THERAPIST EXPERIENCES WITH RELIGION AND SPIRITUALITY IN TREATMENT:
A QUALITATIVE STUDY

A DISSERTATION
SUBMITTED TO THE FACULTY
OF
THE GRADUATE SCHOOL OF APPLIED AND PROFESSIONAL PSYCHOLOGY
OF
RUTGERS,
THE STATE UNIVERSITY OF NEW JERSEY
BY
ALIZA LASKY BIER
IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF PSYCHOLOGY

NEW BRUNSWICK, NEW JERSEY AUGUST 2022

APPROVED: ____________________________
Nicole M. Cain, Ph.D.

______________________________
Shalonda Kelly, Ph.D.

DEAN: ____________________________
Arpana Inman, Ph.D.
Abstract

Despite research suggesting that approximately 72% of Americans self-identify as religious, there is evidence that religion and spirituality (r/s) are not sufficiently addressed in mental health treatment. However, the reasons for this are not well understood. The current study sought to identify barriers in addressing r/s in treatment by interviewing psychologists about their experiences navigating r/s with clients. This study explored both general barriers as well as therapist-specific factors that might serve as barriers. Eight doctoral-level psychologists were interviewed using a semi-structured format. A Grounded Theory analysis was conducted to identify themes present in the data. Findings in the current study did not support the notion that therapists avoid addressing r/s in treatment. However, some barriers and challenges in addressing r/s in treatment were identified: client guardedness, client assumptions about the therapist, therapist lack of knowledge and training, therapist difficulty maintaining a clinical role and withholding personal r/s beliefs, and r/s differences between client and therapist. Regarding therapist-specific barriers, several factors emerged as potentially impacting the ways therapists address r/s in treatment: gender, race, r/s identity, changes in r/s identity over time, therapeutic modality, and years in practice. The Grounded Theory analysis revealed eight global themes; limited supervision and training, r/s as a resource, attention to maladaptive r/s beliefs, increased comfort with r/s over time, following the client’s lead with areas of identity, r/s as a shared language, looking at the relevance of r/s for the specific client, overlap between r/s and relationships, and an “I’m not the judge” mentality. From these themes, a tentative model for incorporating r/s into therapist training, supervision, and clinical work was developed. Additional implications and suggestions for future research are discussed.
ACKNOWLEDGEMENTS

Though this dissertation is intended to be my seminal project toward my doctoral degree, I feel acutely aware that it has taken a village to get me to this point. I would like to thank some of the people who have played a crucial role in getting me to where I am today.

First and foremost, I would like to thank my family, starting with my parents, who raised me, provided for me, and instilled within me the religious values that I hold dear. These values were not a given for you, but you consciously chose to embrace them and raise us with them. Not only did those values inspire me to choose religion and spirituality as my dissertation topic, on a daily basis, they infuse my life with meaning and guide my decisions. To my siblings—Aviva, Shimon, and Shosh—thank you for the love, friendship, and good times that you have each brought into my life.

I don’t know if I ever would have pursued a doctorate in psychology without the persistent encouragement of my undergraduate professor, Dr. Perella Perlstein. Dr. Perlstein, thank you for pushing me to “go the doctoral route” despite my many hesitations. You were right. It was a great choice.

GSAPP has astounded me with the quality of its faculty and training. Unlike some of my study participants, I have always felt supported in expressing my religious identity in graduate school. From kosher food at school events to arrangements made to accommodate the slew of Jewish holidays, I am grateful for my experiences as a Jewish woman at GSAPP.

There are some specific faculty members I would like to thank. Dr. Brook Hersey, you have been a warm and guiding presence ever since you first interviewed me for the clinical Psy.D. program. You have been a true role model as a therapist, advisor, and supervisor and I feel so privileged to have spent time under your mentorship. Drs. Monica Indart and Karen
Riggs-Skean, my courses with you stand out as highlights of my GSAPP experience. Through both instruction and your way of being, you have given me much to strive for in my own clinical work. Sylvia Krieger and Julie Skorny, where would any of us be without you? Thank you for being gracious and helpful, no matter what basic and last-minute questions I threw your way.

To my dissertation committee, Drs. Nicole Cain and Shalonda Kelly, thank you for bearing with me through this arduous process. Between unexpected family emergencies and a COVID-19 quarantine, you were flexible and understanding, bearing with me as I proposed my dissertation from a garage during my quarantine. Nicole, special thanks for the Zoom meetings, phone calls, emails, and encouragement as this project transitioned from idea to plan to reality.

