Vignette I: Application of Clinical Theory.** The next question on the questionnaire asked participants to provide their own text response to the question: What clinical theory(s) would you apply in your work with this client? If you believe your approach would be eclectic, please indicate what theories you would intend to apply. Systems/Family Systems Theory, Cognitive Behavior Theory, and Psychodynamic Theory emerged as predominant in their use by both NASW-IL participants and NACSW participants. Refer to Table 8 for a listing of the primary clinical theories identified for treatment of the client(s) in the first vignette, the frequency with this they were referenced by each group, and information as to whether the differences in frequencies between these two groups were statistically significant. Appendix N has examples of participant responses that were coded for referencing each clinical theory; additionally, the 9 responses that were coded as referencing Faith-based Therapy can be found in their entirety in Appendix K.
Table 8. Clinical Theories Identified: Vignette I

<table>
<thead>
<tr>
<th>Clinical Theory</th>
<th>NASW-IL</th>
<th>NACSW</th>
<th>Test Statistic</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eclectic</td>
<td>51.65%, N = 47</td>
<td>35.83%, N = 43</td>
<td>$\chi^2 = 5.292$</td>
<td>0.021*</td>
</tr>
<tr>
<td>Systems/Family Systems Theory</td>
<td>45.05%, N = 41</td>
<td>35.00%, N = 42</td>
<td>$\chi^2 = 2.193$</td>
<td>0.139</td>
</tr>
<tr>
<td>Cognitive-Behavioral Theory</td>
<td>32.97%, N = 30</td>
<td>28.33%, N = 34</td>
<td>$\chi^2 = 0.529$</td>
<td>0.468</td>
</tr>
<tr>
<td>Psychodynamic Theory</td>
<td>29.67%, N = 27</td>
<td>10%, N = 12</td>
<td>$\chi^2 = 13.29$</td>
<td>0.001**</td>
</tr>
<tr>
<td>Faith-based Therapy</td>
<td>-</td>
<td>7.50%, N = 9</td>
<td>Fisher’s exact test</td>
<td>0.011*</td>
</tr>
</tbody>
</table>

Note: *p < .05, **p < .001

**Significant difference in response to Vignette I: Application of Eclectic Approach.**

51.65% of NASW-IL participants and 35.83% of NACSW participants indicated that they would be eclectic in their approach. Participants indicated this through direct use of the word “eclectic” in their response or through the citing of multiple theories. NASW-IL participants referenced Eclectic approaches significantly more often than NACSW participants. NASW-IL participants were most inclined to have eclectic approaches that included both Systems/Family Systems Theory and Psychodynamic Theory (N = 12) or Cognitive-Behavioral Theory and Systems/Family Systems Theory (N = 11). NACSW participants were most inclined to have eclectic approaches that included use of Cognitive-Behavioral Theory and Systems/Family Systems Theory (N = 10) or Systems/Family Systems Theory and Faith-based Theory (N = 4). Seven out of the 9 NACSW participants who referenced use of a faith-based approach indicated that it would be part of an eclectic treatment approach; Cognitive-Behavioral Theory, Psychodynamic Theory, Problem Solving Therapy, Solution Focused Therapy, Humanistic-Existential Theory, and Strength-based Perspective were also referenced for use in conjunction with a faith-based approach.
Responses to Vignette I: Clinical Interventions or Resources. Participants were asked to respond to the open-ended question: What clinical interventions or resources (secular, religious and/or spiritual) might you use with this client? Participant responses were varied and unique, and a number of categories were created in ATLAS.ti to capture the range of recommended treatment interventions including: CBT Techniques; Communication/Conflict Resolution; Decision Making and Problem Solving; Family Systems Strategies; Religious or Spiritually-Derived Intervention; and Use of Therapeutic Relationship. Of these, three response categories contained treatment interventions referenced by at least 10% of either participant group and none of these differed on a statistically significant level. Table 9 provides an overview of these categories and the frequency with which they were referenced by the two participant groups, and Appendix O has examples of participant responses that were sorted to create each of the identified clinical interventions categories.

Table 9. Clinical Interventions or Resources: Vignette I

<table>
<thead>
<tr>
<th>Clinical Interventions</th>
<th>NASW-IL (%)</th>
<th>NACSW (%)</th>
<th>Test Statistic</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication/Conflict resolution</td>
<td>18.68, N = 17</td>
<td>20.83, N = 25</td>
<td>$\chi^2 = 0.15$</td>
<td>0.698</td>
</tr>
<tr>
<td>Family Systems Strategies</td>
<td>12.09, N = 11</td>
<td>8.33, N = 10</td>
<td>$\chi^2 = 0.814$</td>
<td>0.367</td>
</tr>
<tr>
<td>Religious or Spiritually-Derived Intervention</td>
<td>49.45, N = 45</td>
<td>54.17, N = 65</td>
<td>$\chi^2 = 0.461$</td>
<td>0.497</td>
</tr>
</tbody>
</table>

Responses to Vignette I: Motivation for therapy. The final question for the first vignette was how motivated the participants thought the client was for therapy. Participants were asked to rate the degree of client’s motivation on a 7-point scale wherein 1 indicated “not motivated” and 7 indicated “very motivated”. The
overwhelming majority in both groups, 94.25% of NASW-IL participants and 90.60% of NACSW participants, rated the client’s motivation as a 4 or above indicating that they considered the client to be, at least, somewhat to moderately motivated. 17.24% of NASW-IL participants and 11.11% of NACSW participants rated the client at 7, the highest level of motivation. Thus, both groups appear to be in agreement on the client’s level of motivation for therapy.

**Responses to Vignette I: Summary.** Table 10 provides an overview of the significant differences in how NASW-IL participants and NACSW participants responded to the clinical material presented in Vignette I. In summary, NASW-IL participants were more likely than NACSW participants to identify Anxiety/Stress and Conflict Resolution and Decision Making as presenting problems for Vignette I. NACSW participants were, in turn, more likely to identify the presenting problem as having a Religious or Spiritual Component. NACSW participants were also more likely to request the completion of a Premarital Inventory for additional assessment information. Finally, NASW-IL participants were more likely to utilize Psychodynamic Theory and/or an Eclectic theoretical approach, while NACSW participants were more likely to make use of Faith-based Therapy.
Table 10. Summary of Significant Differences: Vignette I

<table>
<thead>
<tr>
<th></th>
<th>NASW-IL</th>
<th>NACSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenting Problem</td>
<td>Anxiety/Stress was referenced with greater frequency</td>
<td>Religious or Spiritual Component was referenced with greater frequency</td>
</tr>
<tr>
<td></td>
<td>Conflict Resolution and Decision Making was referenced with greater frequency</td>
<td></td>
</tr>
<tr>
<td>Degree of Seriousness</td>
<td>No Difference</td>
<td>No Difference</td>
</tr>
<tr>
<td>Treatment Modality</td>
<td>No Difference</td>
<td>No Difference</td>
</tr>
<tr>
<td>Additional Assessment Requests</td>
<td>No Difference</td>
<td>Premarital Inventory was referenced with greater frequency</td>
</tr>
<tr>
<td>Clinical Theories</td>
<td>Eclectic was referenced with greater frequency</td>
<td>Faith-based Therapy was referenced with greater frequency</td>
</tr>
<tr>
<td></td>
<td>Psychodynamic Theory was referenced with greater frequency</td>
<td></td>
</tr>
<tr>
<td>Treatment Interventions</td>
<td>No Difference</td>
<td>No Difference</td>
</tr>
<tr>
<td>Degree of Motivation</td>
<td>No Difference</td>
<td>No Difference</td>
</tr>
</tbody>
</table>

**Questionnaire Results: Vignette II**

The second case vignette presented Tom, a 57-year-old who has been irritable and moody:

Tom is a 57 year old married father of two. He works full time as a successful physical therapist with an outpatient clinic that has grown over the years. He and his wife have been married for 27 years and have two adult daughters ages 24 and 21, who no longer live in the family home. Tom’s wife encouraged him to talk to a therapist because he’d been irritable and moody over the last month and a half. Tom acknowledges that he’s been down and states that he feels directionless in his life right now. He reports that he and his wife left their church within the past year.
and that his eldest daughter recently got engaged, but he denies any other significant life changes. In talking with him, Tom shares that he’s been questioning the purpose of his life and he expresses some hopelessness that his life has no true meaning. Tom reports that recent natural disasters around the world have brought to the surface thoughts about his own mortality as well as unresolved feelings regarding the loss of his parents (his father died 11 years ago and his mother 5 years ago). Tom expresses some feelings of guilt and regret that he could have been a better son as well as wonders whether he has been a good father to his daughters.

Responses to Vignette II: Presenting Problem. Just as in the first vignette, participants were presented with a series of questions purposed to explore whether identical clinical material presented to NASW-IL members and NACSW members would lead to different treatment conceptualizations and interventions. Participants were first asked to identify the primary presenting problem(s) in the case and were provided space to enter their unique, open-ended responses. Five presenting problems emerged as predominant with regards to the frequency they were reported by participants: Depression/Low Mood; Developmental/Midlife Crisis; Existential/Identity Issues; Grief/Loss; and Religious or Spiritual Component. Each of these presenting problems was cited by a minimum of 10% of either participant group. Table 11 provides a listing of presenting problems and the frequency with which they were cited by both participant groups. Depression/Low Mood was the only presenting problem identified by NASW-IL participants and NACSW participants at a statistically significant difference in frequency.
Table 11. Presenting Problems: Vignette II

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>NASW-IL</th>
<th>NACSW</th>
<th>Test Statistic</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression/Low Mood</td>
<td>65.93%; N = 60</td>
<td>49.17%; N = 59</td>
<td>$\chi^2 = 5.92$</td>
<td>0.01*</td>
</tr>
<tr>
<td>Developmental/Midlife Crisis</td>
<td>38.46%; N = 35</td>
<td>28.33%; N = 34</td>
<td>$\chi^2 = 2.41$</td>
<td>0.12</td>
</tr>
<tr>
<td>Existential/Identity Issues</td>
<td>26.37%; N = 24</td>
<td>25.83%; N = 31</td>
<td>$\chi^2 = 0.01$</td>
<td>0.93</td>
</tr>
<tr>
<td>Grief/Loss</td>
<td>28.57%; N = 26</td>
<td>23.33%; N = 28</td>
<td>$\chi^2 = 0.75$</td>
<td>0.39</td>
</tr>
<tr>
<td>Religious or Spiritual Component</td>
<td>18.68%; N = 17</td>
<td>29.17%; N = 35</td>
<td>$\chi^2 = 3.06$</td>
<td>0.08</td>
</tr>
</tbody>
</table>

Note: *p < .05

Responses to Vignette II: Degree of Seriousness and Treatment Modality.

Following identification of the vignette’s presenting problem(s), participants were asked to rate the presenting problem(s) degree of seriousness and indicate a recommended treatment modality. To rate the degree of seriousness participants were provided with a 7-point scale wherein 1 indicated “not serious” and 7 indicated “very serious”. 95.56% of NASW-IL participants and 95.41% of NACSW participants rated the client’s presenting problem(s) as a 4 or above, indicating that they considered the problem to be, at least, somewhat to moderately serious. Thus, both groups agreed on the seriousness of the problem.

Participants were provided with a list of treatment modalities and were asked to indicate which they would recommend for the vignette’s client; participants were not limited in the number of modalities they could choose. 66.67% of NASW-IL participants and 58.56% of NACSW participants identified individual therapy as a recommended
treatment modality. Couple’s therapy and psychiatric assessment were also treatment modalities that were identified by over 10% of both participant groups. Table 12 details the treatment modalities recommended by participants. There were no significant differences between the two groups of participants on recommended treatment modality.

Table 12. Recommended Treatment Modality: Vignette II

<table>
<thead>
<tr>
<th>Treatment Modality</th>
<th>NASW-IL Relative Frequency</th>
<th>NACSW Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Therapy</td>
<td>66.67%</td>
<td>58.56%</td>
</tr>
<tr>
<td>Couple’s Therapy</td>
<td>10.08%</td>
<td>12.15%</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>2.33%</td>
<td>6.63%</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>3.10%</td>
<td>4.42%</td>
</tr>
<tr>
<td>Psychiatric Assessment</td>
<td>15.50%</td>
<td>12.15%</td>
</tr>
<tr>
<td>Referral to Other Provider/Service</td>
<td>2.33%</td>
<td>6.08%</td>
</tr>
</tbody>
</table>

**Responses to Vignette II: Additional Assessment Information.** Participants were asked to provide their own text responses to the question: “What additional assessment information would you request to create a plan for moving forward with this client?” The majority of participant responses consisted of requests for additional information that fell within one of the following assessment areas: Family/Social History; Grief and Loss; Medical History; Mental Health History; Psychological Wellbeing Components; and Religious or Spiritual History. Each of these assessment areas was cited by a minimum of 10% within both participant groups. Table 13 provides an overview of the identified assessment areas and the frequency with which they were referenced by the two participant groups. Appendix Q can be reviewed for examples of participant responses that were coded as referencing these assessment areas.
To determine whether the differences in frequencies between these two groups were statistically significant, observed frequencies were inputted into an interactive calculation tool for chi-square tests or goodness of fit and independence (Preacher, 2001). This process determined that there was a statistically significant difference between NASW-IL participants and NACSW participants requested additional assessment information for Mental Health History. NASW-IL participants were significantly more likely to reference this area than NACSW participants.

**Responses to Vignette II: Application of Clinical Theory.** The next question on the questionnaire asked participants to provide their own text response to the question: What clinical theory(s) would you apply in your work with this client? If you believe your approach would be eclectic, please indicate what theories you would intend to apply. Participant responses were analyzed with the assistance of ATLAS.ti, and five theoretical approaches were referenced by at least 10% of either participant group: Cognitive-Behavioral Therapy; Faith-based Therapy; Humanistic-Existential Theory; Psychodynamic Theory; and Systems/Family Systems Theory. Table 14 provides a

<table>
<thead>
<tr>
<th>Additional Assessment Information Needed</th>
<th>NASW-IL</th>
<th>NACSW</th>
<th>Test Statistic</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family/Social History</td>
<td>59.34%; N = 54</td>
<td>46.67%; N = 56</td>
<td>$\chi^2 = 3.33$</td>
<td>0.068</td>
</tr>
<tr>
<td>Grief and Loss</td>
<td>13.19%; N = 12</td>
<td>13.83%; N = 13</td>
<td>$\chi^2 = 0.27$</td>
<td>0.601</td>
</tr>
<tr>
<td>Medical History</td>
<td>17.58%; N = 16</td>
<td>22.50%; N = 27</td>
<td>$\chi^2 = 0.77$</td>
<td>0.38</td>
</tr>
<tr>
<td>Mental Health History</td>
<td>58.24%; N = 53</td>
<td>35.00%; N = 42</td>
<td>$\chi^2 = 11.29$</td>
<td>0.001*</td>
</tr>
<tr>
<td>Psychological Wellbeing Components</td>
<td>23.08%; N = 21</td>
<td>21.67%; N = 26</td>
<td>$\chi^2 = 0.06$</td>
<td>0.808</td>
</tr>
<tr>
<td>Religious or Spiritual Beliefs</td>
<td>35.16%; N = 32</td>
<td>44.17%; N = 53</td>
<td>$\chi^2 = 1.74$</td>
<td>0.187</td>
</tr>
</tbody>
</table>

Note: *p < .05
listing of the primary clinical theories identified for treatment of the client(s) in the second vignette, the frequency with which they were referenced by participant groups, and whether there was a statistically significant difference between the groups’ use of theory. Appendix R provides examples of participant responses that were coded as referencing Cognitive-Behavioral Therapy; Humanistic-Existential Theory; Psychodynamic Theory; and Systems/Family Systems Theory. Appendix S lists all 13 responses that were sorted into the category of Faith-based Therapy in their entirety.

Table 14. Clinical Theories Identified: Vignette II

<table>
<thead>
<tr>
<th>Clinical Theory</th>
<th>NASW-IL</th>
<th>NACSW</th>
<th>Test Statistic</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive-Behavioral Theory</td>
<td>46.15%; N = 42</td>
<td>36.67%; N = 44</td>
<td>$\chi^2 = 1.929$</td>
<td>0.16</td>
</tr>
<tr>
<td>Eclectic</td>
<td>47.25%; N = 43</td>
<td>34.17%; N = 41</td>
<td>$\chi^2 = 3.699$</td>
<td>0.05*</td>
</tr>
<tr>
<td>Faith-based Therapy</td>
<td>1.10%; N = 1</td>
<td>10.00%; N = 12</td>
<td>Fisher’s exact test</td>
<td>0.01*</td>
</tr>
<tr>
<td>Humanistic-Existential Theory</td>
<td>18.68%; N = 17</td>
<td>14.17%; N = 17</td>
<td>$\chi^2 = 0.78$</td>
<td>0.38</td>
</tr>
<tr>
<td>Psychodynamic Theory</td>
<td>32.97%; N = 30</td>
<td>12.50%; N = 15</td>
<td>$\chi^2 = 12.92$</td>
<td>0.001**</td>
</tr>
<tr>
<td>Systems/Family Systems Theory</td>
<td>21.98%; N = 20</td>
<td>9.17%; N = 11</td>
<td>$\chi^2 = 6.77$</td>
<td>0.01*</td>
</tr>
</tbody>
</table>

Note: *p < .05, **p < .001

**Significant differences in response to Vignette II: Application of Eclectic Approach.** NASW-IL participants were significantly more likely to reference eclectic approaches than NACSW participants. Participants indicated an eclectic approach through direct use of the word “eclectic” in their response or through the citing of multiple theories. NASW-IL participants were most inclined to have eclectic approaches that included Cognitive-Behavioral Theory and Psychodynamic Theory (N = 10) or
Cognitive-Behavioral Theory and Systems/Family Systems Theory (N = 7). NACSW participants were most inclined to have eclectic approaches that included Cognitive-Behavioral Theory and Humanistic-Existential Theory (N = 7). All 12 of the NACSW participants who referenced use of a faith-based approach indicated that it would be part of an eclectic treatment approach. Faith-based approaches were most frequently combined with Humanistic-Existential Theory (N = 5), Cognitive-Behavioral Theory (N = 5), and/or Psychodynamic Theory (N = 4).