To my “research assistants”—Anna, Lucas, and Julia—thank you for your work on the coding portion of the analysis. Your time and work significantly shortened what would have otherwise been a much longer process, and I’m grateful to each of you for your help.

To Brandon, my husband, I could write a full dissertation’s worth of thank yous on what you’ve done for me in the last few weeks alone, leading up to this submission. For the shopping lists made, dinners cooked, and dishes washed; for keeping me on track when I was tempted to avoid; for proofreading, editing, and having more patience to read my own writing than I did; for encouraging me and celebrating each small dissertation milestone with me, literally serving as the wind in my sails when I had none—thank you. You’ve always valued my studies and career, uprooting your life in Connecticut, and leaving your job so that I could finish my degree. This dissertation is as much yours as it is mine. I love you.

Lastly and most importantly, thank You Hashem (G-d). For every moment, painful and joyous, that has brought me to where I am today, thank You for bringing me to this point—
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Introduction

Do Americans care about religion? According to studies by the Pew Research Center (2019), despite clear declines in religion in the United States, approximately 72% of the population still self-identified as religious (i.e., Christian, Jewish, Muslim, Buddhist, Hindu, or Other). An additional 26% identified as Atheist, Agnostic, or “Nothing in Particular.” The remaining 2% either stated that they did not know how they identified or refused to answer the survey question. (Pew Research Center, 2019). Thus, religion is somewhat salient for at least 72% of Americans, and the remaining 28% may have strong feelings about religion as well.

In contrast, there is evidence that American psychologists tend to be “far less religious than the population they serve” (Delaney et al., 2013, p. 542). There is a strong precedent for non-religiousness in psychology, as Freud (1938), one of the field’s founders, described himself as being Jewish but quite far from his own or any other religion. In the early 2000s, only 32% of psychologists surveyed endorsed belief in God as compared to nearly 88% of the general population (Delaney et al., 2013; Pew Research Center, 2020a). Similarly, only around 52% of psychologists indicated that they felt religion was important as compared to about 82% of the general population (Delaney et al., 2013; Pew Research Center, 2020b). This discrepancy is concerning, especially if it interferes with psychologists’ capacity to work with religious clients.

This concern has ethical implications as well. The American Psychological Association’s (APA, 2017) Principle E states:

Psychologists are aware of and respect cultural, individual, and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, and socioeconomic status, and consider these factors when working with members of such groups.
Thus, in treatment, it is incumbent upon practicing psychologists to consider the role of all aspects of a client’s identity, including the client’s religiosity. Therefore, competence in addressing religious and spiritual matters in therapy should be mandatory for all psychologists.

However, the literature indicates that psychologists often do not feel comfortable exploring these issues with clients and, at times, avoid doing so completely (e.g., Frazier & Hansen, 2009; Moleiro et al., 2018). There are a number of considerations that complicate the treatment of religion and spirituality in therapy. Historically, religion, spirituality and therapy have struggled to resolve their differences with each other ever since psychology developed as a field of study (e.g., Ellis, 1985; Freud, 2013). Moreover, in the therapy room itself, therapists must be wary of influencing client religion or spirituality or vice versa, having their own beliefs called into question by the client (e.g., Gonsiorek, 2009).

Though existing research demonstrates that religion and spirituality are not sufficiently addressed in treatment, the causes of this neglect are not well understood. The current study sought to identify barriers for therapists in addressing religion and spirituality in treatment. This was accomplished by:

a) Comparing and contrasting the ways that religion and spirituality are approached in treatment as compared to other areas of client diversity

b) Identifying specific barriers where religion and spirituality are not explored in treatment

c) Identifying therapist factors that correlate with therapists’ abilities to address religion and spirituality in treatment
Literature Review

History of Psychology and Religion

Psychology and religion have had a long and frequently oppositional relationship with each other. Across the psychoanalytic and cognitive behavioral schools of thought, psychologists have had a lot to say about religion and spirituality. Many of the field’s leading figures have viewed religion as ridiculous, irrelevant, and even diagnosable.

Psychoanalysis and Psychodynamic Psychology

Freud (2013), the founder of psychoanalysis wrote strongly against religion, calling it an “illusion” full of “fairy tales” and indicating that its importance to so many people was problematic (p. 34). According to Freud (2013), religion was defensive, providing humanity with a way to feel better about its helplessness by creating powerful guiding forces in the universe, an afterlife, and a supernatural system of justice. Freud (1991) even went so far as to outright pathologize religion, comparing religious practices to neurotic rituals. Given Freud’s tremendous influence on the field, it is unsurprising that his attitude toward religion made an impact. As early as 1939, psychoanalysis was described as a setting in which psychological development correlated with a decreased connection to religion (Fenichel, 1939).

Many of Freud’s successors, however, departed from his view. Religion was actually one of the issues that led Carl Jung to split from Freud (Schechter, 2000). Unlike his mentor, who viewed religion as a primitive defense, Jung (1960) acknowledged the value of religion for a number of people, even suggesting that religious dogma could do a better job expressing the unconscious than scientific theories, which could only speak for the conscious mind (Schechter, 2000). In other words, he proposed that the esoteric actually aligned well with the Freudian...
unconscious (Jung, 1960). Instead of dismissing and trying to “cure” religion, Jung integrated an appreciation for religion into his understanding of psychoanalytic theory.

Erik Erikson (1958) also expressed hesitation to accept Freud’s pessimistic view of religion. He argued that even if regression is inherent to religious observance, the regression could be useful, perhaps fostering increased clarity on the individual’s present life (Erikson, 1958). He compared this to the process of dreaming by which unconscious material may be accessed, processed, and organized (Erikson, 1958). Thus, like Jung, Erikson considered the possible psychological utility of religion for patients.

More recently, relational psychology has further contributed to this effort to de-pathologize religion. In essence, relational psychology rejects the notion of the therapist as an objective expert on the client and instead considers the impact of both the therapist and the client on what happens in treatment. According to Aron (2004), relational theory’s movement away from supposed objectivity and toward an acknowledgement of subjectivity created more space to consider the impact of religion on, not only the client, but the analyst as well. In fact, in keeping with this approach, not only can the clinician make space for the client’s religious or spiritual identity; the clinician can actually use the client’s religion and spirituality to inform the case conceptualization and treatment.

Several relational psychologists have done exactly that. Harry Guntrip (1956), for example, considered the fact that religion includes a primary object relation with a godly or spiritual being. In doing so, he attributed importance to patients’ religiosity and spirituality and made space for their religious and spiritual object relations in treatment. Indeed, Guntrip (1956) also noted that the way religion is presented can either subordinate or promote the right of
individuals to be their authentic selves, thereby demonstrating openness to the possibility that
religion could be either harmful or helpful.

*Cognitive Behavioral Psychology*

In the cognitive-behavioral therapeutic (CBT) tradition as well, many of the greats were
strongly opposed to religion. B.F. Skinner’s (1971) radical behaviorism, for example, offered an
alternative to the religious perspective. According to Skinner (1971), people were not very
different from animals; indeed, human behavior could be explained by a series of antecedents
and contingencies. Whereas Freud merely expressed his poor opinion of religion, Skinner
actually tried to replace religion with theory.

Albert Ellis was another CBT giant who, in his time, was rated more influential than
Sigmund Freud in a survey of psychologists (Smith, 1982). With regard to religion, however, he
more closely followed Freud’s than Skinner’s approach and wrote strongly against it. In his *The
Case Against Religion*, Ellis (1985) argued that the goals of mental health treatment were in
direct conflict with a religious point of view. He indicated that “self-interest,” “self-direction,”
tolerance,” and “acceptance of uncertainty” were all important aspects of psychotherapy and
that these goals were irreconcilable with religion (Ellis, 1985).

Despite this proposed lack of compatibility with religion, over time, parts of the CBT
world came to incorporate religion and spirituality into treatment. In the 1990s, several
laboratories adapted aspects of cognitive therapy and Rational Emotive Behavioral Therapy
(which was developed by none other than Albert Ellis!) to include characteristics of Christianity
(e.g., Johnson et al., 1992; Propst et al., 1992 as cited in Rosmarin, 2018). In 2005, Aaron Beck,
considered by many to be the father of CBT, met with the Dalai Lama to discuss similarities
between CBT and Buddhism (Beck, 2005). Unlike Ellis (1985), who felt that religion suppressed
individual autonomy, Beck (2005) suggested that Buddhism and CBT shared a value for self-responsibility.