**Responses to Vignette II: Clinical interventions or resources.** Participants were asked to respond to the open-ended question: What clinical interventions or resources (secular, religious and/or spiritual) might you use with this client? A number of categories were created in ATLAS.ti to capture the variety of recommended clinical interventions, including: CBT Techniques; Encourage Involvement in Activities; Grief/Loss; Group Work; Homework/Bibliotherapy; Medical/Psychiatric Evaluation; Religious or Spiritually-Derived Intervention; Stress Management Techniques; Couple’s Therapy or Family Systems Strategies; and Use of Therapeutic Relationship. Of these, five response categories contained treatment interventions referenced by at least 10% of either participant group. Table 15 provides an overview of these categories, the frequency with which each group referenced the interventions, and whether there was a statistically significant difference between the groups’ use of the interventions. There were statistically significant differences between how frequently NASW-IL and NACSW participants referenced CBT Techniques, Religiously or Spiritually-Derived Intervention,
and Use of Therapeutic Relationship. Appendix T has examples of participant responses that were coded under each category of clinical intervention.

Table 15. Clinical Interventions: Vignette II

<table>
<thead>
<tr>
<th>Clinical Interventions</th>
<th>NASW-IL</th>
<th>NACSW</th>
<th>Test Statistic</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT Techniques</td>
<td>13.19%, N = 12</td>
<td>5.00%, N = 6</td>
<td>$\chi^2 = 4.44$</td>
<td>0.03*</td>
</tr>
<tr>
<td>Medical/Psychiatric Evaluation</td>
<td>15.38%, N = 14</td>
<td>8.33%, N = 10</td>
<td>$\chi^2 = 2.55$</td>
<td>0.11</td>
</tr>
<tr>
<td>Religious or Spiritually-Derived Intervention</td>
<td>41.76%, N = 38</td>
<td>59.17%, N = 71</td>
<td>$\chi^2 = 6.28$</td>
<td>0.01*</td>
</tr>
<tr>
<td>Couple’s Therapy or Family Systems Strategies</td>
<td>15.38%, N = 14</td>
<td>12.54%, N = 15</td>
<td>$\chi^2 = 0.36$</td>
<td>0.55</td>
</tr>
<tr>
<td>Use of Therapeutic Relationship</td>
<td>29.67%, N = 27</td>
<td>15.00%, N = 18</td>
<td>$\chi^2 = 6.64$</td>
<td>0.01*</td>
</tr>
<tr>
<td>More Information Needed</td>
<td>5.49%, N = 5</td>
<td>2.50%, N = 3</td>
<td>Fisher’s exact test</td>
<td>0.29</td>
</tr>
</tbody>
</table>

Note: *p < .05

**Responses to Vignette II: Motivation for treatment.** The final question participants were asked to respond to in relation to the second vignette was how motivated they thought the client was for therapy. Participants were asked to rate the degree of client’s motivation on a 7-point scale wherein 1 indicated “not motivated” and 7 indicated “very motivated”. There were no participants in either group who rated the client’s motivation at the level 1 minimum on the scale. 84.27% of NASW-IL participants and 86.92% of NACSW participants rated the client’s motivation as a 4 or above, indicating that they considered the client to be, at least, somewhat to moderately motivated. 3.37% of NASW-IL participants and 2.80% of NACSW participants rated the client at 7, the highest level of motivation. Thus, there were no differences between the two groups on their responses to this question.
Responses to Vignette II: Summary of significant differences. Table 16 provides an overview of the significant differences in how NASW-IL participants and NACSW participants responded to the clinical material presented in Vignette II. In summary, NASW-IL participants were more likely than NACSW participants to identify Depression/Low Mood as presenting problems for Vignette II. NASW-IL participants were also more likely to request client Mental Health History for additional assessment information. NASW-IL participants were more likely to utilize Psychodynamic Theory, Systems/Family Systems Theory, or an Eclectic theoretical approach, and NACSW participants were more likely to make use of Faith-based Therapy. Finally, with regards to treatment interventions, NASW-IL participants were more likely to use CBT Techniques, the Therapeutic Relationship, or an intervention categorized under Other, and NACSW participants were more likely to make use of a Religious or Spiritually-Derived Intervention.

Table 16. Summary of Significant Differences: Vignette II

<table>
<thead>
<tr>
<th></th>
<th>NASW-IL</th>
<th>NACSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenting Problem</td>
<td>Depression/Low Mood was referenced with greater frequency</td>
<td>No Difference</td>
</tr>
<tr>
<td>Degree of Seriousness</td>
<td>No Difference</td>
<td>No Difference</td>
</tr>
<tr>
<td>Treatment Modality</td>
<td>No Difference</td>
<td>No Difference</td>
</tr>
<tr>
<td>Additional Assessment Requests</td>
<td>Mental Health History was referenced with greater frequency</td>
<td>No Difference</td>
</tr>
<tr>
<td>Clinical Theories</td>
<td>Eclectic was referenced with greater frequency</td>
<td>Faith-based Therapy was referenced with greater</td>
</tr>
<tr>
<td></td>
<td>frequency</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Psychodynamic Theory</td>
<td>referenced with greater frequency</td>
<td></td>
</tr>
<tr>
<td>Systems/Family Systems</td>
<td>Theory was referenced with greater frequency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>frequency</td>
<td></td>
</tr>
<tr>
<td>Treatment Interventions</td>
<td>CBT Techniques was referenced with greater frequency</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Use of Therapeutic Relationship was referenced with greater frequency</td>
<td></td>
</tr>
<tr>
<td>Religious or Spiritually-</td>
<td>Intervention was referenced with greater frequency</td>
<td></td>
</tr>
<tr>
<td>Derived Intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degree of Motivation</td>
<td>No Difference</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Difference</td>
<td></td>
</tr>
</tbody>
</table>

**Questionnaire Results: Summary of Responses to Vignettes I & II**

NACSW participants and NASW-IL participants shared many similarities in how they responded to the vignettes. There were no significant differences between the groups with regards to how they responded to questions about the seriousness of the presenting problem(s), the choice of treatment modality, and the client’s degree of motivation. Further, the two groups identified many of the same presenting problems, made similar assessment requests, cited many of the same clinical theories, and named corresponding treatment interventions. There were also, however, a number of statistically significant differences between how the NACSW participants and NACSW-IL participants responded to the vignettes. Table 17 summarizes the response differences and similarities.
Table 17. Summary of Responses for Vignettes I and II

<table>
<thead>
<tr>
<th>Presenting Problems</th>
<th>NASW-IL</th>
<th>NACSW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression/Low Mood identified more frequently</td>
<td>Religious or Spiritual Component identified more frequently</td>
<td></td>
</tr>
<tr>
<td>Anxiety/Stress identified more frequently</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conflict Resolution and Decision Making identified more frequently</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified Similarly:</td>
<td>Identified Similarly:</td>
<td></td>
</tr>
<tr>
<td>• Communication Issues</td>
<td>• Communication Issues</td>
<td></td>
</tr>
<tr>
<td>• Family of Origin and Differentiation</td>
<td>• Family of Origin and Differentiation</td>
<td></td>
</tr>
<tr>
<td>• Developmental/Midlife Crisis</td>
<td>• Developmental/Midlife Crisis</td>
<td></td>
</tr>
<tr>
<td>• Existential/Identity Issues</td>
<td>• Existential/Identity Issues</td>
<td></td>
</tr>
<tr>
<td>• Grief/Loss</td>
<td>• Grief/Loss</td>
<td></td>
</tr>
<tr>
<td>• Religious or Spiritual Component</td>
<td>• Religious or Spiritual Component</td>
<td></td>
</tr>
</tbody>
</table>

| Degree of Seriousness | No Difference | No Difference |
| Treatment Modalities | No Difference | No Difference |
| Additional Assessment Requests | Mental Health History identified more frequently | Premarital Inventory identified more frequently |
| Identified Similarly: | Identified Similarly: |
| • Conflict Management Skills | • Conflict Management Skills |
| • Couple’s Relationship History | • Couple’s Relationship History |
| • Mental Health History/Assessment | • Mental Health History/Assessment |
| • Religious or Spiritual Beliefs | • Religious or Spiritual Beliefs |
| • Family/Social History | • Family/Social History |
| • Grief/Loss | • Grief/Loss |
| • Medical History | • Medical History |
| • Psychological Wellbeing | • Psychological Wellbeing |

<p>| Clinical Theories | Eclectic identified more frequently | Faith-based Therapy identified more frequently |
| Psychodynamic Theory identified | | |</p>
<table>
<thead>
<tr>
<th></th>
<th>Treatment Interventions</th>
<th>Degree of Motivation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cognitive-Behavioral Theory</td>
<td>No Difference</td>
</tr>
<tr>
<td></td>
<td>Humanistic-Existential Theory</td>
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</tr>
<tr>
<td>Identified Similarly:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT Techniques identified more frequently</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Use of Therapeutic Relationship identified more frequently</td>
<td></td>
</tr>
<tr>
<td>Identified Similarly:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communication/Conflict Resolution</td>
<td></td>
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<tr>
<td></td>
<td>Family Systems Strategies</td>
<td></td>
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<tr>
<td></td>
<td>Medical/Psychiatric Evaluation</td>
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<tr>
<td></td>
<td>Couple’s Therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More information needed</td>
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<tr>
<td></td>
<td>Religious or Spiritually-Derived Intervention</td>
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<td></td>
<td>identified more frequently</td>
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<tr>
<td>Identified Similarly:</td>
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<td></td>
<td>Communication/Conflict Resolution</td>
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<td>Family Systems Strategies</td>
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<td>Medical/Psychiatric Evaluation</td>
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<td>Couple’s Therapy</td>
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<td></td>
<td>More information needed</td>
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**Focus Group Results**

At the conclusion of the online Opinion survey, participants were invited to submit their contact information to volunteer for focus group discussion. Participants were notified of the goal to keep focus groups homogenous with regards to participants’ self-identification as Christian or secular in their social work practice, and they were asked to self-select which group they should be placed in accordingly. Nine participants volunteered for the Secular focus group and 6 participants volunteered for the Christian focus group. Based on participant availability, efforts to coordinate dates/times for focus group sessions resulted in the scheduling of 4 participants for the Secular focus group.
session and 4 participants for the Christian focus group session. Subsequently, 2 of the 4 scheduled participants presented for the Secular focus group session and 3 of the 4 scheduled participants presented for the Christian focus group session. Due to a failure in attendance, participant number for the Secular focus group fell below the set minimum of 3; rather than cancel the group, however, the decision was made to gather the limited data that could be obtained from the 2 participants who presented. This decision was seen as preferable to canceling the group because it demonstrated respect for the time and energy invested by those who presented as well as respect for the value of the opinions and viewpoints they could provide. Focus group sessions were audio-taped and then transcribed by a professional transcriptionist. Transcripts were loaded into ATLAS.ti for assistance with content analysis.

The intent of the focus groups was to address the following research questions:

How do Christian Social Workers and Secular Social Workers view their training and clinical skills relative to identifying and responding to client problems of a religious and/or spiritual nature or client problems with a religious and/or spiritual component? Is there a set of clinical skills expected from Christian social workers and not secular social workers? What clinical issues prompt a referral to a faith-based provider (Christian Social Worker, pastoral counselor, priest, pastor, chaplain, rabbi)? These broad questions were approached through a series of 12 questions, found in Appendix G, which inquired about training and experiences in the clinical setting as well as opinions about the interface of spirituality and social work.
Focus Group Responses: Training Related to Addressing Religious or Spiritual Matters in Clinical Practice

Participants in both the Christian and Secular focus groups reported little, if any, exposure to religion and spirituality in their masters of social work programs. Two of the three participants in the Christian focus group reported that broad overviews of the topic were embedded in cultural diversity courses but, as one participant stated, “…they didn’t even offer as an extracurricular anything more focused on including spirituality…into your practice.” The other participants, both Christian and Secular, reported that their MSW programs didn’t prepare them to respond to client spirituality, noting, “…I can’t think of a single class that really focused on that as a topic/subject at all”, “I can’t remember anything that had to do with spirituality…this was ’81 and we really weren’t supposed to deal with spirituality in therapy”, and “I graduated almost 40 years ago through Loyola and in those days they didn’t bring in spirituality at that time…spirituality or religion just wasn’t brought in.”

Participants were asked if they’d pursued training or study outside of their MSW programs on the topic of spirituality or religion, and 2 of the 3 Christian focus group participants reported that they had not. The third Christian focus group participant cited membership to NACSW and the organization Social Work and Spirituality as sources of exposure to the topic. One Secular focus group participant echoed similar literature exposure, reporting that he had read “articles by researchers and clinicians who believed that spirituality should be a part of psychotherapy.” The same participant reported that he had taken workshops in mindfulness and stated “I absolutely consider mindfulness a
spiritual practice.” The second Secular focus group participant cited his Catholic upbringing and his participation in AA as sources of his spiritual base.

Focus Group Responses: Assessment and Identification of Religious or Spiritual Concerns in Clinical Practice

Participants were asked if their practice settings had formal or informal assessment tools for looking at client spirituality and/or religiosity. All Christian focus group participants indicated that client spirituality and/or religiosity was attended to during the intake process/initial assessment. One Christian focus group participant stated “…there’s one question that specifically focuses on like your spiritual beliefs and how important it is in your life” and another reported “…they’re asked if they’re a member of the church of if they’re a member of any denomination…. ” The third Christian focus group participant explained that client spirituality was looked at in the assessment process and then in subsequent treatment plan updates:

“In our assessment where I work we have about five questions asking what their spiritual beliefs are, if they think that will be helpful to their treatment, if they’re angry at god or a higher power and maybe that’s negatively impacting where they’re at. Then we have a form we use when we do treatment planning which we do ever six months that ask if they want to include… I forgot how it’s phrased but basically if they want to include their spirituality in their treatment…. ”

The Secular focus group participants reported informal efforts to assess client spirituality; one participant stated, “…if somebody brings it up and they talk about it, I’m definitely open to going there…”, and the second Secular focus group explained, “I don’t use any formal assessments, but… I’m always informally assessing.”
Focus group participants were asked if they would want to make changes to their practice settings’ assessment of spirituality and religion, and most participants indicated that change was not needed. The Christian focus group participant who reported that assessment included one question that focused on spiritual beliefs and their importance to clients stated, “I don’t know…I like it being open ended…I don’t necessarily want it changed.” Similarly, the Christian focus group participant who stated that assessment included five questions relative to spiritual beliefs stated, “Yeah, I agree, I like it open and to begin where the client is, which is a social work principle that we follow and if it is important to the client then we go with that at that point and what that means to the client’s life and issues.” The third Christian focus group participant, who reported that faith assessment at her practice site consisted of one question, expressed an interested in “having some sort of form like making sure that if a client is saying ‘I want to work on this’, that we’re actually including that into their treatment on a regular basis”; this was the only participant in either focus group who voiced interest in making changes to the assessment of spirituality/religion at his/her practice site.

Focus group participants were asked how often they identified a spiritual concern as a client’s presenting problem. Christian focus group participants reported that it was rare for them to encounter a spiritual concern as a client’s presenting problem: “I don’t know that I find it very often”; “Yeah, I also feel like it’s not very often…I never see it as the presenting problem”; and “Yeah, I think a very small chunk and usually typically it’s my more severe mentally ill participants and also it’s more like the guilt…But I wouldn’t say that’s their presenting problem. Their presenting problem is the fact that they have
very severe mental illness….” While the responses of the two Secular focus group participants did not indicate their perceptions of frequency, they did offer their perspectives on the question. One participant stated, “What I’m seeing now are people coming to me with concerns about...existential angst. They don’t come directly expressing, ‘I’ve got a crisis with God’; I don’t think I’ve had anybody like that.” The second Secular participant offered the following perspective: “…I think that’s open to interpretation. I think that there’s a part of me that has more recently begun to look at a lot of things that we consider biochemistry as potentially spiritual problems...that it’s possible that psychotic breaks are actually some sort of spiritual experience that if it was allowed to move through, if they were supported in moving through it, would cause an evolution to occur.”

Participants identified a number of problems in response to the question of whether there were specific types of presenting problems that were more or less likely to have a spiritual or religious component. One Christian focus group participant identified abortion and domestic violence, responding:

“...I know people who’ve chosen to have abortions before they come to me and have a tremendous amount of guilt and out of that can come self-incrimination and depression...also if you have the view that getting divorced is a sin and you’re in domestic violence, that creates quite a conflict because you need to protect yourself and your children. But depending on the church and support group they’re involved in may say you’re committed for life and you need to stay with that commitment. And that can be a conflict at times.”

A second Christian focus group participant reiterated the view that faith can impact decision making in situations of domestic violence, noting, “…their faith kind of plays a role in choosing whether or not to leave their partner in...domestic violence situations.”
The third Christian focus group participant identified guilt resulting from client’s family environment:

“…people who have really struggled with a guilt and stuff like that and it’s oftentimes how their family or like their grownup environment…view religion…whether it’s like, you know, looked down on them for not going to church on weekend so then they start having this, yeah, this identity issue almost…I’m thinking more about like many of my clients who are like came from Catholic families, pretty strict Catholic families….”

The Secular focus group participants discussed presenting problems that involve a loss of connection or meaning as more likely to have a spiritual or religious component. One Secular participant stated, “…I view substance abuse as having a spiritual basis…I think that it’s usually when people become so ego centric that they’ve lost their connecting to everything outside of themselves, anything bigger than themselves, that I see that as a spiritual problem.” The second Secular focus group participant added to the discussion: “I’m thinking about substance abuse, addictions, depression, anxiety that sort of I think a common core of those is a person not having – they can’t find a meaning in their lives. So in that sense, I think that all these things have a spiritual dimension.”

**Focus Group Responses: Responding to Religious or Spiritual Concerns in Clinical Practice**

Focus group participants were asked to consider how often they encounter clients who are interested in integrating spiritual beliefs and/or practices into treatment. Participant responses to this question varied. The first Christian focus group participant to respond to this question reported a range of 30% to 50% of her clients include spiritual beliefs and/or practices into treatment. She explained that “it might not be the core clinical work” and “we don’t really have a lot of dialogue about god” but that it is
“helping get them linked with a spiritual community and helping that expand their support system.” A second Christian focus group participant echoed this sentiment, “…in the therapy session it is definitely a very low percentage actually like talks about god or, yeah, their special beliefs and how that impacts. But…church as their support is oftentimes like encouraged….” The final Christian focus group participant expressed a sense of puzzlement at the lack of interest her clients tend to show:

“Even though it’s a church-related consult center I don’t see that very often people have clients wanting to talk about their faith or their spirituality and sometimes I really wonder about it…And then sometimes, it really amazes me. I had several clients that had been at the seminary and they never bring up their faith or god or what it means in their life and I think what is going on, you know, and why.”