Interestingly, Buddhism has been incorporated into several respected CBT treatments, including Mindfulness-Based Stress Reduction (MBSR), Dialectical Behavior Therapy (DBT) and Acceptance and Commitment Therapy (ACT). Fung and Wong (2017) suggested that Buddhism was appealing to the Western world because it emphasized personal process rather than service of a divine power. Nevertheless, the adoption of Buddhism into therapy did not occur overnight. In fact, Jon Kabat-Zinn (2011), the creator of Mindfulness-Based Stress Reduction, described feeling conflicted as to whether he should acknowledge that Buddhism was the basis of his therapeutic approach. Moreover, even when incorporating aspects of Buddhism into mental health treatment, therapies like ACT included some aspects, such as mindfulness, while excluding others, like the emphasis on lack of self (Fung & Wong, 2017). In this way, ACT could dip into the wisdom of the Zen Buddhist tradition without becoming a religious or spiritual therapy.

Similarly, in integrating mindfulness into DBT, Marsha Linehan (2015) acknowledged its Zen Buddhist roots but explained that DBT is a nondenominational treatment. She suggested that DBT therapists encourage clients to use whatever religious, spiritual, atheist, or agnostic terminology they felt most comfortable with when discussing the concepts of mindfulness, connectedness, and “ultimate reality” (Linehan, 2015, p. 157). Linehan (2015) effectively took the integration of religion and spirituality into therapy one step further by not only incorporating a spiritually-based practice into her work but also urging practitioners to take client religion and spirituality into account.
Any discussion of religion and spirituality in treatment would be lacking without mention of multicultural psychology. Until the arrival of multicultural psychology, the tendency of psychological research was to try to establish theories and practices as universally applicable (Dawson, 1971, p. 291). As compared to the supposedly ubiquitous products of research, culture was viewed as trivial and inconsequential (Smith & Trimble, 2016). However, moving into the second half of the 20th century, there was a growing realization that identity factors might actually be important to mental health, and there was a subsequent increase in research on the subject (Smith & Trimble, 2016).

Over time, this research gave rise to multicultural psychology, which has contributed tremendously to psychology by promoting an understanding of clients’ cultural identities in terms of their individual experiences (Tummula-Narra, 2009). The multicultural psychology movement was so powerful that the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) included culturally-based qualifiers for its diagnostic criteria (Schechter, 2000). The introduction to DSM-IV warned clinicians against misjudging culturally normative behavior as pathological; it cautioned that clinicians should be familiar with their client’s cultural context before making a diagnosis (APA, 1994).

The movement toward multiculturalism has both helped and hurt the incorporation of religion and spirituality into psychological treatment. On the one hand, multicultural psychology has created more space for addressing all areas of client diversity in treatment. The presence of multicultural psychology has increased dialogue around, attention to, and training for considering client identity in therapy. In theory, this would include identities related to race, ethnicity, socioeconomic status, ability, sexuality, and gender as well as religion and spirituality.
At the same time, multicultural psychology has increased the field’s attention to issues of power and oppression. And religion, as the APA (2007) Resolution on Religious, Religion-Based and/or Religion-Derived Prejudices points out, is contradictory in that it has been both an excuse for and “victim of” discrimination and oppression (n.p.). In other words, there has been much discrimination, both past and present, on the basis of religion and spirituality. One only has to consider the recent prevalence of Islamophobia or the increase in violent acts of Anti-Semitism to acknowledge the truth of that statement. However, religion and spirituality have also historically been used to discriminate against others. Among other acts of oppression, religion and spirituality have been used to rationalize violent crusades and wars, the subjugation of women, and the oppression of LGBTQIA individuals. This history could justifiably leave those who are sensitive to issues of oppression with negative feelings toward religious and spiritual traditions. Thus, psychologists with an attention to multicultural issues might find themselves torn between wanting to respect clients’ religious and spiritual identities and holding their own negative feelings toward particular religious beliefs or practices.

**Summary**

The relationship of religion and spirituality with psychology over time has been anything but simple. Among leaders in psychology, the attitudes toward religion and spirituality have ranged from antipathy to apathy and included everything in between. Current trends, however, seem to lean toward integration.

**Religion and Spirituality in the Therapy Room**

Much of the existing literature on religion and spirituality has focused on either creating new spiritually/religiously integrated treatments or incorporating religion/spirituality into existing treatments. For example, Knabb (2010) explored the use of centering prayer as a
possible replacement for mindfulness-based cognitive therapy. Worthington et al. (2010) conducted a meta-analysis of 46 studies in which therapies were accommodated with religious elements and discovered that, while these therapies seem to work well, they did not demonstrate consistent advantages over secular therapies. Several studies have been focused specifically on the integration of religion and spirituality into marriage and family therapy (e.g., Hoogestraat & Trammel, 2003; Nedumaruthumchalil, 2009; Wendel, 2003). However, it is important to understand, not only the research on specifically spiritual or religious treatments but also on the ways in which religion and spirituality may present in the general therapy context.

**Potential Challenges**

Although it is clear that psychology has found ways to make space for religion and spirituality over time, it seems that the contentious beginnings of the relationship between religion and psychology were not without consequence (Hathaway et al., 2004). The issue of religion and spirituality in the treatment room remains multifaceted and complex. Therapist values with regard to religion and spirituality can easily create bias and impact treatment with clients. For example, highly religious or spiritual therapists often hold negative attitudes toward “unconventional sexual behavior,” which could conceivably influence the manner in which they address issues of sex and sexuality with clients (Cumming et al., 2014, p. 128). Consequently, a religious therapist who is opposed to pre-marital sex might find an endless list of reasons that a client ought not to move in with their partner. Conversely, non-religious therapists may view religion and spirituality as almost pathological, conceptualizing them as primitive coping mechanisms (Gonsiorek et al., 2009). With this in mind, a therapist could view a Muslim client’s conservative style of dress as a sign that the client lacks autonomy and the freedom to self-
express and might devote numerous sessions to trying to cure this client of their “religious oppression.”

Furthermore, therapists do not only have to be wary of negative attitudes toward client religiosity or secularism. Gonsiorek et al. (2009) noted that idealization of client religiosity or spirituality can be as harmful as devaluation, potentially leading clinicians to dismiss real psychopathology. For example, a therapist who almost rigidly decides to respect client’s religious or spiritual practices may not realize that the hours each day spent praying or the excessive fear of sinning are actually symptoms of an Obsessive-Compulsive Disorder. In other words, regardless of the therapist’s particular stance toward religion and spirituality, their attitudes toward these issues can significantly impact treatment.

**Barriers for Clients**

In light of the above, religious, spiritual, and secular clients alike might appropriately fear working with a therapist whose religious or spiritual values are markedly different than their own. Indeed, members of some religions express hesitation to seek psychological treatment, instead choosing religiously-based support services, such as pastoral counseling or faith-based support groups (Delaney et al., 2007). Other clients may seek mental health treatment but withhold from speaking about their religious or spiritual lives. For example, one group of clients indicated that whether or not they will discuss religion and spirituality in treatment is heavily dependent upon whether they perceive their clinician to exhibit cultural humility (Judd, 2019). Another study suggests that clients may express interest in exploring religion and spirituality in treatment but may do so in covert ways, subtly hinting to their clinicians that these issues are important (Golsworthy & Coyle, 2001).
Those who refrain from pursuing mental health treatment altogether may fear that therapists will not respect or will even try to change their religious beliefs. Hathaway (2016) described a Jewish couple who confessed to their therapist that they did not think they could discuss their religion with mental health professionals; they shared that none of their previous clinicians had ever asked them about their faith. With this in mind, one could imagine that potential clients who would benefit from therapy might instead turn to a religious leader for support or refrain from reaching out altogether.

**Problems with Avoidance**

In light of the above, it stands to reason that some psychologists might adopt an “out of sight, out of mind” approach, feeling it is best to leave issues of a religious or spiritual nature outside of the therapy room. Nedumaruthumchalil (2009) asserts, “The unspoken assumption has been that religion is not our proper domain and we should not "intrude" into it. This has translated into an implicit understanding between professionals and clients of ‘Don't ask, don't tell’” (p. 16). Indeed, in one survey, therapists indicated that they only discussed spirituality or religion with 30% of their clients (Frazier & Hansen, 2009). However, Tummala-Narra (2009) noted that “In the therapeutic relationship, silence on issues of religion and spirituality indicate a tacit avoidance of core aspects of the client’s inner life” (p. 84). Unsurprisingly, this avoidance can have adverse effects. According to Rosmarin (2018), if therapists are not prepared to navigate religion and spirituality with clients, they lack important tools for connecting with and deeply knowing their clients. In the words of Becker (1973), “[W]e can see how truly inseparable are the domains of psychiatry and religion, as they both deal with human nature and the ultimate meaning of life” (p. 253). People are typically not compartmentalized beings, and it therefore stands to reason that multiple aspects of a client’s life would spill into treatment, that
even a straightforward treatment of anxiety, as an example, could include discussions of the patient’s finances, physical health, and relationships. With religion and spirituality as well, it is important that clinicians are able to detect and appropriately leverage those issues that are germane to mental health (Rosmarin, 2018).