One Secular focus group participant reported that “15-20% of the time” his clients spiritual beliefs were integrated into treatment, but he did not indicate in which ways they were integrated, and the second Secular focus group participant stated that his clients rarely had an interest in integrating their spiritual beliefs, rather “they’re very often totally shut off to it.”

Participants were asked whether they felt well equipped to integrate client spirituality into interventions. One Christian focus group participant described her ability to integrate prayer, when asked to do so directly by a client, and to “incorporate examples” from the bible “when it seems like it might fit.” She noted, however, that “another thing that sometimes occasionally comes up is where people ask me about my faith, and I find it kind of hard to define….” She explained that she feels she fits into the categories of “born again” or “evangelical”, but these categories have a “stereotype of today…it’s very negative or very extremely conservative or not understanding of a lot of
the realities of life that many people deal with”, and she does not feel she fits this stereotype. Another Christian focus group member echoed this sentiment:

“Yeah, I mean I definitely feel a lot of discomfort when it comes to like talking about…my faith. Or I don’t usually get asked that, I wouldn’t say and then like I usually just avoid it altogether if I get the talk...because I feel like in the society out there...it’s like people’s view of Christianity is not what I feel like I believe in you know...but I mean I guess I can in clinical practice...use examples from the bible that I know that they know to make a point....”

The third Christian focus group participant explained that she did not feel equipped to integrate client spirituality into interventions. She explained that she was familiar with the bible but felt additional training was needed in order to feel clinically confident in its use during sessions: “I feel like I would like to get additional training on that...even if it was just a onetime training get a training on like how to include bible stories in sessions and like when is the appropriate time to use that....” This participant also expressed confusion about how to integrate faith into practice while working for a secular agency. She stated, “I just feel like it’s this weird ethical, like I don’t know what’s appropriate” and noted that if she worked at Christian agency she “would have felt much more comfortable.” Secular focus group participants, on the other hand, expressed confidence about the prospect of integrating client spirituality into interventions. One stated, “I think being open minded is a real key to allowing spirituality to sort of seep in...and then if they don’t have anything going, there’s always – you know, it’s okay to just toss something out.” The second Secular focus group participant added, “It’s my willingness to learn from them and I think that that’s pretty much all I need to be equipped to deal with spirituality. It’s a genuine curiosity.”
Focus Group Responses: Referral Related to Religious or Spiritual Concerns in Clinical Practice

Participants were asked what clinical issues, if any, would prompt them to refer to a faith-based provider. One Christian focus group participant explained that she makes efforts to encourage clients to (re)connect with a church community once they have indicated an interest: “…ones that are struggling…[with] the guilt of feeling like I can’t go back to church because I’m doing all these bad things. You know, I do try to help link them up with the church community there.” Another Christian focus group participant agreed that she also encourages clients who have voiced an interest: “I feel like when the client brings up how like they want to. Like one lady I’m thinking of that brought it up, she’s already going to church and like wanted to talk to her pastor so I just encouraged her to do so.” With regards to specific clinical issues that would prompt a referral, however, this participant stated, “I don’t know. I don’t think I’ve really referred”; the third Christian focus group participant concurred, “I don’t know because it’s never come up.” Secular focus group participants echoed the sentiment that there were not any specific clinical issues that would prompt a referral but that a referral and/or encouragement to connect with a faith-based provider would occur once a client has indicated an interest: “…You know, somebody will tell me that they haven’t been to church for ten years, but they found it a great comfort, I’ll say well have you thought about that….”

Focus Group Responses: Interface of Spirituality and Social Work
Focus group participants were asked whether they felt social workers generally possess the knowledge and skill set to respond to spiritual issues in clinical practice. Christian focus group participants responded: not necessarily. Two Christian focus group participants identified self-awareness as a key component of being able to respond to spiritual issues in clinical practice:

“I think again it depends on where you’re at in your own faith journey and how comfortable you are with that whatever that faith journey is...You know, it depends how they feel about in their life experiences and how have they worked through in those life experiences whether they can be open or not.”

“I guess when it comes to like knowing your own spiritual beliefs and being comfortable with it, I almost feel like it’s similar to just like being a good clinician totally like you just knowing yourself...like to be a good clinician you need to be self aware and you need to figure what’s going on, like figure out your own issues is what I’m saying. I feel like a lot of social workers don’t. So I mean I think spirituality falls in part as a part of that, you know, and I think that’s what oftentimes is an issue just like in general.”

The third Christian focus group participant described a “level of judgment” from colleagues with regards to those who identify as Christian and linked this to a lack of training on spirituality:

“But I do think though in general that the level of training we get at least in my graduate program and even beyond that in terms of like regular CEUs that you get, there isn’t a lot that’s necessarily brought in about spiritual beliefs at all and definitely not in a purposeful way...I think that when you have settings and there’s no background...I think it then becomes really easy to sort of have this negative connotation in it. Like if you are very Christian – you know, if you’re a very strong Christian how that’s almost looked at negatively instead of positively.”

One secular focus group participant also commented on the current atmospheres of work environments as impacting how social workers respond to spirituality: “…the
environment we work in doesn’t encourage us to work that way. I think that we’ve been shaped.” The second secular focus group participant noted, “I don’t know many that many social workers would be able to answer that question fairly. All I can say is that I assure you that it’s sort of part of what a social worker is supposed to be and I hope a lot of them are.”

Participants were asked what changes they would make, if any, to how MSW programs prepare social workers to attend to spirituality. One Christian focus group participant initially questioned how it would be possible to improve MSW programs with regards to this issue:

“I think that’s a hard one because how do you teach spirituality?...And how do you talk about working – talking about the bible because each situation is different and where it might fit in and how it might be appropriate as opposed to offensive with your client. So I don’t know exactly how schools can better equip.”

The next Christian focus group participant to respond to the question emphasized the importance of offering training on this issue post master’s program. She explained that “…if you’re getting your masters in your early to mid-20s, I think where you are in your life when you enter your 30s, 40s, 50s is going to look a lot different...just like any other cultural competency, I think it would be good to make sure that it’s a key component” of continuing education. These comments prompted the initial Christian focus group respondent to suggest integrating content on spirituality and religion into courses that look at human behavior and human development – “As she’s talking, I’m wondering if it couldn’t be worked into the class in human behavior...what the spiritual environment or the religious environment growing up was like and what it – how that has impacted the client in adulthood. In some way work it into that more than a direct class on spirituality
in the bible.” This suggestion was endorsed by the third Christian focus group participant who stated, “…if it is incorporated in human behavior…that would be more helpful…I think it’s important to integrate that into throughout all the classes.” Secular focus group participants also recommended the integration of information on spirituality into existing courses focused on multicultural approaches; it was noted that ethnographic interviewing could be taught as a method of “teaching students to inquire.” Secular focus group participants also suggested that MSW programs could be improved by increasing the amount of information shared about diverse approaches to spirituality as well as offering a course on spirituality and psychotherapy as part of the core curriculum.

Participants were asked to share their thoughts on the idea of social work programs offering a specialty track or certification along the lines of spirituality. Secular focus group participants were in agreement that they did not think this was needed or appropriate at the MSW level, but the responses of the Christian focus group participants were mixed. One participant expressed that a specialty track would be off putting to her, and another participant explained that her endorsement of a specialty track would depend on its emphasis. She voiced concern about the prospect of counselors “imposing something on the client” and stressed that social workers need to be “compassionate and understanding and accepting and tolerate and accept the client wherever the client is at…. The third Christian focus group participant thought the idea of a specialization “would be neat.” She explained, “…I do think there is a market to have like more clinically trained counselors or therapists that also feel really equipped and whether it be in a Christian lens or you know any other spiritual lens….”
Christian focus group participants were asked to comment on whether there was a minimum skill set expected of those who would identify as Christian social workers. The first participant to respond to this question expressed concern about the clinical quality of Christian social workers – “It’s kind of bad but when I think of a Christian social worker I always often think…of somebody who’s not as equipped clinically but has a strong spiritual belief…I tend to think that like, you know, Christian counselors tend to impose their views way more than just a counselor.” Another participant noted that she had heard of client experiences with “questionable clinicians” and felt it was “kind of scary” that there is not a clear certification process for Christian social workers, and the third participant expressed that it was not a Christian social worker’s role to convert people or proselytize. As a whole, respondents were united in their emphasis that Christian social workers need to be equipped with strong clinical skills, good self-awareness, and a commitment to social work ethics, including meeting clients were they are at.

Focus Group Responses: Evidence of Ambivalence

Both focus groups identified faith matters as important and expressed a desire for more content on religion and spirituality in masters of social work programs; however, their comments also captured feelings of ambivalence and anxiety present within the field about how to move forward in addressing these topics in education and practice. Both groups reported little, if any, exposure to faith matters in their masters of social worker programs but expressed confidence in their own ability to assess and identify faith matters in practice. Both groups identified the ability to navigate faith matters as an important clinical skill but then stated that clients rarely presented with faith-based
concerns. Secular focus group participants voiced an appreciation for the role of faith in the lives of their clients but made disparaging comments that highlighted an underlying mistrust of clergy. Christian focus group participants asserted that the stereotypes about Christians inaccurately portrayed their views and motivates as Christian social workers but expressed concern that faith-focused social work courses would attract the oft-stereotyped Christian social worker. Finally, Christian focus group participants identified concerns about the ability of their Christian peers to balance a strong faith with sound clinical skills.
CHAPTER FIVE
DISCUSSION

Chapter five provides a thorough review and discussion of the major results of this two-phase study. Statistically significant response differences to the questionnaire and meaningful components of the focus group discussions are explored as this study’s implications for clinical practice and education are identified. Additionally, the limitations and related recommendations for future research are highlighted within the context of identifying this study’s implications for research.

Implications for Clinical Practice

This study compared the clinical practices of Christian social workers and secular social workers. The questionnaire presented participants with two vignettes and related question sets to pursue the question of whether identical clinical material presented to a Christian audience and a secular audience would lead to different treatment conceptualizations and interventions. Further, the focus group discussions explored how Christian social workers and secular social workers view their training and clinical skills relative to identifying and responding to client problems of a religious and/or spiritual nature.

A thorough review and analysis of participant responses to the questionnaire found that NACSW participants and NASW-IL participants shared many similarities in how they responded to the vignettes. There were no significant differences between the
groups with regards to how they responded to questions about the seriousness of the presenting problem, the choice of treatment modality, and the client’s degree of motivation. Further, the two groups identified many of the same presenting problems, made similar assessment requests, cited many of the same clinical theories, and named corresponding treatment interventions. There were also, however, a number of significant differences between the groups and their clinical social work perspectives and approaches.

In response to a vignette with an overt reference to religion, NASW-IL participants were more likely to: identify Anxiety/Stress and Conflict Resolution and Decision Making as presenting problems and more prone to be Eclectic and/or Psychodynamic in their theoretical approach. NACSW participants, on the other hand, were more likely to: identify a Religious or Spiritual Component to the presenting problem; use a Premarital Inventory to gather additional assessment information; and make use of a Faith-based Therapy. In response to a vignette with a subtle reference to religion, NASW-IL participants were more likely to: identify Depression/Low Mood; assess Mental Health History; use Psychodynamic and Systems/Family Systems theories; use interventions that relied on the therapeutic relationship; and apply CBT techniques. NACSW participants were more prone to make use of Faith-based Therapy and implement a Religious or Spiritually-Derived Intervention.

These findings suggest the presence of some variable(s) inherent to these two groups of participants that influenced their perception of, and response to, the clinical components of the vignettes. Participants were drawn from the NASW-IL and the NACSW membership lists in pursuit of obtaining two groups of participants that
diverged with regards to the variable of religiosity/religious identification. Results from
the standardized measures confirmed the two groups were different; NACSW participants
scored higher on these measures. Results also showed that these two groups differed on
some demographic and background characteristics. A significantly higher percentage of
NACSW participants reported: haven taken a credited class in religion; have taken a non-
credited class in religion; having current religious affiliation as Christian; and being a
current member in a church which further demonstrates the two groups are different on
religious practices and interests. In summary, these findings indicate that the sampling
method was successful in recruiting two groups of participants that diverged with regards
to their religiosity/religious identification.

It is possible that the variable of religiosity was related to the differing responses.
The NASW-IL group’s reduced religiosity may have led to greater adherence to a
scientific model of problem identification and treatment intervention – a model largely
embedded in the biopsychosocial sphere of wellness defined during the phase of
professionalization and secularization in the early to mid-1900s. While, in contrast, the
NACSW group’s higher degree of religiosity might have made them more prone to
approach the vignettes from a holistic perspective that incorporated the spiritual sphere of
wellness.

The ability to assert that degree of religiosity drove the observed response
differences is undercut by the presence of additional significant demographic differences
between the two groups. Statistical analysis indicated that the two groups differed
significantly with regards to the characteristics of race/ethnicity, age, and time spent
weekly with clients. The NASW-IL group tended to be less ethnically/racially diverse,
older in age, and spend more time per week in clinical interactions with clients. These differences must be considered and accounted for during the process of interpreting the results of this study.

While this study had few minority participants in general, the NASW-IL sample had three participants who identified as a race/ethnicity other than Non-Hispanic White and the NACSW group had fifteen, the impact of race/ethnicity on clinical perspective and practice cannot be overlooked or minimized. Race/ethnicity and culture create a lens through which clinical situations are viewed, interpreted, and approached. McGoldrick, Giodano, and Garcia-Preto (2005) stress the importance of attending to culture in therapy noting, “Only recently have we begun to consider the underlying cultural assumptions of our therapeutic models and of ourselves as therapists” (p. 3). It is possible that this variable contributed to the response differences between the two groups.

If the assumption is made that the variable of age was positively correlated with professional experience, then the NASW-IL group tended to have more professional experience and averaged more time spent weekly in clinical practice than the NACSW group. The degree to which this study’s participant group demographics were representative of their larger membership groups is unknown; however, the significant difference of time spent weekly with clients may be the result of a sampling bias in this study. NASW-IL, a group with a large membership base, required the selection of a Field of Practice (e.g., aging, child/family welfare, mental health, and school social work) during the process of mailing label rental. Due to the clinical focus of this study’s questionnaire, the decision was made to sample from the Mental Health field of practice membership labels. In contrast, due to NACSW’s smaller membership size their sample
was drawn from their entire membership pool. It is possible that the NACSW sample represented a broader array of practice fields, including those who might identify as strictly policy/administrative in their professional role. Therefore, the response differences to the vignettes might be the result of the NASW-IL group being more predisposed to clinical thinking.

While the intent of the study was to explore how religiosity impacted clinical conceptualization and treatment, these additional demographic differences suggest an alternative explanation for the groups’ responses to the vignettes: one would anticipate that a group of more professionally seasoned and clinically oriented social workers would respond differently to clinical material than a group of less experienced social workers with a broader array of professional identities. Perhaps the NASW-IL group’s propensity to identify mental health concerns, assess mental health history, and apply a wider variety of clinical theories was attributable to their greater clinical expertise rather than their level of religiosity. It is of concern, however, that this group of more seasoned clinicians did not recognize the religious components intentionally written into the case vignettes at the same frequency as their younger, less clinically oriented counterparts.

Focus group discussion further explored how Christian Social Workers and Secular Social Workers viewed their training and clinical skills relative to identifying and responding to client problems of a religious or spiritual nature or client problems with a religious or spiritual component. Participants in both the Christian and Secular focus groups reported that they received very little, if any, exposure to religion and spirituality in their masters of social work programs. Further, aside from one participant’s experience with mindfulness workshops, participants stated they had not received any structured
training on the topic of religion or spirituality subsequent to their MSW degrees. Despite this lack of formal or structured training, all participants expressed confidence in their own ability to assess and identify client problems of a religious or spiritual nature or problems with a religious or spiritual component. They reported, however, that it was rare for them to encounter such problems in clinical practice. Certainly the ability and propensity to recognize religious or spiritual concerns in clinical practice is influenced by the amount of training and education one has received in the area, but participants did not express concern that this dynamic impacted their self-report.

Participants were not as equally confident in their ability to respond to client interest in integrating spiritual or religious beliefs into treatment. The Christian social worker participants expressed feelings of uncertainty and anxiety about how to respond to questions about their own faith in clinical practice. One Christian social worker expressed concern that a lack of training had left her unsure as to when it was “appropriate” to integrate faith in clinical practice and indicated that she viewed inappropriate integration of faith in clinical practice as an ethical issue. The responses of the secular focus group participants, however, suggested that they were much more comfortable with the prospect of integrating client spirituality into clinical practice. The secular focus group participants expressed that being “open minded”, having a “willingness to learn”, and having “genuine curiosity” were all one needs to “be equipped to deal with spirituality.”

The dichotomy in confidence level between the focus groups with regards to integrating spiritual or religious beliefs into treatment is interesting to consider and, within the limits of this study, open to multiple interpretations. Through the course of focus group conversation, the secular participants framed religion and spirituality in
broad terms, inclusive of mindfulness practices, and with limited direct reference to Christianity. Additionally, their self-selection into the Secular Focus Group suggests that their clinical practice was not intentionally influenced or informed by their personal faith; for them these matters were separate and secular focus group participants could approach the conversation from the perspective that they were not expected to have special knowledge or expertise on the topic of faith. It could be that these conditions resulted in the secular focus group participants maintaining a relaxed approach to the prospect of integrating faith into clinical practice – an approach where curiosity and an open mind were the only tools one needed to navigate the diverse expanse of client spirituality.

In contrast, participants in the Christian focus group were more likely to reference the specific religion of Christianity and its sacred text the Bible in their efforts to discuss and describe the integration of religion and spirituality in clinical practice. It could be that, for these social workers, their self-selection into the Christian Focus Group primed them to focus on Christianity. Further, their personal identification as Christian in faith might have impelled them to approach the focus group conversation from the perspective that they were expected to have special knowledge or expertise on the topic of faith. These conditions could have resulted in the Christian focus group participants maintaining a self-critical approach to the prospect of integrating faith into clinical practice – an approach wherein they were prompted to reflect on the limited training and education that they had received on the task of responding to client spirituality.

The feelings of uncertainty Christian focus group participants expressed about their own ability to integrate religion and spirituality into clinical practice were echoed in the concerns they expressed about their peers’ ability to do so. They cited concerns about
whether their social worker peers had the openness and self-awareness required to respond to matters of faith in practice. One Christian focus group participant identified the lack of training on religion and spirituality in graduate programs as fostering an environment that is hostile toward the presentation of faith, and this sentiment was shared by a secular focus group participant who noted, “…the environment we work in doesn’t encourage us to work that way. I think that we’ve been shaped.” In response to the question of whether social workers generally possess the knowledge and skill set to respond to spiritual issues in clinical practice, one of the secular social worker who had voiced confidence in his own ability to identify and respond to spiritual issues noted, “I don’t know that many social workers would be able to answer that question fairly. All I can say is that I assure you that it’s sort of part of what a social worker is supposed to be and I hope a lot of them are.” In general, focus group participants were more confident in their own ability to identify and respond to presentations of religion and spirituality in clinical practice than they were in the ability of their peers. This dynamic – the view that there is a problem but that the problem resides largely in “the other” – undermines the field from the amassing the initiative needed to genuinely shift how religion and spirituality are addressed by educators and practitioners.

Christian focus group participants were asked whether there were certain clinical skills expected from Christian social workers and not secular social workers, and the Christian focus group participants were united in their emphasis that Christian social workers need to be equipped with strong clinical skills, good self-awareness, and a commitment to social work ethics. These attributes, fundamental to the practice of any clinical social worker, were emphasized in response to shared concerns that Christian
social workers struggle to balance their strong Christian faith with solid clinical skills. Christian focus group participants commented on the existence of stereotypes about Christians, such as a stereotype that faithful Christians lack an “understanding of a lot of the realities of life that many people deal with,” that prompted one participant to “avoid [discussions of her faith] altogether.” One participant’s response indicated that these stereotypes had, on some level, been internalized: “It’s kind of bad but when I think of a Christian social worker I always often think…of somebody who’s not as equipped clinically but has a strong spiritual belief.”

The topic of which clinical issues might prompt a social worker to refer a client to a faith-based provider was the final topic pursued by focus group discussion. Focus group participants identified efforts to connect clients to church communities after a client has indicated an interest, but both Christian and secular focus group participants denied having encountered any specific clinical issue that prompted them to refer to a faith-based provider. Secular focus group participants offered additional comment on the careful and selective nature of their referral process. They expressed concern that faith-based counsel had the potential to be detrimental to client wellbeing; one described those who had received faith-based counsel as “cattle that had been led down the ramp to slaughter”, and the other voiced fear of unintentionally referring to a “religious Nazi”. Focus group discussion did not seek participant comment on referral to other types of care providers, such as primary care physicians or psychiatrists, and it is not known whether these secular social workers would approach these referrals with the same critical and cautious manner. Regardless, the pejorative nature of their descriptions of faith-based providers suggests that these secular social workers navigate through an
underlying mistrust of clergy; this dynamic did not present itself in the focus group discussion with Christian social workers.

The response of the focus group participants to the topic of referral can be supplemented with data gathered via the questionnaire’s vignettes. Referral to a faith-based provider or faith community was a subset of the Religious or Spiritually-Derived Intervention category which included a variety of faith-based interventions. While the majority of participants did not indicate that referral to a faith-based provider or faith community would be a component of their treatment intervention, such referrals were identified by both NASW-IL and NACSW participants in response to each vignette. Participant responses suggested that secular social workers are more likely to consider referral to a faith-based provider or faith community in cases where faith is a strongly exerted component of the clinical picture, whereas Christian social workers present as consistent in their use of referral to a faith-based resource in treatment.

The use of referral to a faith-based provider or referral to a faith community was a treatment intervention used by the minority of both Christian social workers and secular social workers in this study; the majority of participants did not include this intervention in their response to either vignette. It could be argued that a hallmark of the social work profession, something that differentiates social work practitioners from mental health practitioners hailing from other degree programs, is its emphasis on person-in-environment perspective and yet it was the minority of social workers in this study that sought to mobilize a potential community support for the vignettes’ clients. Similarly, it was the minority of social workers in this study that sought to refer the client of Vignette II for physical evaluation or consultation with a medical provider. The majority of
participants relied heavily on interventions offered via the clinical/therapeutic relationship as the primary catalyst for improving client wellbeing. It is beyond the scope of this study to comment on how clinical social workers make use of environmental/community resources in their work with clients, but it is worth note that it was a minority of this study’s participants who sought to access and mobilize community supports in their efforts to effect change for the vignettes’ clients.

**Implications for Social Work Education**

Participants in both the Christian and Secular focus groups reported that they received very little, if any, exposure to religion and spirituality in their masters of social work programs, and this sentiment aligned with what participants in other recent research studies have reported (Mulder, 2014; Barker, 2013; Sheridan, 2009). Further, Christian social workers expressed fundamental questions about the ability of social work programs to effectively support the development of Christian social workers. One Christian focus group participant doubted the capability of social work programs to “teach spirituality” and another expressed concerns about the developmental limitations of individuals in their early to mid-20s. Self-awareness was repeatedly cited as a critical component of clinical practice, but participants circled around the question of whether it was possible for social work programs to instill self-awareness. The incorporation of more content on religion and spirituality into preexisting courses, such as those focusing on human behavior and human development, was recommended, but Christian focus group participants generally discouraged the practice of offering specific classes focused on religion and spirituality. Further, some expressed concern that a specialty track or certification on spirituality could attract social workers prone to imposing their religious
views on others. Once again, Christian focus group participants voiced the concern that social workers struggle to balance a strong faith with sound clinical skills.

The comments of this study’s focus group participants captured some of the ambivalence and anxiety present within the field about how to move forward in addressing faith matters in education and practice: both Christian and Secular focus group participants identified the ability to navigate faith matters as an important clinical skill but then stated that clients rarely presented with faith-based concerns; secular focus group participants voiced an appreciation for the role of faith in the lives of their clients but made disparaging comments that highlighted an underlying mistrust of clergy; and Christian focus group participants asserted that the stereotypes about Christians inaccurately portrayed their views and motives as Christian social workers but expressed concern that faith-focused social work courses would attract the oft-stereotyped Christian social worker. It is particularly important to attend to the anxiety Christian social workers express about the integration of religion and spirituality in social work education.

Christian social workers, embedded in a secularized profession, can serve as the proverbial canaries in a coal mine; they are positioned to provide unique feedback on how tolerant and open the profession is to the existence of difference and diversity. Over a decade ago, Ressler (2002) noted that “a great deal of tension remains just below the surface” and cited “a significant level of animosity among some social work educators and practitioners toward religious persons and institutions” (p. 100). The Christian focus group participants in this study remarked that social work environments are hostile toward presentations of faith and noted efforts to avoid discussions of faith altogether;
these remarks indicate that considerable tension about the integration of religion and spirituality continues to circulate within the profession.

While attention to religion as a dimension of diversity has been required of social work programs since the mid-1990s (Canda and Furman, 2010), the tension about the topic has manifested in a scattered and uneven approach to meeting this requirement. Cnaan, Boddie, and Danzig (2005) remarked:

The means to achieve these goals are many and diverse. They range from a one time lecture on the topic in an introductory class (policy, practice or HBSE) to a full fledged five year dual degree jointly offered by seminaries and schools of social work (p. 104).

According to Barker (2013), “…while the profession agrees that spirituality is important for social work practice there is little purposeful discussion or dialogue in the classroom” (p. 11). Moss (2012) added, “… the majority of social workers are not receiving adequate preparation from their professional programs to address religious and spiritual issues in practice (p. 597). Senreich (2013) reported that many of the common practice textbooks “discuss spirituality in the context of respecting clients’ values and culture,” but “they do not meaningfully integrate working with clients’ spirituality into their chapters on assessment and intervention strategies” (p. 549). Mulder (2014) suggested that “compressed time frames may create situations where this topic is only surveyed if considered at all” and that faculty may be “unsure of how much spirituality and religion material should be integrated into classes” (p. 18). Mulder (2014) recommended that faculty may benefit from training about religion and spirituality themselves as well as more specific guidance for curricula. Streets (2009) echoed this recommendation:

Schools of social work might initiate faculty forums and workshops that address the interests, experiences, and challenges social work faculty encounter when
dealing with religion in the teaching of social work. This would give faculty the opportunity to share ideas and develop pedagogical approaches to including religion in social work courses. This would also encourage conversation among faculty members and enhance their sense of competence to address religion in their classes (p. 191).

Rothman (2009) provided an overview of a variety of models and resources developed by researchers to address the task of teaching about religion and spirituality in social work education. Some models focused on the inclusion of content on religion and spirituality as a component of diversity, including specific resources for assisting faculty in the task of integrating and teaching this material. Other models involved the addition of new elective courses or more extensive training programs, such as Hodge’s (2002) Equipping Social Workers to Address Spirituality in Practice Settings: A Model Curriculum or the framework provided in Canda and Furman’s (1999; 2010) text Spiritual Diversity in Social Work Practice: The Heart of Helping. Rothman (2009) provided her own recommended model for integrating spirituality in the social work curriculum. With regards to use of her model, which included content that addressed spirituality in the areas of knowledge, skills, and self awareness, Rothman (2009) explained:

Although these can readily constitute a dedicated course on the subject of spirituality, it is also very possible to infuse elements into other courses in the curriculum. Spirituality, when it is offered as a discrete course, is generally considered as an elective; in order to ensure that all students have exposure to spiritual content in social work, it is essential that these elements be integrated into required courses (p. 172).

Williams and Smolak (2007), who acknowledged that scholars have advocated different strategies for including religious and spiritual issues in social work curricula, provided the observation: “Rather than deciding to integrate faith matters or add them in the form
of an elective, both strategies would likely be the most effective way to adequately prepare future social work practitioners” (p. 39). In fact, a combination of both strategies would be required to address the varied interests and opinions of this study’s focus group participants.

Rothman (2009) and others - including focus group participants in this research study - have stressed the role of self-awareness in the development of competent social workers (Mulder, 2014; Canda & Furman, 2010; Northcut, 2004). Northcut (2004) has provided a framework for teaching religion and spirituality that includes helping students to become more self-aware. Mulder (2014) noted that, while participants in her study reported limited attention to religion and spirituality in their coursework, “several participants identified self-awareness, openness, and acceptance as prominent elements of the social work curriculum” (p. 35). She suggested that course instruction clearly frame spirituality as including meaning, purpose, and relationships to a higher power so that students can more readily link self-awareness and relational skills to spirituality.

As Rothman (2009) noted, many social workers have embraced spirituality as offering a path through the tension that the integration of social work and religion creates. Spirituality, according to Canda (2008), “is a more inclusive and larger concept than religion” (p. 27) and has the key quality of “seeking integration, integrity, and connectedness” (p. 28). Senreich (2013) advocated for a “definition of spirituality for social work students that fully conforms to social work values and that can be used when working with all clients” (p. 551), and he proposed the following:

   Spirituality refers to a human being’s subjective relationship (cognitive, emotional, and intuitive) to what is unknowable about existence, and how a
person integrates that relationship into a perspective about the universe, the world, others, self, moral values, and one’s sense of meaning (p. 553).

Senreich (2013) stressed that the solidification of this more inclusive definition of spirituality for social work education and practice would empower clinicians to formulate “bio-psycho-social-spiritual” perspectives that are “fully consonant with social work values as taught in schools of social work” (p. 548).

Senreich’s point is well taken. It is possible that a widely adopted, clearly articulated and inclusive definition of spirituality that compliments social work’s ethics and values would help reduce anxiety about the integration process and allow educators and practitioners to move forward with greater confidence. It is important, however, that social workers not sidestep the tensions that arise when Christianity and social work line up face-to-face. The willingness and ability to navigate the tensions of diversity are key components of the NASW Code of Ethics.

Ressler (2002) noted, “While similarities can be demonstrated between Christianity and social work at the value and ethical level, there are many areas of difference, some of which result in significant tension” (p. 103). These differences not only create tension among social workers who maintain different worldviews, but can also create challenging ethical dilemmas for those who seek to balance conflicting beliefs. It is a common human tendency to experience difference as anxiety provoking and, in response to this tension, seek to eliminate, minimize, avoid, or ignore the difference. Perhaps it was an instinct to avoid intrapersonal and/or interpersonal tension about differing worldviews that prompted Christian focus group participants in this study to discourage the practice of offering further courses on religion and spirituality in
masters of social work programs. Ressler (2002) noted, however, that those working within the field of social work cannot avoid grappling with perplexing ethical dilemmas:

All social workers have a vision of what constitutes the general welfare of society. Each social worker must wrestle with the tension between the patterns which are consistent with this vision and ideas or practices that are at odds with it (p. 106). It is the responsibility of the profession’s liberal or “progressive-minded” (Ressler, 2002) majority to embrace diversity by creating and maintaining space for multiple worldviews. Social workers need to lean into the tension created by diversity, engage in dialogue, “listen to those who see injustice and feel oppressed…[and]…find solutions that make room for as many opinions as possible” (p. 115).

Cnaan, Boddie, & Danzig (2005) provided a concise argument for the inclusion of content on religion and spirituality in social work curriculum: “The United States is the most religious country among all modern democracies” (p. 100). Further, they noted that “many social workers practice under religious auspices or in collaboration with religious-based social services”, and social work students are often placed in faith-based organizations for practicum rotations (p. 102). Other researchers have emphasized the personal benefits social work students experience as a result of coursework that includes religion and spirituality (Ying, 2008; Bethel, 2004). The most compelling reason for social work educators to strengthen and expand their attention to religion and spirituality in the curriculum, however, is the ongoing call from the student body that this be done (Northcut, 2004; Graff, 2007; Sheridan, 2009; Moss, 2012; Barker, 2013; Mulder, 2014).

Implications for Research

Participant responses to this study’s vignettes, as well as other data gathered through the questionnaire, both support and add to the findings of the studies detailed in
the literature. Sheridan (2004) found that a positive attitude toward the inclusion of spiritually-derived interventions was related to their increased use. This study found that the NACSW group, which averaged higher scores on religiosity, was more likely to make use of a religious or spiritually-derived intervention. Previous research found that the behavior of personal participation in religious or spiritual services was positively correlated with the use of spiritually-derived interventions in social work practice (Sheridan, 2004; Stewart, Koeske, & Koeske, 2006). Similarly, this study found that the NACSW group was more prone to employ a faith-based therapy, make use of a religious or spiritually-derived intervention, and identify a religious or spiritual component to a client’s presenting problem.

The research of Heyman, Buchanan, Marlowe, and Sealy (2006) found that social workers’ attitudes toward the role of religion and spirituality in social work practice were positively correlated with increased personal spiritual participation, and this study’s results mirror these findings. This study found that there was a strong positive correlation between attitude toward religion and spirituality in clinical practice, as measured by the RRSP scale, and degree of social worker religiosity in his or her personal life, as measured by the Religiosity Measure.

Previous research studies have highlighted concerns about the presence of negative attitudes and hostility toward conservative Christian social workers by the profession’s liberal majority (Ressler & Hodge, 2003; Hodge, 2002; Ressler & Hodge, 2005; Thyer & Myers, 2009). While there was no evidence of hostility toward religion in the text comments provided by participants on the questionnaire, the secular focus group participants made comments that revealed the presence of some underlying bias. Of
greater interest, however, were comments made by the Christian focus group participants expressing concern that their Christian social worker peers struggle to balance a strong faith with sound clinical skills. Further, they expressed concerns about the possible propensity of their Christian social worker peers to impose their religious views on others, and they discouraged the practice of offering specific courses focused on religion or spirituality due to concerns that such courses would attract those seeking to evangelize.

The Christian focus group participants were firm in articulating their own desires to align their use of religion and spirituality in practice with social work ethics and values, but they were openly wary of the motives of others interested in integration. The reasons for this dichotomy are unclear, but Christian social workers are, after all, embedded in a profession that continues to wrestle with the integration of religion and spirituality. Streets (2009) remarked, “Some people have an image of religion and pastoral counseling as ideologically narrow, wanting to control and manipulate how people think about God and live. Many people are generally suspicious of religion and view it as something to avoid” (p. 186). While the profession of social work moves toward fully embracing the benefits of attending to religion and spirituality in practice, splinters of anxiety about proselytization remain; the Christian focus group participants of this study embodied this tension. Future research could benefit the profession by further exploring the narratives of Christian social workers and pursuing greater understanding of the dynamic of balancing strong religious beliefs with professional ethics and values, particularly in instances where there is perceived conflict between the two.
The primary limitation that impacted this study was its small sample size. The questionnaire had a smaller than anticipated response rate, and only five participants presented to share their views, insights and ideas in focus group discussion. Sample size was largely anchored to the financial constraints of the researcher; a similarly designed study with greater funding resources would have the ability to reach out to a larger audience and include additional contacts, follow-up requests, and opportunities for focus group discussion. The small sample size made the task of identifying significant relationships from the data difficult and impacted the generalizability of the findings. This study targeted a relatively small group of regionally-based social workers and resulted with a response rate considerably lower than anticipated. The focus group findings, in particular, have very limited generalizability. Additionally, another limitation specific to the use of focus groups is linked to the role of the facilitator in generating the data. There is no denying that the behavior of the facilitator, the primary instrument in qualitative research, has consequences for the nature of the focus group discussion. This weakness, however, is not limited to focus groups and efforts were made to mediate this impact through use of predetermined questions from which this researcher did not deviate.

This study sought to compare the clinical approaches of two groups of social workers that differed on their degree of religiosity with the intent of exploring how religiosity interacts with clinical conceptualization and treatment. The study successfully captured two groups of social workers that differed on their degree of religiosity, and the results of this study suggested that the variable of religiosity may influence perception of a client’s presenting problem, additional assessment requests, and choice of clinical
theory. It is interesting to consider why and/or how religiosity may impact these components of the clinical process, however this study was limited by the presence of other significant demographic variables that muddied the picture. Thus, this study is limited in its ability to comment on the relationship between religiosity and decision making in clinical social work practice. The replication of similar, statistically significant differences in clinical approach between two groups wherein religiosity is the only significant demographic difference is the necessary next step for future research on this topic.