Addressing spirituality and religion can be important, not only for religious and spiritual clients but for atheistic and agnostic clients too. Indeed, Rosmarin et al. (2015) found that clients’ levels of religiosity or spirituality were not directly correlated with the clients’ interest in spiritually integrated therapies. In their study, only 42% of religiously/spiritually affiliated clients expressed interest in treatment that integrated spirituality, while 37% of unaffiliated clients expressed interest (Rosmarin et al., 2015). This suggests that client religiosity or spirituality is not a sufficient metric for assessing whether these issues should be addressed in treatment. Aron (2004) explained that “The feeling that God is absent is no less a legitimate religious experience than the sense of divine presence” (p. 448). In other words, a relationship—even one of anger, disbelief, or scorn—is still a relationship. Thus, an atheist who truly never thinks about God may not have much to say on the subject, but an atheist who thinks “If God existed, the world wouldn’t be this painful” may actually have a lot to process in treatment. With this in mind, the therapist’s ability to discuss religion and spirituality in treatment may be important, not just for the 72% of the population who report religious affiliation, but also for the growing population of “religious nones” who identify as atheistic, agnostic or “nothing in particular” with regard to religion (Pew Research Center, 2019). Sahker (2016) explained that the rise in the non-religious population in the United States means that therapists must be prepared to address “nonreligiousness” in treatment.
Religion and Spirituality as Client Diversity

It is clear that silence is not the answer with regard to religion and spirituality in treatment. What then is a clinician to do?

A number of clinicians and researchers identify religion and spirituality as important aspects of individual diversity and identity. For example, Sue et al. (2013) in their book *Case Studies in Multicultural Counseling and Therapy*, include a chapter on American Jews. Similarly, the *Handbook of Multicultural Counseling Competencies* has a chapter entitled “Developing Competency in Spiritual and Religious Aspects of Counseling” (Eirckson et al., 2010). As religion and spirituality are important aspects of client identity and culture, the literature on client diversity would seem instructive.

Moleiro et al. (2018) defined culture as “a process of meaning-making that is under the influence of multiple, intersecting facets of a person’s identity” (p. 192). The research clearly demonstrates the importance of understanding the individualized meaning that religion and other areas of identity hold for clients (e.g., Schechter, 2000). Moreover, although the ultimate focus in treatment must be on the client, Watts-Jones (2010) also emphasized the importance of acknowledging the therapist’s identity and its intersection with the client’s (Gonsioreck et al., 2009). Identity—the client’s, the therapist’s, and their meeting points—is essential in therapy, and the only way to create an environment that welcomes all aspects of client identity is for the therapist to get comfortable with issues of identity (Watts-Jones, 2010).

However, despite the fact that diversity and our awareness of it are increasing, most psychological studies still focus on young members of the Western middle class and are not at all representative of humanity as a whole (Henreich et al., 2010; Moleiro et al., 2018). This lack of attention to issues of multiculturalism is also reflected in the clinical sector where the process of
increasing multicultural competence has been slow (e.g., Sue, 2001). In a recent study, a worrying number of clinical psychologists suggested that it was challenging for them to understand the impact of their own cultures on themselves and on their interactions with clients from different cultural backgrounds (Moleiro et al., 2018). In the same study, clinicians also indicated that they often did not address issues of identity in treatment, did not “see” color, sexuality, etc., and tended to view differences between themselves and clients as a challenge rather than a resource (Moleiro et al., 2018). In other words, despite significant advances in multicultural research, issues of diversity are often ignored or outright neglected in the therapy room.