Finally, this study’s findings were potentially undermined by misprints of the RRSP scale and Religiosity Measure. Despite the misprint of the RRSP scale, resulting from researcher error, the measure showed good reliability for all those for whom a score could be calculated, good reliability for the NASW-IL sample, acceptable reliability for the NACSW sample, and there was good evidence for unidimensionality in the full sample. It was reasonable, therefore, to use the data gathered via the RRSP scale with confidence. Similarly, basic psychometrics indicated that the Religiosity Measure showed good reliability for all those for whom a score could be calculated and good reliability for the NASW-IL sample – supporting the quality of the data despite the misprint. The Religiosity Measure did show poor reliability for the NACSW sample; however, the poor reliability was not interpreted as resulting from the measure’s misprint. Rather, the Religiosity Measure was standardized through, what appears to have been, a religiously diverse sample and may not have been designed to capture the more nuanced and potentially more complex concept of religiosity within a very religious sample. Use of
alternative measures of religiosity should be considered for use in future study of these populations

Concluding Remarks

This study sought to increase our understanding of the tension that exists around the interface of religion and the profession of social work by exploring the treatment approaches of Christian social workers and secular social workers. Through a two-phase study that involved use of questionnaires and focus group discussion, this study found that the approaches of Christian social workers and secular social workers were not fundamentally different. In response to the questionnaire’s vignettes, Christian social workers and secular social workers shared more similarities in treatment approach than they displayed differences. Similarly, the viewpoints and opinions shared in focus group discussion overlapped in many areas.

There was, however, evidence of significant differences between the groups and their clinical social work perspectives and approaches. In response to a vignette with an overt reference to religion, NASW-IL participants were more likely to: identify Anxiety/Stress and Conflict Resolution and Decision Making as presenting problems and more prone to be Eclectic and/or Psychodynamic in their theoretical approach. NACSW participants, on the other hand, were more likely to: identify a Religious or Spiritual Component to the presenting problem; use a Premarital Inventory to gather additional assessment information; and make use of a Faith-based Therapy. In response to a vignette with a subtle reference to religion, NASW-IL participants were more likely to: identify Depression/Low Mood; assess Mental Health History; use Psychodynamic and Systems/Family Systems theories; use interventions that relied on the therapeutic
relationship; and apply CBT techniques. NACSW participants were more prone to make use of Faith-based Therapy and implement a Religious or Spiritually-Derived Intervention.

While these response differences were present, this study was unable to demonstrate that they were directly associated with degree of religiosity. Additional demographic differences between the groups might have influenced the results. Ultimately, though, the differences offer interesting opportunities for future consideration and study. These differences, should future studies link them to degree of religiosity, need not be a source of tension or division within the profession of social work; rather, they could be embraced as providing an opening for additional growth and discussion.
APPENDIX A

REQUEST TO PARTICIPATE IN RESEARCH
Dear Fellow Social Worker,

You are being asked to share your clinical perspective and expertise as a participant in a research study exploring the interface of religion and clinical social work practice. This phase of the study consists of an online questionnaire – directions on how to access this questionnaire are provided below. Please read this form carefully, your time and consideration is invaluable and greatly appreciated.

**Project Title:** Comparing the Clinical Approaches of Christian Social Workers and Secular Social Workers  
**Researcher(s):** Kristin Larsen, LCSW, ACSW  
**Faculty Sponsor:** Michael Kelly, Ph.D.

**Introduction:**
You are being asked to take part in a research study being conducted by Kristin Larsen, LCSW, ACSW for a doctoral dissertation under the supervision of Michael Kelly, Ph.D. in the Department of Social Work at Loyola University of Chicago.

You are being asked to participate in this study because you have been identified as a member of the Illinois chapter of the National Association of Social Workers (NASW-IL) or as a member of the North American Association of Christians in Social Work (NACSW).

**Purpose:**
There is a tension that exists around the interface of religion and the profession of social work that has been recognized and commented on by recent researchers. This study seeks to investigate the ways in which religious and spiritual beliefs are currently interfacing with clinical social work by drawing on the perspectives of practicing social workers.

**Procedures:**
If you agree to be in the study, you will be asked to:
- Go to: (web-address) to complete an online questionnaire. The questionnaire is designed to address the question: How do the clinical treatment approaches of NACSW members and NASW-IL members differ: does identical clinical material presented to these two different audiences lead to different treatment conceptualizations and interventions? In addition to providing some demographic information, you will be asked to respond to two brief clinical vignettes and complete two short scales.
- At the completion of the questionnaire, you will be invited to submit your contact information if you have an interest in participating in further focus group discussion on the interface on the interface of religion and social work.

**Risks/Benefits:**
There are no anticipated risks to participating in this phase of the research study.
Reflection on one's therapeutic practices can lead to professional growth, therefore participants who take part in this online questionnaire might benefit from the opportunity to consider, describe, and define how they engage with clients around the topic of religion/spirituality. Additionally, the information gathered will help us better understand the ways in which social work clinicians are addressing religion and spirituality in clinical practice.

Compensation:
While greatly appreciated, you will not be compensated for your time and attention.

Confidentiality:
- Information gathered during the course of this study will be kept confidential. The survey software used for this study meets strict criteria for secure transmission, database security, and server security.

Voluntary Participation:
Participation in this study is voluntary. If you do not want to be in this study, you do not have to participate. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without penalty.

Contacts and Questions:
If you have questions about this research study, please feel free to Kristin Larsen, LCSW, ACSW at klarse1@luc.edu or Michael Kelly, Ph.D.mkell17@luc.edu.

Thank you for your time and consideration, and I’d like to encourage you to participate further by going to (website) to complete the brief questionnaire.

Thank you!
Kristin Larsen, LCSW, ACSW
Doctoral Candidate, Loyola University Chicago
Questionnaire

Sex: Male______ Female______ Age: ________

Degree(s): ____________________________________________________________

Date of most recent degree obtained: ________

Did you receive your social work degree from a sectarian (religious-based) university?: Yes No

Specify Licensure: ____________________________

Years of Professional Social Work Experience: ________

Member of National Association of Social Workers: Yes No

Member of North American Association of Christians in Social Work: Yes No

Religious Affiliation: Childhood religion (if any)__________________________

Current religion (if any) ________________________________

Do you currently belong to a church/religious community?: Yes No

Race/Ethnicity: (circle)
African American American Indian Asian Hispanic/Latino
Pacific Islander White Other___________________________

My current place of employment is: (check all that apply)

__Secular community mental health agency  __Substance abuse treatment center
__Public welfare agency  __Private practice
__Adoption and foster care agency  __Employee assistance program
__Home-based services  __Juvenile or adult justice system
__Homeless shelter or housing program  __Hospital
__College/University  __Hospice
__School  __Residential treatment center
__Nursing home or retirement center  __Other _____________________
__Religious-based or affiliated agency (e.g. Lutheran Social Services, Catholic Charities)

Each week, I spend approximately the following number of hours with clients:
CASE SCENARIO #1
Anna, a 27 year old female, reports feeling over-stressed in her life right now. She and Jeff, her boyfriend of 4 years, have begun to plan their wedding after a long engagement. Anna explains that she’s been frustrated by Jeff’s lack of involvement in the planning process, and she’s concerned that the tasks she’s delegated to him won’t get done. Further, they’ve been arguing over where to hold the wedding ceremony and who will perform it. Anna explains that she was raised Lutheran and Jeff was raised Catholic and, while this difference in religious backgrounds has not previously been an issue, it is currently a major source of tension in their relationship. Anna would like to have a religious ceremony but has felt pressured to convert to Catholicism in order to be married in the church Jeff’s family attends. Anna explains that Jeff’s family has offered to help fund the wedding, but only if they get married in their church. In addition, Jeff, who initially argued in favor of a civil ceremony, has begun pushing for a Catholic ceremony in an effort to please his parents and avoid conflict with them. Anna explains that Jeff has traditionally been very flexible and willing to compromise, and she now feels that she is seeing a “whole new side” of him. She tearfully remarks that planning their wedding has become associated with feelings of anger and anxiety instead of the feelings of joy and excitement she was anticipating.

1. What would you identify as the primary presenting problems in this case?

2. How serious would you rate this client’s presenting problems?
   (not serious) 1 2 3 4 5 6 7 (very serious)

3. How impaired is this client’s functioning?
   (not impaired) 1 2 3 4 5 6 7(very impaired)

4. Which treatment modality(s) would you recommend for this client:
   ___Individual Therapy   ___Psychiatry
   ___Couple’s Therapy   ___Referral to other provider/service
   ___Family Therapy   ___No treatment necessary
   ___Group Therapy

With regards to psychotherapy:
5. What additional assessment information is needed to create a plan for moving forward with this client?

6. What clinical theory(s) would you apply in your work with this client?
   __Cognitive Behavioral    __Jungian
   __Christ-Centered         __Self Psychology
   __Ego Psychology          __Solutions Focused
   __Family Systems          __Object Relations
   __Feminist                __Narrative
   __Person-Centered         __Other______________________________

7. What clinical interventions might you use with this client?

8. Would there be any spiritual interventions or resources that you would consider for this client?

9. How much of your clinical approach would be informed by evidenced based practice?
   (not informed)  1  2  3  4  5  6  7 (very informed)

10. How motivated do you think this client is for therapy?
    (not motivated)  1  2  3  4  5  6  7 (very motivated)

11. How would you rate this client’s prognosis for therapy?
    (poor prognosis)  1  2  3  4  5  6  7 (excellent prognosis)

12. How many treatment sessions do you think will be necessary?________

CASE SCENARIO #2
Tom is a 57 year old married father of two. He works full time as a successful physical therapist with an outpatient clinic that has grown over the years. He and his wife have been married for 27 years and have two adult daughters ages 24 and 21, who no longer live in the family home. Tom’s wife encouraged him to talk to a therapist because he’d been irritable and moody over the last month and a half. Tom acknowledges that he’s been down and states that he feels directionless in his life right now. He reports that he and his wife left their church within the past year and that his eldest daughter recently got engaged, but he denies any other significant life changes. In talking with him, Tom shares that he’s been questioning the purpose of his life and he expresses some hopelessness that his life has no true meaning. Tom reports that recent natural disasters around the world
have brought to the surface thoughts about his own mortality as well as unresolved feelings regarding the loss of his parents (his father died 11 years ago and his mother 5 years ago). Tom expresses some feelings of guilt and regret that he could have been a better son as well as wonders whether he has been a good father to his daughters.

1. What would you identify as the primary presenting problems in this case?

2. How serious would you rate this client’s presenting problems?
   (not serious)  1  2  3  4  5  6  7 (very serious)

3. How impaired is this client’s functioning?
   (not impaired)  1  2  3  4  5  6  7 (very impaired)

4. Which treatment modality(ies) would you recommend for this client:
   ___Individual Therapy   ___Psychiatry
   ___Couple’s Therapy    ___Referral to other provider/service
   ___Family Therapy      ___No treatment necessary
   ___Group Therapy

   With regards to psychotherapy:
   5. What additional assessment information is needed to create a plan for moving forward with this client?

6. What clinical theory(ies) would you apply in your work with this client?
   ___Cognitive Behavioral   ___Jungian
   ___Christ-Centered         ___Self Psychology
   ___Ego Psychology         ___Solutions Focused
   ___Family Systems         ___Object Relations
   ___Feminist               ___Narrative
   ___Person-Centered        ___Other

7. What clinical interventions might you use with this client?

8. Would there be any spiritual interventions or resources that you would consider for this client?

9. How much of your clinical approach would be informed by evidenced based practice?
   (not informed)  1  2  3  4  5  6  7 (very informed)

10. How motivated do you think this client is for therapy?
(not motivated) 1 2 3 4 5 6 7 (very motivated)

11. How would you rate this client’s prognosis for therapy?
(poor prognosis) 1 2 3 4 5 6 7 (excellent prognosis)

12. How many treatment sessions do you think will be necessary? _______

Religiosity Measures
Instructions: Please answer the following questions by marking the appropriate choice for the multiple-choice items and providing the most accurate number for the fill-in-the-blank question.

1. How many times have you attended religious services during the past year? _____ times.
2. Which of the following best describes your practice of prayer or religious meditation?
   a. Prayer is a regular part of my daily life.
   b. I usually pray in times of stress or need by rarely at any other time.
   c. I pray only during formal ceremonies.
   d. I never pray.
3. When you have a serious personal problem, how often do you take religious advice or teaching into consideration?
   a. Almost always
   b. Usually
   c. Sometimes
   d. Never
4. How much influence would you say that religion has on the way that you choose to act and the way that you choose to spend your time each day?
   a. No influence
   b. A small influence
   c. Some influence
   d. A fair amount of influence
   e. A large influence
5. Which of the following statements comes closest to your belief about God?
   a. I am sure that God really exists and that He is active in my life.
   b. Although I sometimes question His existence, I do believe in God and believe He knows of me as a person.
   c. I don’t know if there is a personal God, but I do believe in a higher power of some kind.
   d. I don’t know if there is a personal God or a higher power of some kind, and I don’t know if I ever will.
   e. I don’t believe in a personal God or in a higher power.
6. Which one of the following statements comes closest to your belief about life after death (immortality)?
   a. I believe in a personal life after death, a soul existing as a specific individual spirit.
b. I believe in a soul existing after death as a part of a universal spirit.
c. I believe in a life after death of some kind, but I really don’t know what it would be like.
d. I don’t know whether there is any kind of life after death, and I don’t know if I will ever know.
e. I don’t believe in any kind of life after death.
7. During the past year, how often have you experienced a feeling of religious reverence or devotion?
   a. Almost daily
   b. Frequently
   c. Sometimes
   d. Rarely
   e. Never
8. Do you agree with the following statement? “Religion gives me a great amount of comfort and security in life.”
   a. Strongly disagree
   b. Disagree
   c. Uncertain
   d. Agree
   e. Strongly agree

**Role of Religion and Spirituality in Practice Scale**
The following questions ask your views about the appropriate role of religion or spirituality in social work practice. To aid you in responding to these questions, the following definitions are provided below. You will note that, for the purposes of this study, spirituality is more broadly defined than religion.

**Spirituality** is defined as “the human search for meaning, purpose, and connection with self, others, the universe, and ultimate reality, however one understands it. This may or may not be expressed through religious forms or institutions”.

**Religion** is defined as “an organized and structured set of beliefs and practices shared by a community that is related to spirituality”.

Please rate your level of agreement or disagreement with each statement by circling the one number that best reflects your opinion on the 5-point scale.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Not Certain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Spirituality is a fundamental aspect of being human.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Social workers should become more sophisticated than they are now in spiritual matters.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) It is important for social workers to have knowledge about different religious faiths and traditions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4) Religious concerns are outside of the scope of social work practice.

1……………..2………………3…………..….4…………………5

5) Spiritual concerns are outside of the scope of social work practice.

1……………..2………………3…………..….4…………………5

6) Social work practice with a spiritual component has a better chance to empower clients than practice without such a component.

1……………..2………………3…………..….4…………………5

7) Knowledge of clients’ religious or spiritual belief systems is important for effective social work practice.

1……………..2………………3…………..….4…………………5

8) Social Workers should be able to assess the positive or beneficial role of religious or spiritual beliefs and practices in clients’ lives.

1……………..2………………3…………..….4…………………5

9) Social workers should be able to assess the negative or harmful role of religious or spiritual beliefs and practices in clients’ lives.

1……………..2………………3…………..….4…………………5

10) The use of religious language, metaphors and concepts in social work practice is inappropriate.

1……………..2………………3…………..….4…………………5

11) The religious backgrounds of clients do not particularly influence the course or outcome of social work practice.

1……………..2………………3…………..….4…………………5

12) A social worker’s use of scripture or other religious texts in practice is appropriate.

1……………..2………………3…………..….4…………………5

13) It is against social work ethics to ever pray with a client.

1……………..2………………3…………..….4…………………5

14) The use of spiritual language, metaphors and concepts in social work practice is inappropriate.

1……………..2………………3…………..….4…………………5

15) It is sometimes appropriate for a social worker to share his or her own religious or spiritual beliefs with a client.

1……………..2………………3…………..….4…………………5

16) Addressing a client’s religious or spiritual beliefs is necessary for holistic social work practice.

1……………..2………………3…………..….4…………………5

17) Social work education should include content on religious and spiritual diversity.

1……………..2………………3…………..….4…………………5
18) Social work education should include content on how to effectively deal with religious or spiritual issues in practice.
APPENDIX C

POSTCARD THANK YOU AND REMINDER
Last week an invitation to participate in an online questionnaire for a study exploring the interface of religion and clinical social work practice. You were asked to participate in this study because you were identified as a member of the Illinois chapter of the National Association of Social Workers or a member of the North American Association of Christians in Social Work.

If you have already completed the questionnaire, please accept my sincere thanks. I am especially grateful for your help because it is only by asking clinical social workers to share your experiences that we can better understand the ways in which social work clinicians are addressing religion and spirituality in clinical practice.

If you have not completed the online questionnaire, please go to (Opinio Questionnaire website address) and do so today.

Sincerely,
Kristin Larsen, LCSW, ACSW
Doctoral Candidate Loyola University Chicago
APPENDIX D

FOCUS GROUP DISCUSSION INVITATION
Thank you for completing this online questionnaire. Your time is greatly appreciated.

The second phase of this study involves the use of focus groups that will discuss additional questions about the interface of religion and clinical practice in social work. Focus group discussion will occur on Loyola University Chicago’s downtown campus (820 North Michigan Avenue) and last 1.5 hours. Participants will not be compensated for their time or travel expenses, however light refreshments will be provided. The date for focus group discussion is yet to be determined.

To facilitate safe and open dialogue around the topic of religious beliefs, the focus groups will be kept homogeneous with regards to participants’ religious self-identification as Christian or secular in their social work practice.

If you are interested in participating in focus group discussion, please use this link (xxxx@luc.edu) to submit your name, telephone number, and e-mail address. To facilitate accurate focus group placement, please indicate whether you identify as CHRISTIAN or SECULAR in your social work practice.

The submission of your contact information will be separate from, and not traceable to, the submission of your online questionnaire.

THANK YOU.
TREATMENT
- How often do you encounter clients who are interested in integrating their spiritual beliefs and/or practices into treatment?
- Do you feel well equipped to integrate your client’s spirituality into interventions?
- Are there specific, religious or spiritually based interventions that you use?
- Are there clinical issues that would prompt you to refer to a faith-based provider (Christian Social Worker, pastoral counselor, priest, pastor, chaplain, and rabbi)?

TRAINING
- What preparation have you received that has equipped you to respond to client spirituality?
- How did your MSW program prepare you to respond to client spirituality?
- Have you pursued training or study outside of your MSW program on the topic of spirituality?

ASSESSMENT
- Do you have an assessment tool you use in your practice setting to assess a client’s spirituality and/or religiosity? If so, is this a formal or informal instrument you use?
- Does your practice setting have tools that enable sufficient assessment of client spirituality?
- What changes would you make, if any, to your practice setting’s assessment of spirituality?
- How often do you encounter a spiritual concern as a client’s presenting problem or a main component of the presenting problem? Do you find that there are specific types of problems (e.g. depression, domestic violence, substance abuse, problems with adolescents) that might be more or less likely to have a spiritual/religious component?
- Do you feel well equipped to assess the area of spirituality?

CONCLUDING QUESTIONS
- Is there a minimum skill set expected of those who identify themselves as Christian Social Workers?
- Do you feel social workers generally possess the knowledge and skill set to respond to spiritual issues in clinical practice?
- What changes would you make, if any, to how MSW programs prepare social workers to attend to spirituality (e.g. should an introductory course on religion/spirituality be a standard component of the general curriculum; should social workers be better trained at assessment and referral; should social work programs offer a specialty track/certification)?
- What distinguishes a Christian Social Worker from a social worker who doesn’t self-identify as Christian?
APPENDIX F

INFORMED CONSENT FOR OPINIO QUESTIONNAIRE
**Project Title:** Comparing the Clinical Approaches of Christian Social Workers and Secular Social Workers  
**Researcher(s):** Kristin Larsen, LCSW, ACSW  
**Faculty Sponsor:** Michael Kelly, Ph.D.

**Introduction:**
You are being asked to take part in a research study being conducted by Kristin Larsen, LCSW, ACSW for a doctoral dissertation under the supervision of Michael Kelly, Ph.D. in the Department of Social Work at Loyola University of Chicago.

You are being asked to participate in this study because you have been identified as a member of the Illinois chapter of the National Association of Social Workers (NASW-IL) or as a member of the North American Association of Christian’s in Social Work (NACSW).

**Purpose:**
There is a tension that exists around the interface of religion and the profession of social work that has been recognized and commented on by recent researchers. This study seeks to investigate the ways in which religious and spiritual beliefs are currently interfacing with clinical social work by drawing on the perspectives of practicing social workers.

**Procedures:**
If you agree to be in the study, you will be asked to:
- Provide some demographic information, respond to two brief clinical vignettes, and complete two short scales. Completion of this online questionnaire requires approximately 15 minutes.
- At the completion of this questionnaire, you will be invited to submit your contact information if you have an interest in participating in further focus group discussion on the interface of religion and social work.

**Risks/Benefits:**
There are no foreseeable risks involved in participating in this research beyond those experienced in everyday life.

There are no direct benefits to participating in this research. However, reflection on one’s therapeutic practices can lead to professional growth, and participants who take part in this online questionnaire might benefit from the opportunity to consider, describe, and define how they engage with clients around the topic of religion/spirituality. Additionally, the information gathered will help us better understand the ways in which social work clinicians are addressing religion and spirituality in their clinical practice.

**Compensation:**
While greatly appreciated, you will not be compensated for your time and attention.

**Confidentiality:**
• Information gathered during the course of this study will be kept confidential. The survey software used for this study meets strict criteria for secure transmission, database security, and server security. Copies of any information removed from the server will be stored within a locked cabinet in a home office. All research material will be securely disposed of at the conclusion of the research project.

• Only project personnel who have completed a specialized training course will have access to private, individually identifiable data.

Voluntary Participation:
Participation in this study is voluntary. If you do not want to be in this study, you do not have to participate. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without penalty.

Contacts and Questions:
If you have questions about this research study, please feel free to Kristin Larsen, LCSW, ACSW at klarse1@luc.edu or Michael Kelly, PhD at mkell17@luc.edu.

If you have questions about your rights as a research participant, you may contact the Loyola University Office of Research Services at (773) 508-2689.

Statement of Consent:
If you have read the information provided above and agree to participate in this research study, please click “I CONSENT” below and continue onto the questionnaire.
APPENDIX G

INFORMED CONSENT FOCUS GROUP DISCUSSION
Project Title: Comparing the Clinical Approaches of Christian Social Workers and Secular Social Workers
Researcher(s): Kristin Larsen, LCSW, ACSW
Faculty Sponsor: Michael Kelly, Ph.D.

Introduction:
You are being asked to take part in a research study being conducted by Kristin Larsen, LCSW, ACSW for a doctoral dissertation under the supervision of Michael Kelly, Ph.D. in the Department of Social Work at Loyola University of Chicago.

You are being asked to participate in today’s focus group discussion because, in an earlier phase of this study that consisted of an online questionnaire, you submitted your contact information indicating that you were willing to further discuss the interface of religion and social work in a focus group format. For the focus group phase of this study, two separate groups of 3 to 8 participants have been formed. Participants have been grouped based on their self-identification as Christian or secular in reference to their clinical social work practice. Please read this form carefully and ask any questions you may have before deciding whether to participate in the study.

Purpose:
There is a tension that exists around the interface of religion and the profession of social work that has been recognized and commented on by recent researchers. This study seeks to investigate the ways in which religious and spiritual beliefs are currently interfacing with clinical social work by drawing on the perspectives of practicing social workers.

Procedures:
If you agree to be in the study, you will be asked to:
- Participate in a 1.5 hour focus group discussion with peers. Participants will be asked to discuss their views and opinions about what motivates positive and negative responses to conservative Christian social workers from their peers. Efforts have been made to assemble groups of similar and/or like-minded individuals to facilitate open discussion.

Risks/Benefits:
Discussions that involve religion can become emotionally charged, and it is foreseeable that you could become frustrated or anxious during the course of group discussion. Efforts have been made to manage this risk by grouping participants based on their self-identification as Christian or secular with regards to their social work practice. At any point during the discussion you can choose, without penalty, to remove yourself either for a brief break or to no longer participate in the focus group.

There are no direct benefits of participating in this research. However, critical reflection on one’s therapeutic practices can lead to professional growth, and participants who take part in focus group discussion might benefit from the opportunity to engage in discourse that helps them consider, describe, and define how they engage with clients around the topic of religion/spirituality. Additionally, the information gathered will help us better understand the ways in which social work clinicians are addressing religion and spirituality in clinical practice.
Compensation:
Focus group participants will be provided with light refreshments during the 1.5 hour focus group session. Participants will be offered reduced parking fees through ticket validation, if applicable.

Confidentiality:
- Confidentiality cannot be guaranteed due to the researcher’s inability to control what is said by participants outside of the focus group. Expectations regarding confidentiality will be reviewed at the start of your focus group session, and other participants will not be provided with your last name or contact information.
- Focus group sessions will be audiotaped, and the services of a transcription professional with a confidentiality policy will be secured to transcribe the recordings. Only project personnel who have completed a specialized training course will have access to private, individually identifiable data.
- Information gathered by project personnel during the course of this study will be kept confidential. Signed consent forms, audiotapes and transcriptions will be stored within a locked cabinet in a home office until the conclusion of the research project at which point the material will be securely disposed of.

Voluntary Participation:
Participation in this study is voluntary. If you do not want to be in this study, you do not have to participate. Even if you decide to participate, you are free not to answer any question or to withdraw from participation at any time without penalty.

Contacts and Questions:
If you have questions about this research study, please feel free to Kristin Larsen, LCSW, ACSW at klarse1@luc.edu or Michael Kelly, Ph.D mkell17@luc.edu.

If you have questions about your rights as a research participant, you may contact the Loyola University Office of Research Services at (773) 508-2689.

Statement of Consent:
Your signature below indicates that you have read the information provided above, have had an opportunity to ask questions, and agree to participate in this research study. You will be given a copy of this form to keep for your records.

____________________________________________   __________________
Participant’s Signature                                Date

____________________________________________  ___________________
Researcher’s Signature                                      Date
APPENDIX H

SPIRITUALLY-DERIVED INTERVENTIONS CHECKLIST
Spiritually-Derived Interventions Checklist (SDIC) (Sheridan, 2004)

1. Gather information on clients’ religious or spiritual background
2. Use or recommend religious or spiritual books or writing
3. Pray privately for a client
4. Pray or meditate with a client
5. Use religious or spiritual language or concept
6. Help clients clarify their religious or spiritual value
7. Recommend participation in a religious or spiritual program
8. Refer clients to others for religious or spiritual counseling or direction
9. Recommend regular religious or spiritual self-reflective diary/journal
10. Recommend religious or spiritual forgiveness, penance or amends
11. Discuss role of religious or spiritual beliefs in relation to significant others
12. Assist clients to critically reflect on religious or spiritual beliefs or practices
13. Help clients assess religious or spiritual meaning of dreams
14. Help clients consider spiritual meaning of current life situation
15. Help clients reflect on beliefs about what happens after death
16. Help clients reflect on beliefs about loss or other difficult life situations
17. Touch clients for “healing” purposes
18. Help clients develop religious/spiritual rituals as practice intervention
19. Participate in client’s religious/spiritual rituals as practice intervention
20. Help clients consider ways religious/spiritual beliefs or practices are helpful
21. Help clients consider ways religious/spiritual beliefs or practices are harmful
22. Help clients consider ways religious/spiritual support systems are helpful
23. Help clients consider ways religious/spiritual support systems are harmful
24. Share your own religious or spiritual beliefs or views
APPENDIX I

RESOLVING THE DEBATE ABOUT R/S IN SOCIAL WORK
Table 1.1. Resolving the Debate about Studying Religion and Spirituality (R/S) in Social Work

<table>
<thead>
<tr>
<th>Opposing Views</th>
<th>Supporting Views</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inherent Deficiencies of R/S</td>
<td>Responding to Challenges and Strengths of R/S</td>
</tr>
<tr>
<td><strong>Institutional Problems</strong></td>
<td><strong>Institutional Challenges</strong></td>
</tr>
<tr>
<td>- Sectarian views are too limiting or biased for the profession</td>
<td>- Use inclusive view of spirituality and religion (s/r)</td>
</tr>
<tr>
<td>- Rigidity, dogmatism, and judgmentalism of religions are worrisome</td>
<td>- Engage diverse ideological and spiritual perspectives in dialogue; avoiding negative stereotyping</td>
</tr>
<tr>
<td>- Religions are basically status quo maintaining</td>
<td>- Address the role of s/r in both restricting and promoting well-being and justice</td>
</tr>
<tr>
<td>- Spiritual perspectives are overly focused on personal issues rather than macro justice</td>
<td>- Identify both micro and macro implications of s/r perspectives</td>
</tr>
<tr>
<td><strong>Personal Deficits</strong></td>
<td><strong>Personal Strengths</strong></td>
</tr>
<tr>
<td>- Religion is an expression of psychopathology</td>
<td>- Identify the role of s/r in both restricting and promoting mental health</td>
</tr>
<tr>
<td>- Spirituality is inherently personal and idiosyncratic</td>
<td>- Compare diverse s/r perspectives for similarities, differences, and mutual understanding</td>
</tr>
<tr>
<td><strong>Religion and Spirituality Are Inconsistent with the Nature of the Profession</strong></td>
<td><strong>Religion and Spirituality Express the Nature of the Profession</strong></td>
</tr>
<tr>
<td><strong>Professional Boundary Concerns</strong></td>
<td><strong>Domain Implications</strong></td>
</tr>
<tr>
<td>- Religion and social work are separate and mutually exclusive domains</td>
<td>- Religion, spirituality, and social work are interrelated and can be complementary</td>
</tr>
<tr>
<td>- S/r are not important for understanding clients</td>
<td>- Evidence shows that s/r are crucial for understanding many clients and their cultures</td>
</tr>
<tr>
<td>- Addressing s/r would undermine the status of the profession</td>
<td>- Addressing s/r competently enhances the status of the profession</td>
</tr>
<tr>
<td>- S/r are the responsibility of clergy</td>
<td>- Prepare workers to address s/r or refer and collaborate with clergy as client prefers</td>
</tr>
<tr>
<td><strong>Value Conflicts</strong></td>
<td><strong>Value Dilemmas</strong></td>
</tr>
<tr>
<td>- Involving religion increases the danger of proselytization and violation of clients’ self-determination</td>
<td>- Address s/r in a manner consistent with professional values and ethics</td>
</tr>
<tr>
<td>- Addressing religion weakens church/state separation</td>
<td>- Support church/state separation. Freedom of religious practice, and respect for diversity</td>
</tr>
<tr>
<td>- Social work should be value free or objective</td>
<td>- Social work is inherently value based</td>
</tr>
<tr>
<td>- S/r are inconsistent with a scientific base for practice</td>
<td>- Addressing spirituality is consistent with current scientific evidence</td>
</tr>
<tr>
<td>- Social workers tend to be irreligious or uninterested</td>
<td>- Social workers are often religion and always spiritual</td>
</tr>
<tr>
<td><strong>Logistical Problems</strong></td>
<td><strong>Logistical Solutions</strong></td>
</tr>
<tr>
<td><strong>Inadequate State of the Art</strong></td>
<td><strong>Emerging State of the Art</strong></td>
</tr>
<tr>
<td>- Concept of spirituality is too vague for use</td>
<td>- Create clear definitions and conceptual models</td>
</tr>
<tr>
<td>- Efforts to combine s/r and social work are not adequately developed</td>
<td>- Utilize extensive available knowledge for linking s/r to service</td>
</tr>
<tr>
<td>- Supporting evidence is not yet adequate</td>
<td>- Explore extensive interdisciplinary research and expand social work research</td>
</tr>
<tr>
<td>- Workers are unprepared to address, so better to ignore or refer</td>
<td></td>
</tr>
</tbody>
</table>
| Educators are unprepared to teach, so better to ignore | Enhance education of workers  
*Curriculum Opportunities and Responsibilities*  
- Implement both infusion and specialization in curriculum  
- Engage educators in continuing education and curriculum development |

(Canda & Furman, 2010, p. 7-8)
APPENDIX J

SAMPLE CODING PROCESS
“Communication” (Coded: Communication Issues)

“spiritual differences; communication issues; anxiety over life change” (Coded: Anxiety/Stress; Communication Issues; Religious/Spiritual Differences)

“The presenting problem would be interpersonal conflict between Anna, and her boyfriend (Jeff). In addition, there are conflicts arising from the expectations of Jeff’s family of origin. The couple are learning about one another and the impact that each person’s family of origin has on their relationship.” (Coded: Conflict Resolution and Decision Making; Family of Origin/Differentiation)

“decision making: how/process of decision making; who makes the final decision (FDR – ‘buck stops here’); and how does one react to the decision made (current and years later)?” (Coded: Conflict Resolution and Decision Making)

“The couple is allowing outside pressures (funding of their wedding and Jeff’s family pressure) to negatively affect their ability to stand together and prepare to ‘become one’ and to “leave and cleave” to one another. They need to discuss their expectations of one another and learn to encourage each one to operate out of their strength instead of trying to make the other ‘change.’” (Coded: Family of Origin/Differentiation)

“The wedding planning is not what Anna expected, now associated with anger, anxiety, and new behaviors in Jeff. It does not appear that the engaged couple have discussed the meaning of marriage in their religions, including the legality of a non-religious ceremony in the eyes of their religions, plus in what religion they plan to raise any children they may have. In order to be truly married to a Catholic the Catholic Church expects both persons to be Catholic. The pressure Anna feels about conversion may not be solely for the purpose of ceremony location; Jeff’s family may be pushing for that option so that their son will be truly married and not committing a sin by living in sin with a non-Catholic.” (Coded: Communication Issues; Anxiety/Stress; Other; Religious/Spiritual Differences)
APPENDIX K

APPLICATION OF FAITH-BASED THERAPY VIGNETTE 1
“Spiritually enriched ecological systems approach” (Coded: Faith-based Therapy; Systems/Family Systems Theory)

“1. If they both say yes we are born again Christians (having a person ongoing relationship with Jesus Christ) then I would use a Biblical approach looking at Genesis leaving, cleaving and becoming one flesh. 2. If they say they are Christians (meaning going to church on a regular basis, but no mention of a personal relationship with Jesus Christ, then I might use a systems approach to this issue. (Coded: : Faith-based Therapy; Systems/Family Systems Theory)

“Transpersonal and Family Systems theory” (Coded: Eclectic; Faith-based Therapy; Systems/Family Systems Theory)

“Eclectic: individual therapy to help her ID & express feelings, communication skills building, spontaneous prayer to cover the presenting issues, reality therapy, problem solving; couple’s therapy” (Coded: Eclectic; Cognitive-Behavioral Theory; Faith-based Therapy; Problem Solving Therapy)

“Bio, psycho, social, spiritual assessment Fowler stages of faith development Narrative Therapy along with problem solving and couples therapy I would want the couple to explore the possibilities of each maintaining their own faith and explore the strengths and weakness of a family commitment to one faith. I would see this as something that could be resolved by the couple as they hear each others past experiences, importance of faith and religion from each perspective, and their needs as a couple.” (Coded: Eclectic; Faith-based Therapy; Other; Problem Solving Therapy; Systems/Family Systems Theory)

“Maslow's Hierarchy of Needs, Erikson's Stages of Development, Fowler's Stages of Faith, Carl Jung's concept of individuation, Dr. Earl Jabay's book The Kingdom of Self, CS Lewis Mere Christianity” (Coded: Eclectic; Faith-based Therapy; Humanistic-Existential Theory; Psychodynamic Theory)

“Eclectic. Use of some Family Systems work to evaluate how family of origin has shaped and contributed to current issue. Conflict Resolution/Mediating from a scriptural perspective if the couple would be open to that. Encouraging them to approach their extend family with their plan for the wedding.” (Coded: Eclectic; Faith-based Therapy; Systems/Family Systems Theory)

“faith-based strength based and client centered, solution focus, psychodynamic” (Coded: Eclectic; Faith-based Therapy; Humanistic-Existential Theory; Psychodynamic; Solutions Focused; Strength-based Perspective)
“I use a strengths perspective. I also strongly believe in systems theories, and would want to help them explore the family and societal systems they are part of and how those have shaped what they desire/expect for a wedding and a marriage. Since they both come from Christian backgrounds I would use Biblical principles of marriage, communication, and love for others.” (Coded: Eclectic; Faith-based Therapy; Strength-based Perspective; Systems/Family Systems Theory)
APPENDIX L

PRESENTING PROBLEMS VIGNETTE I
Vignette I: Presenting Problem of Anxiety/Stress

Examples of participant responses that were coded as having identified Anxiety/Stress as a presenting problem include: “Anxiety on the part of both over making a significant adult decision…”; “Extreme stress leading to self questioning of her and her fiancé decisions threatening coping”; “Anna’s sense of isolation and anxiety about her own feelings…”; “stress related to pending marriage”; “feeling over-stressed in her life right now…”; and “I see fear and anxiety about life change as the primary presenting problem.”

Vignette I: Presenting Problem of Conflict Resolution and Decision Making

Examples of participant responses that were coded as having identified Conflict Resolution and Decision Making as a presenting problem include: “Capacity to compromise on the place and religion of ceremony…”; “Lack of experience at couple [sic] problem resolution”; “Difficulty resolving differences in wedding planning ideas”; “Conflict between Anna and Jeff over negotiation and compromise in the relationship…”; “A shift or new awareness of differences and the struggle to blend self with inter-dependence of the emerging relationship”; and “Conflict over how to make decisions that will affect them both.”

Vignette I: Presenting Problem of Religious or Spiritual Component

Examples of participant responses that were coded as Religious or Spiritual Component include: “weakness of the personal/spiritual relationship of this couple which is being exacerbated by their individual and family based dogmatic belief in their church based spiritual practice”; “…unacknowledged unconscious effects of their religion on their identities…”; “Difference in faith”; “religious conflict surrounding the wedding
The presenting problem of Communication Issues was identified by 20.88% of NASW-IL participants and 30% of NACSW participants. It was the 5th most frequently cited presenting problem for NASW-IL participants and the 4th most frequently cited presenting problem from NACSW participants. NACSW participants cited Communication Issues with greater frequency than NASW-IL participants, but this difference was not statistically significant. Examples of participant responses that were codes as having identified Communication Issues as a presenting problem include: “Communication issues and changes between Jeff and Anna…”; “POOR COMMUNICATION BETWEEN ANNA AND JEFF”; “…possible difficulties in successfully discussing emotional-charged issues with each other”; “I would identify a lack of communication between [sic] Jeff and Anna…”; “Issues of communicating across difference…”; and “The primary presenting problem in this case is the lack of communication Anna and Jeff have had since they starting dating to the present…”
The presenting problem of Family of Origin Issues and Differentiation was identified by 36.26% of NASW-IL participants and 40% of NACSW participants. It was the 2nd most frequently identified presenting problem by both NASW-IL and NACSW participants. NACSW participants cited Family of Origin Issues and Differentiation with greater frequency than NASW-IL participants, but this difference was not statistically significant. Examples of participant responses that were coded as having identified Family of Origin Issues and Differentiation as a presenting problem include: “Jeff’s relationship to his parents and their attempt at manipulating Anna into converting..”;
“…excessive involvement of extended family in the dynamics of the couples’ relationship”; “…Lack of separation from parents”; “Jeff’s family trying to control Jeff and how he should live his life”; “…concerns over husband’s ability to effectively separate from the expectations of his family and form a relationship with wife in marriage…”; “Impact and influence of families of origin upon current relationship…”; and “…boundary issues.”
APPENDIX M

ADDITIONAL ASSESSMENT REQUESTS VIGNETTE I
Vignette I: Additional Assessment Request of Premarital Inventory

Examples of participant responses that were identified as referencing Premarital Inventory include: “Some sort of pre-marital inventory such as FOCCUS”; “…a pre-marital assessment…”; “I would see value in administering a Taylor-Johnson to highlight what their current perceptions are…”; “Would evaluate their preparation for the marriage by means of a standardized test such as Prepare…”; “Complete Prepare assessment to further uncover important premarital issues for discussion and resolution”; “Marriage-Enrich”, “Assessments evaluating the compatibility of Anna and Jeff”; and “Some basic compatibility rating scales to help them examine their relationship and learn ways of conflict resolution.”

Vignette I: Additional Assessment Request of Religious or Spiritual Beliefs

The assessment area of Religious or Spiritual Beliefs was referenced by 51.65% of NASW-IL participants and 50.83% of NACSW participants; this difference in frequency was not statistically significant. This assessment area, which was the most frequently referenced area by both groups, contains a variety of inquires about the client’s religious and/or spiritual beliefs, including questions about current faith practices, religious upbringing, and the future role of religion in the marriage. Examples of participant responses that were identified as requesting additional assessment information related to Religious or Spiritual Beliefs include: “Psychosocial h/x that includes importance of religious faith of both Anna and Jeff and their families…”; “1. Have they discussed their spiritual life together – how will they raise their children. 2. Is this really about their spiritual beliefs or about control? 3. If money weren’t an issue what kind of wedding would they like to have.”; “I would want to take a history of each of them to
understand whether their religious differences are due to fundamental beliefs that are core to each or whether there are other dynamics at work”; “Family spiritual and religious history”; “Bio, psycho, social, spiritual assessment with the couple together I would want to assess each regarding their stages of faith development which would give me an idea of their openness to other faith perspectives, their separation from their own community of faith and if they have moved back to their faith as a new person with greater openness…”; and “More information on each individual’s religious background in childhood, how religious were they, what were their religious beliefs and practices.”

**Vignette I: Additional Assessment Request of Family/Social History**

Family/Social History was the second most frequently referenced additional assessment area by both groups of participants. 50.55% of NASW-IL participants indicated that they would request more information about family and/or social history of the client(s) to create a plan for moving forward, and 45.83% of NACSW participants indicated they would request this information. NASW-IL participants referenced Family/Social History with greater frequency than NACSW participants, but this difference was not statistically significant. Examples of participant responses that were identified as requesting additional assessment information related to Family/Social History include: “Family/social history of each partner, including religious upbringing, thoughts on their experience”; “Brief childhood and family social history on both…”; “detailed family background, particularly regarding parental relationships of Anna; sibling history, particularly as it relates to marriages, parental expectations of other sibling Jeff’s family”; “Additional information from Anna pertaining to understand her background and though process”; “More information on Jeff’s relationship with his
family and his separation/individual issues”; and “Find out more about Anna’s parents and if they are creating stress or pressure in this area.”

**Vignette I: Additional Assessment Request of Conflict Management Skills**

The assessment area of Conflict Management Skills was referenced by 28.57% of NASW-IL participants and 21.67% of NACSW participants; the difference in frequency with which this assessment area was referenced by both groups was not statistically significant. This assessment area, which was the third most frequently referenced area by both groups, includes inquiries about previous conflicts, communication skills, and problem solving skills. Examples of participant responses that were identified as requesting additional assessment information related to Conflict Management Skills include: “Ask her fiancé to come in to ‘help’ evaluate Anna’s stresses to determine if the couple can find a mutual understanding about their current differences and develop skills to negotiate differences now and in the future”; “…history related to problem solving and use of coping skills (both individually and within relationship)...”; “Are there other issues that have come up that have been put aside and not resolved?”; “cft and fiancé communication styles ways in which cft and fiancé resolve conflict willingness to compromise in both anna and fiancé”; “Ways the couple has handled past conflicts with one another as well as individuals outside of their relationship...”; “More of their history together and how they have handled disagreements in the past four years”; and “…Some sense of couple’s negotiating tactics heretofore.”

**Vignette I: Additional Assessment Request of Couple’s Relationship History**

The assessment area of Couple’s Relationship History was referenced by 23.08% of NASW-IL participants and 20.83% of NACSW participants making it the fourth most
frequently referenced area by both groups. NASW-IL participants referenced Couple’s Relationship History with greater frequency than NACSW participants, but this difference was not statistically significant. Examples of participant responses that were identified as requesting additional assessment information related to Couple’s Relationship History include: “I would explore the history and dimensions of their relationship getting a sense of the childhood emotional pattern which they bring to and help them to talk through the issues that emerge”; “…overview of relationship dynamics over the past 4 years…”; “I’d want to see the couple together and observe dynamics of their system”; “I would create a plan that enables this couple to explore strengths and weaknesses during the past four years that have brought them to this place so that this can be used to move forward”; “…Background information on their Courtship/Relationship”; and “It would be important to find out what each of them wants out of the relationship and expectations for the future…if they are even wanting the same things for their future.”

**Vignette I: Additional Assessment Request of Mental Health History**

The Assessment area of Mental Health History was referenced by 13.19% of NASW-IL participants and 6.67% of NACSW participants. It was the 5th most frequently referenced assessment area by NASW-IL participants and the 6th most frequently referenced assessment area by NACSW participants. NASW-IL participants referenced Mental Health History with greater frequency than NACSW participants, but this difference was not statistically significant. Examples of participant responses that were identified as referencing Mental Health History/Assessment include: “Mental health evaluation for both to begin”; “…Mental Health Hx of both…”; “History of mental
health”; “…History of anxiety/stress in and out of relationships…”; “Any physical symptoms of stress or mental health issues…”; “First I would use a measure for Anna’s anxiety, to make sure it is not just ‘wedding stress,’ and to get a baseline for her…”; and “past mental health involvement of each member of the couple.
Vignette I: Identification of Psychodynamic Theory

Examples of participant responses that were identified as referencing Psychodynamic Theory, include: “…empathic holding environment…”; “My internal frame is psycho-dynamic from a strengths perspective…”; “My theoretical commitment is to self psychology. I would see it essential to understand how much of their belief systems are part of a fundamental sense of self. Furthermore, I would want to know what each seeks from the other in terms of self/object needs”; and “Brief therapy, maybe Yung.”

Vignette I: Identification of Systems/Family Systems Theory

Systems/Family Systems Theory was the most frequently referenced clinical theory by NASW-IL participants and NACSW participants. 45.05% of NASW-IL participants and 35.00% of NACSW participants referenced this theory for use with the client(s) of the first vignette. NASW-IL participants referenced Systems/Family Systems Theory with greater frequency than NACSW participants, but this difference was not statistically significant. Examples of participant responses that were identified as referencing Systems/Family Systems Theory, include: “Family systems”; “Couples therapy-Bowen Systems, Family”; “…I have been trained in systems approach, which can be helpful in working on issues involving the extended families”; “Relationship based treatment – not focused on ‘religious’ based treatment component – would try and help clients understand/identify their motives”; “Bowen’s theory of triangulation would be fitting for this couple”; “Ecosystems perspective, empowerment model”; and “Family systems approach, Bowenian and Minuchin.”

Vignette I: Identification of Cognitive Behavior Theory
Cognitive Behavior Theory was the second most frequently cited clinical theory for both participant groups. It was identified for use in the first vignette by 32.97% of NASW-IL participants and 28.33% of NACSW participants. NASW-IL participants referenced Cognitive Behavior Theory with greater frequency than NACSW participants, but this difference was not statistically significant. Examples of participant responses that were identified as referencing Cognitive Behavior Theory, include: “CBT to uncover the beliefs affecting her anxious feelings and anger…”; Cognitive Behavioral Therapy”; “cognitive/behavioral”; “Rational Emotive Behavior Therapy”; “Cognitive theory”; and “Supportive psychotherapy with the goal of reducing stress, supporting and enhancing her strengths, and coping skills, and her capacity to use available supports. Behavioral and cognitive approaches seem best for this situation.”
APPENDIX O

CLINICAL INTERVENTIONS OR RESOURCES VIGNETTE I
Vignette I: Religious or Spiritually-Derived Interventions

Participant responses that were sorted into the category of Religious or Spiritually-Derived Interventions include, “Provide information/resources on interfaith marriages Consultation with church pastor/clergy”; “My basic tactic would be to have the individuals and family look at the effect their religious allegiance was having on a relationship which has been functioning well prior to having dogmatic religious beliefs superimposed on it”; “I might suggest that they attend services at each other’s churches as a way to get comfortable and help with deciding where to have their ceremony. Maybe speaking with a pastor at each would be helpful as well”; “validation of religious identity, and understanding of how important religious identity is (genogram) to Anna’s identity as a spouse, which influences her motivation to strengthen her religious beliefs or be open to new ones in the context of marriage”; “I would utilize practices within Gottman therapy and provide an opportunity to this couple (if comfortable) to use scripture and prayer during sessions”; “Discussion of faith perspective”; “Scriptural references to ‘leaving and cleaving’”; and “Premarital counseling and homework exercises and much prayer.”

Vignette I: Communication/Conflict Resolution

18.68% (n = 17) of NASW-IL participants and 20.83% (n = 25) of NACSW participants submitted responses that were sorted into the category of Communication/Conflict Resolution, making this category the second most frequently referenced by both participant groups; the difference in frequency with which these groups referenced this category was not statistically significant. Examples of participant responses that were sorted into this category include: “Exploration of feelings concerning these issues; how they recognize and explore differences; this is an early conflictual issue
and needs to be addressed as such so that tolerance of and effective handling of conflict can be encouraged”; “secular individual and couples counseling to work on a compromise that both parties can agree on helping clt and fiancé set expectations using couples counseling improving communication btwn clt and fiancé discussing conflict resolution”; “I would meet with the couple one session, and then have an individual session with each. Thereafter, I would anticipate meeting with the couple conjointly to facilitate communication and conflict resolution”; “This couple needs to talk about what each expects and how to understand it”; “Some of Gottman’s works Process of communication skills/style”; and “Suggest meeting with the couple. Clarification of Anna’s needs, new issues about the relationship, and clarification of any common ground for the couple.”

Vignette I: Family Systems Strategies

Family Systems Strategies was the third most frequently referenced treatment intervention category by both NASW-IL and NACSW participants. 12.09% (n = 11) of NASW-IL participants and 8.33% (n = 10) of NACSW participants provided responses that were identified as referencing this response category; the difference in frequency with which these groups referenced this category was not statistically significant. Examples of participant responses that were sorted into this category include: “Using a genogram to identify the family dynamics/triangulation/emotional cutoff within Jeff and Anna’s families and how they are also playing into the dynamics to gain insight on how their relationship is affected by family of origin”; “Strategies as learned from Bowen theory-eg. Triangulation”; “Systems observations and providing data based feedback to them”; “If I did practice family/couples counseling, I might systematically explore each
partners family background (genogram) and use an instrument to help determine congruencies and discongruencies between Anna and Jeff in terms of familial rules and mental rules...”; and “Functional Family Therapy to reduce blaming and create a family focus.”

**Vignette I: Additional Interventions**

Decision Making and Problem Solving, CBT Techniques, and Use of Therapeutic Relationship were treatment intervention categories that were referenced by at least 5% of one participant group. Decision Making and Problem Solving (e.g., “problem-solving for couple”) was referenced by 9.89% \((n = 9)\) of NASW-IL participants and 7.50% \((n = 9)\) of NACSW participants; the difference in frequency with which these groups referenced this category was not statistically significant. CBT Techniques (e.g., “reading and workbook assignments that require/allow first exploration of individual thoughts, beliefs, and attitudes, then comparison/discussion as a couple, finally looking at it with therapist”) was referenced by 8.79% \((n = 8)\) of NASW-IL participants and 4.17% \((n = 5)\) of NACSW participants; the difference in frequency with which these groups referenced this category was not statistically significant. Use of Therapeutic Relationship (e.g., “I would suggest empathic and supportive listening”) was referenced 8.79% \((n = 8)\) NASW-IL participants and 2.50% \((n = 3)\) NACSW participants; fisher’s exact test found this difference in frequency to be not quite statistically significant.

The remaining two categories of Table 8 are More Information Needed and NA/None; there were no statistically significant differences between the two groups with regards to these categories. 5.49% \((n = 5)\) of NASW-IL participants and 5.00% \((n = 6)\) of NACSW participants indicated that they were unable to identify recommended treatment
interventions without additional assessment information; these responses were sorted into the category of More Information Needed. Finally, 3.30% (n = 3) of NASW-IL participants and 2.50% (n = 3) of NACSW participants indicated that they were either unable to answer the question or that no intervention was indicated.
APPENDIX P

PRESENTING PROBLEMS VIGNETTE II
Vignette II: Identification of Depression/Low Mood

Examples of participant responses that were codes as having identified Depression/Low Mood as a presenting problem include: “Tom is depressed”; “His presentation of what appears to be depression”; “Major Depressive Disorder”; “Tom seems to be presenting with symptoms of major depressive disorder”; “Although Tom doesn’t specify a presenting problem, he describes a moderate depression regarding confusion about the creation of meaning specific to several different experiences and events”; “The major problem is the depression Tom is suffering from at this time”; “Situational depression that often comes with life changes, especially daughters getting married for fathers”; and “Tom may be experiencing some depression/depressive thoughts. These could be due to not having their children in their home any longer and starting their own new lives.”

Vignette II: Identification of Developmental/Midlife Crisis

The presenting problem of Developmental/Midlife Crisis was referenced by 38.46% of NASW-IL participants and 28.33% of NACSW participants. It was the 2nd most frequently referenced presenting problem by NASW-IL participants and the 3rd most frequently referenced presenting problem for NACSW participants. There was no statistically significant difference between these groups with regards to this presenting problem. Examples of participant responses that were coded as having identified Developmental/Midlife Crisis include: “Midlife age related questions about life, possible depression”; “Tom is entering a transition point to older age and facing pretty typical questions related to that adult developmental period…”; “Midlife crisis; Erikson’s stage of Integrity vs. Despair. He’s looking back at life and seeing failures”; “Tom is struggling
with a ‘mid-life crisis’ and feeling he has become stagnant and not contributed what he could have to this world”; “another life transition issue (midlife)”; “Adjustment to developmental, ‘season of life’ changes”; “Tom is going through what some call male menopause because of the irritability and moodiness, but it is necessary reviewing and revamping his roles in life…”; and “At 57, Tom is experiencing life changes, doing some accountability, and reflecting on the difference he has made in life. Doing an inventory can be threatening and bring challenges to a person’s sense of meaning. Keeping the home fires burning has tired him out as he has watched his family grow and said good-bye to his parents. He is doing the difficult work of his developmental stage.”

Vignette II: Identification of Existential/Identity Issues

The presenting problem of Existential/Identity Issues was the 4th most frequently referenced presenting problem by both participants groups. It was referenced by 26.37% of NASW-IL participants and 25.83% of NACSW participants. There was no statistically significant difference between these groups with regards to this presenting problem. Examples of responses that were coded as referencing the presenting problem of Existential/Identity Issues include: “How does Tom view the world/universe/supernatural and his relationships in and to the world”; “I would view this as an issue with identifying future goals, and understanding purpose and mission in his life…”; “Basic identity issues, meaning and purpose of his life”; “That Tom is questioning the purpose of his life”; “Existential questioning…”; “Existential feelings and challenges”; “Tom is evaluating his life (past and future). He is searching for meaning”; “Tom has existential questions that he would like answered: purpose of his life grasping the meaning of mortality; wanting/need of an ‘anchor’ in his life, and wanting to know ‘Has my life been worth
living’’; and “I would want to rule out depression but focus on the existential issues that he is grappling with that may have precipitated his leaving his church.”

**Vignette II: Identification of Grief/Loss**

The presenting problem of Grief/Loss was referenced by 28.57% of NASW-IL participants and 23.33% of NACSW participants. Grief/Loss was the 3rd most frequently referenced presenting problem for NASW-IL participants and the 5th most frequently referenced presenting problem for NACSW participants. There was no statistically significant difference between these groups with regards to this presenting problem. Examples of participant responses that were coded as referencing the presenting problem of Grief/Loss include: “Bereavement, grief, loss affecting his life-view”; “Tom’s depression and grief over the loss of his parents”; “Tom has experienced a number of recent losses and needs help mourning them”; “Unresolved grief and related issues…”; “The grief of his loss of both of his parents”; “Need to complete the grieving process over losses in the last few years”; “I see unresolved grief and loss issues, as well as possible current depression (which may be connected with the unresolved grief)”; and “experience of loss and grief.”

**Vignette II: Identification of Religious or Spiritual Component**

18.68% of NASW-IL participants and 28.17% of NACSW participants reported that there was a Religious or Spiritual Component as a presenting problem in the second vignette. Religious or Spiritual Component was the 5th most frequency referenced presenting problem by NASW-IL participants and the 2nd most frequently referenced presenting problem by NACSW participants. NACSW participants referenced Religious or Spiritual Component with greater frequency that NASW-IL participants, but this
difference was not statistically significant. Examples of participant responses that were coded as having referenced the presenting problem of Religious or Spiritual Component include: “Lack of meaning and spiritual connection to a larger purpose or power greater then himself”; “loss of church affiliation – depression”; “…possible sense of loss due to lack of connection with his church”; “1.) Depressed mood 2.) Loss of spiritual community and identity (in part) 3.) Unresolved grief”; “Spiritual. I think that he is at a life stage which may cause such reflection, but that his leaving the church may have something to do with his relationship with his spiritual questioning of the world at large…”; “1. Tom’s lost religious identity 2. Unresolved issues with his parents”; “Mild depression, disconnection from faith”; “Tom’s anxieties related to aging, spirituality and death”; and “loss of church family support system.”
APPENDIX Q

ADDITIONAL ASSESSMENT REQUESTS VIGNETTE II
Vignette II: Additional Assessment of Mental Health History

Examples of participant responses that were identified as referencing the need for additional assessment information about Mental Health History include: “Fuller assessment to r/o clinical depression, including any history of depression for himself or family members…”; “History of possible depressive episodes, question regarding suicidal ideation…”; “I would use the BDI to determine current symptoms…”; “Lethality assessment”; “Good history about depression”; “Previous experiences of irritability and moodiness. Most severe episode. Usual coping mechanisms. Level of personal distress”; “I may look to see if he has ever had a history of depression and any treatment”; “I would want to get a full psychosocial evaluation done, if possible including an MMPI, to rule out any major psychiatric issues first. If nothing more than a depressive disorder showed up I would proceed”; “I would probe the depression to ascertain how entrenched it actually is. Were there specific vegetative symptoms I would refer for a psychiatric consult”; and “About how often do you experience these feelings of hopelessness? Have you ever had thoughts of hurting yourself? Do you have a plan to hurt yourself?”

Vignette II: Additional Assessment of Family/Social History

Family/Social History was the most frequently referenced assessment area by NASW-IL participants and NACSW participants. It was referenced by 59.34% of NASW-IL participants and 46.67% of NACSW participants. NASW-IL participants referenced Family/Social History with greater frequency than NACSW participants, but this difference was not statistically significant. This assessment area contains a variety of inquires about client’s family and social life, including social supports, his relationship with his wife, parents, and daughters, and recent and historical life events. Examples of
participant responses that were identified as requesting additional assessment information related to Family/Social History include: “The relationship between Tom and his parents and Tom and his wife”; “Additional family history”; “Family history of his family of origin and also his own family…”; “I would want to know all available support systems to which he might respond, assessing which of these losses is primary. Seeing the couple together would be important as indicated as time goes on”; “Tom’s feelings about his marriage, especially whether he’s having or contemplating having an affair…”; “Tom’s feelings and thoughts about his daughter’s engagement as it relates to his stage and role in life”; “Get a thorough psychosocial history”; and “how important his faith/church have been to him in his life. Is this an anniversary of a traumatic time in his parents’ or his childhood life? How does he view his marriage? How is his current relationship with his children?”

Vignette II: Additional Assessment of Grief and Loss

The assessment area of Grief and Loss was referenced by 13.19% of NASW-IL participants and 13.83% of NACSW participants. It was the 6th most frequently referenced assessment area by both groups, and there was no statistically significant difference between the groups with regards to this area. Examples of participant responses that were identified as requesting additional assessment information about Grief and Loss include: “Grief and loss”; “I would talk with Tom more about his history, what he experienced with his parents, and how he responded at time of their death…”; “…develop a better understanding of his mid-life crisis, and his multiple losses, both actual and symbolic”; “Delineate/discuss all grief issues which may be compounding the
grief response (loss of his parents, the loss of his church)...”; and “…Hx of how he dealt with the loss of both of his parents.”

**Vignette II: Additional Assessment of Medical History**

The need for additional Medical History was referenced by 17.58% of NASW-IL participants and 22.50% of NACSW participants. It was the 5th most frequently referenced assessment area by NASW-IL participants and the 4th most frequently referenced area by NACSW participants. NACSW participants referenced this assessment area with greater frequency than NASW-IL participants, but the difference was no statistically significant. Examples of participant responses that were identified as referencing the assessment area of Medical History include: “Physical health assessment…”; “medical workup to r/o physical possible physical contributors…”; “…Health screening”; “Full evaluation which would include psycho-social history and medical information”; “Health information to rule out other causes of his depressive symptoms…”; “Other symptoms/concerns that Tom is experiencing. I would also encourage him to see his PCP to determine there isn’t an underlying medical condition”; and “I would want to receive his medical records to see if there are any physical problems that would add to the feelings of hopelessness.”

**Vignette II: Additional Assessment of Psychological Wellbeing**

The assessment area of Psychological Wellbeing Components contains inquires related to client strengths, his sense of purpose in life, and his sources of satisfaction and enjoyment. The assessment area of Psychological Wellbeing Components was referenced by 23.08% of NASW-IL participants and 21.67% of NACSW participants; it was the 4th most frequently referenced assessment area of NASW-IL participants and the 5th for
NACSW participants. There was not a statistically significant difference between NASW-IL and NACSW participants with regards to this area. Examples of participant responses that were identified as referencing the additional assessment area of Psychological Wellbeing Components include: “…what he feels passionately about…”; “…What did he think life would be like at his age? Are there goals that he feels he has not achieved? What provided him meaning in the past?...”; “…client strengths, current relationship assets and liabilities…”; “…where is he getting his sustenance for enjoyment and fulfillment in life?...”; “…rating overall satisfaction with work, marriage, church and life”; “…Tom’s history of meaningful non-work activities, interests and hobbies”; “outside interests, areas in which to volunteer, help others, feel a sense of contribution...”; and “Coping skills, self-nurturing skills, communication skills.”

Vignette II: Additional Assessment of Religious or Spiritual Beliefs

The assessment area of Religious or Spiritual Beliefs was referenced by 35.16% of NASW-IL participants and 44.17% of NACSW participants. Religious or Spiritual Beliefs was the 3rd most frequently referenced additional assessment area by NASW-IL participants and the 2nd most referenced additional assessment area by NACSW participants. NACSW participants referenced this area with greater frequency than NASW-IL participants, but this difference was not statistically significant. Examples of participant responses that were identified as referencing this assessment area include: “History with religious tradition. Why did they leave prior church...”; “…importance of Tom’s religious faith to him and his family (how long was he involved with church and the reason for leaving)”; “…Also more information on his church affiliation, how long he was there, what religion, his involvement with the church and why he left”; “…Spiritual
beliefs about his mortality”; “…Role of ‘the church’ in his life – view of God in relationship to himself”; “How was his church experience? Meaningful? Helpful?”; “Is he a Christian?...Why did he drop out of church?”; “…what role his faith plays in his sense of having a meaning or purpose”; and “History of depression, spiritual assessment, assessment of stressors within ecological system – i.e. why couple left their church, current spiritual beliefs, was support system impacted by leaving church, ex. were their friends at church.”
APPENDIX R

APPLICATION OF CLINICAL THEORY VIGNETTE II
Vignette II: Application of Psychodynamic Theory

Examples of participant responses that were identified as referencing Psychodynamic Theory include: “I would utilize object relations and self psychology”; “Self psychology to explore the unconscious dynamics that are leading to his current feelings”; “Psycho dynamic with psychoanalytic under pinnings”; “Individual Psychology of Alfred Adler”; “Psychoanalytic”; “Psychodynamic concepts”; and “…If his suicidal assessment is negative, an object relations approach could help him to explore the basis for his regrets about his performance as son and father.”

Vignette II: Application of Systems/Family Systems Theory

Examples of participant responses that were identified as referencing Systems/Family Systems Theory include: “Transgenerational Family Dynamics…”; “systems”; “systemic family constellation modality”; “…I have some training in internal family systems approach which might also be useful for this client”; “Bowen theory…”; “Family of Origin/Bowenian work…”; and “Family Systems taking a look at the current losses of the children leaving home coupled with a look at his family of origin and some of the losses of the recent past.”

Vignette II: Application of Cognitive-Behavioral Theory

Cognitive-Behavioral Theory (CBT) was the most frequently referenced theoretical approach by NASW-IL participants and NACSW participants. 46.15% of NASW-IL participants and 36.67% of NACSW participants identified CBT as an approach they would utilize with the client(s) in the second vignette. NASW-IL participants referenced CBT with greater frequency than NACSW participants, but this difference was not statistically significant. Examples of participant responses that were
identified as referencing CBT include: “…Cognitive-behavioral approaches to help client reorganize his experience”; “CBT focused on building insight regarding triggers and assisting client with management of symptoms…”; “Cognitive Behavioral Therapy”; “Cognitive-behavioral, if depressed…”; “…Rational Emotive Behavior Therapy”; “Cognitive for the main part…”; “CBT to identify dysfunctional thoughts surrounding the anxiety about his age, his purpose in life, and thoughts about God”; and “Cognitive-Behavioral and Rational Emotive concepts.”

Vignette II: Application of Humanistic-Existential Theory

Humanistic-Existential Theory was referenced by 18.68% of NASW-IL participants and 14.17% of NACSW participants. It was the 4th most frequently referenced theoretical approach by NASW-IL participants and the 2nd most frequently referenced approach by NACSW participants. The difference in frequency with which this theory was referenced by the two groups was not statistically significant. Examples of participant responses that were identified as referencing Humanistic-Existential Theory include: “Most likely existential tx”; “Eclectic. Would probably combine existential approach with some life coaching techniques…”; “Existential therapy, Logotherapy, focus on meaning and purpose and to what extent Tom has integrated around these issues”; “Humanistic theory”; “Existential, client centered, maybe Gestalt if unresolved issues with parents”; and “client centered.”
APPENDIX S

APPLICATION OF FAITH-BASED THERAPY VIGNETTE II
“Depending on results of assessment, biological if related to Tom’s aging process, medical issue, or substance use. Medication if indicated for depressive symptoms if recommended after psychiatric assessment. Spiritual focus on Tom’s sense of a meaningful life and his goals for that. Cognitive behavioral for his thoughts, feelings, and actions. Couple’s therapy if his wife is needed for support or if she is part of the etiology.” (Coded: Eclectic; Faith-based Therapy; Cognitive-Behavioral Theory; and Other)

“Spiritually enriched ecological systems perspective.” (Coded: Eclectic; Faith-based Therapy; and Systems/Family Systems Theory)

“I would use the spiritual assessment developed by Hodge 2001) as well as the book ‘The Portable Pilgrim: Seven Steps to Spiritual Enlightenment’ by McMahon (bibliotherapy). Additionally, I would explore his perceptions utilizing existential techniques of Rollo May to answer the questions of meaninglessness, freedom, isolation, and death. I would additionally focus upon forgiveness of self. Love for self and others, acceptance of what is, and purpose for life.” (Coded: Eclectic; Faith-based Therapy; and Humanistic-Existential Theory)

“Choice Theory, integrating ideas of Viktor Frankl, Biblical concepts related to forgiveness and a view of the future with hope” (Coded: Eclectic; Faith-based Therapy; Humanistic-Existential Theory; and Other)

“I would initially look at some cognitive and behavioral theory at first and then because of the issues the client brought up would look into religious and spiritual issues.” (Coded: Eclectic; Faith-based Therapy; and Cognitive-Behavioral Theory)

“Eclectic: Psychospiritual education; psychodynamic, reality therapies, spiritual approaches w/ his permission, CBT for distorted thoughts; unconditional positive regard” (Coded: Eclectic; Faith-based Therapy; Humanistic-Existential Theory; Psychodynamic Theory; and Cognitive-Behavioral Theory)

“Modern Psychoanalytic, integrated with Biblical perspectives.” (Coded: Eclectic; Faith-based Therapy; Psychodynamic Theory)

“Cognitive behavioral, pastoral, discussion on stages of life” (Coded: Eclectic; Faith-based Therapy; Developmental Theory; Cognitive-Behavioral Theory)

“Relational, possibly behavioral and also some spiritual work.” (Coded: Eclectic; Faith-based Therapy; Humanistic-Existential Theory; and Cognitive-Behavioral Theory)
“Again, the hierarchy of needs and the description of his stage of life. Also spiritually-focused exploration of why he left his church” (Coded: Eclectic; Developmental Theory; and Faith-based Therapy)

“Psychoanalytic and spiritual theories” (Coded: Eclectic; Faith-based Therapy; and Psychodynamic Theory)

“faith-based strengths and client centered, psychodynamic and possible cognitive behavioral” (Coded: Eclectic; Faith-based Therapy; Humanistic-Existential Theory; Psychodynamic Theory; and Cognitive-Behavioral Theory)

“Cognitive for the main part and would include religion and psychosocial viewpoint to examine. Help the client process through things going on in his mind” (Coded: Eclectic; Cognitive-Behavioral Theory; and Faith-based Therapy)
APPENDIX T

CLINICAL INTERVENTIONS OR RESOURCES: VIGNETTE II
Vignette II: Identification of Cognitive Behavioral Techniques

Examples of participant responses that were sorted into this category include:
“Use CBT to identify problematic thoughts and replace them...”; “I would begin with Individual Therapy and help Tom focus on his thinking about all of the issues he has presented. I would focus on how his thinking impacts his feelings...”; “…Interventions: Diary, recording automatic thoughts, behavioral activation, MI based on Tom’s goals”; “Thought records/journaling to identify emotions and beliefs...”; “Would probably start with some educational information regarding depression and cognitive behavioral treatment. Would also have him do a thinking error/faulty assumption inventory...”;
“dysfunctional thought record”; and “Journaling CBT – change thoughts and schemas.”

Vignette II: Identification of Religious or Spiritually-Based Intervention

In general, examples of participant responses that were sorted into the category of Religious or Spiritual Intervention include: “…After assessing religious history may encourage exploration of new tradition”; “Depending on clients relationship to his church and feeling about it, I might suggest he return to services or at least try. If he had issues with the minister or church, perhaps, he might speak to his minister/priest or someone else of his church with whom he felt sufficient trust to discuss his separation from church...which had previously, it would see, he had at least a minimally positive association”; “May direct client to consider a spiritual approach such as Pathwork as set forth by Eva Pierrakos”; “I would want to learn something about the church that he left if I were unfamiliar with it”; “Urge Tom to get involved in church (men and couple’s) activities to change focus”; “The Bible, if they are open to it...”; “I would encourage to read scripture to boost his faith and reliance upon God to remind him that there is always
hope. That God has a plan”; and “Meeting with a pastor. Joining a men’s Bible Study or Fellowship Group. He and his wife joining a Bible Study or Fellowship Group together.”

Significant Differences in Response to Vignette II: Use of Therapeutic Relationship

Examples of participant responses that were sorted into this category include: “Clinical intervention imply doing something to the patient. What happen to what evolves in the transference that the patient creates with the [Therapist]; “I would use conventional secular relationship based treatment…”; “Thorough, thoughtful, careful questioning of the issues brought forth with gentle, compassionate listening”; “Relational approach to individual treatment”; “I’d look at how he’s gone about defining his sense of ‘self’”; “secular, I would suggest empathic and supportive listening…”; and “Psychodynamic Psychotherapy. Initiate a process of self reflection, self exploration, and self discovery within Tom that will eliminate his depression. Also, help Tom to develop inner capacities/resources that will allow him to live life with a greater sense of freedom and joy.”

Vignette II: Identification of Medical/Psychiatric Evaluation

The treatment intervention of Medical/Psychiatric Evaluation was also referenced by 15.38% (n = 14) of NASW-IL participants, and, therefore, shares the status as 3rd most frequently referenced treatment intervention for this group. It was the 5th most frequently referenced treatment intervention by NACSW participants (8.33%, n = 10). The difference in frequency with which this category of intervention was referenced by the two groups was not statistically significant. Examples of participant responses that were sorted into the category of Medical/Psychiatric Evaluation include: “…Referral for meds if needed…”; “…psychiatric evaluation for medication”; “As noted above, Tom should
have a physical with blood work if he hasn’t done so in a year…”; “Determine need for psychiatric consult for medication depending on his level of depression”; “Might need to refer to his PCP or a psychiatrist”; “…I would suggest a medication evaluation for possible antidepressant meds”; “…refer for thorough medical exam”; and “…I would also do a referral to a medical doctor to see if there are any medical problems contributing to his change in perspective.”

Vignette II: Identification of Couple’s Therapy or Family Systems Strategies

15.38% (n = 14) of NASW-IL participants and 12.54% (n = 15) of NACSW participants provided responses that were sorted into the category of Couple’s Therapy or Family Systems Strategies. This category was the 3rd most frequently referenced category for both groups. The difference in frequency with which this category of intervention was referenced by the two groups was not statistically significant. Examples of participant responses that were sorted into the category of Couple’s Therapy Family Systems Strategies include: “…internal family systems approach…”; “…genograms…”; “Genogram to identify family themes…”; “May include couple’s therapy…”; “Resources accessed would include any identified supports including his wife and other supports the client identified”; “Community based supports through established contacts”; “…use of genogram results to his current situation…”; “experiential family therapy (Satir) reality therapy”; and “Individual and family therapy.”
REFERENCE LIST


VITA

Kristin Larsen was born and raised in Michigan. Before attending Loyola University Chicago, she attended the University of Michigan, Ann Arbor, where she earned a Bachelor of Arts in Psychology in 2000. From 2001 to 2003, she also attended the University of Chicago’s School of Social Service Administration, where she received a Master of Arts in Social Work.

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