This is true of diversity in general, but what of religious and spiritual diversity specifically? In 1999, Fukurama and Sevig published a book called *Integrating Spirituality into Multicultural Counseling*. This suggests that while the notion of multicultural counseling was, at that time, somewhat established, spirituality had not yet been adopted into the model. More recently as well, it seems that at least with regard to training, religion and spirituality receive even less attention than other aspects of client identity (Vogel et al., 2013). Vogel et al. (2013) surveyed students, faculty members, and directors of clinical training in doctoral psychology programs. They found that diversity training followed a definite pecking order by which religion and spirituality, age, and ability status received the smallest amount of focus (Vogel et al., 2013). Evans and Nelson (2021) echo this finding, explaining how and why religion and spirituality have lagged behind other multicultural competencies in counseling. Similarly, Magaldi-Dopman (2014) identifies religion and spirituality as a domain of multicultural counseling but tellingly entitles their article on the subject “An ‘Afterthought’: Counseling Trainees’ Multicultural Competence Within the Spiritual/Religious Domain.”
Potential Barriers to Addressing Religion and Spirituality into Treatment

The literature reviewed above suggests that religion and spirituality are not receiving enough attention in mental health treatment. Given the history between religion, spirituality, and therapy, it seems reasonable some conflict might remain. However, historical underpinnings do not sufficiently explain the dramatic lack of attention that religion and spirituality receive in therapy. This begs the question: what else prevents clinicians from addressing these important areas of client identity?

**Therapist Factors**

In recent years, there has been a growing attention to the impact of therapist factors on treatment. Noting significant differences in treatment outcomes for similar groups of patients, researchers have proposed that it may be the therapist who makes the difference (e.g., Goldberg et al., 2018). Indeed, Goldberg et al. (2018) demonstrated that “therapist effects” did significantly impact treatment outcomes for patients. It then stands to reason that with regard to religion and spirituality, therapist factors could also influence their treatment of these issues.

**Therapist Religiosity.** There is evidence that the therapist’s own religiosity or spirituality is related to if and how they address these matters with clients. Therapists with higher levels of spirituality or religiosity seem to be particularly mindful of these issues in treatment (Cummings et al., 2014). Cummings et al. (2014) reviewed a number of studies indicating that therapists who held positive associations of or who were personally affiliated with religion or spirituality tended to feel more competent in addressing religion and spirituality in treatment and were more likely to integrate religion and spirituality into their treatments. Likewise, Frazier and Hansen (2009) found a positive correlation in which therapists who identified as religious were more likely to engage in religiously and spiritually sensitive therapeutic behaviors such as
expressing respect for client’s religious and spiritual beliefs and consulting with religious and
spiritual leaders on cases. In contrast, therapists with lower levels of spirituality or religiosity
tended to be more likely to either avoid these issues in treatment or imply that they were less
important than other treatment issues (Cummings et al., 2014). Indeed, Hathaway (2016)
suggested that many clinicians simply felt that religion and spirituality were not important issues
to address in treatment.

In addition to shaping the perceived importance of religion and spirituality, the therapist’s
own affiliation could impact their comfort level with addressing these issues in treatment. At
both ends of the spectrum, religious/spiritual and secular, therapists might fear unwanted
influence, worrying that their beliefs might adversely impact the client or vice versa (e.g.,
Gonsiorek et al., 2009). Hathaway (2016) warned clinicians about the dangers of imposing either
a religious or secular worldview on their clients. He gave the example of a Baptist therapist
treating a Baptist client and assuming that it would be detrimental for the client to pursue
divorce, since divorce is looked down upon in the conservative Baptist community (Hathaway,
2016). Likewise, a religious therapist might be concerned that deep discussion with an atheistic
client could throw the clinician’s beliefs into question. Lest secular therapists feel they are
unimpeded by this problem, Hathaway (2016) indicated that clinicians who convey a lack of
esteem for religious or spiritual issues might be imposing a secular perspective on their clients.

**Therapist Experience.** Though most people would like to believe that ability increases
with experience, this does not seem to be the case for therapists. Goldberg et al. (2018)
conducted a longitudinal study of 170 therapists and found that only 39% improved as therapists
over time, while an astounding 61% actually got worse. Other studies have found no evidence
that therapist experience impacts therapy outcomes with clients (e.g., Norton et al., 2014). Miller
and Chow (2017) likewise demonstrated that even conscious attempts at self-improvement, such as supervision, personal therapy, and continuing education courses, have not yet been linked with demonstrable improvements in client outcomes.

To date, there is little research examining the impact of experience on clinicians’ abilities to address religion and spirituality in treatment with clients. On the one hand, if even experienced therapists have described difficulty navigating religion and spirituality with clients, it stands to reason that trainees and new clinicians who feel less secure in their professional identities may feel even less confident addressing these issues with clients. Thus, lack of experience might act as a barrier for therapists in this area. On the other hand, given the fact that therapist outcomes do not seem to improve with experience, it is possible that it is the experienced clinicians who are at a disadvantage. After all, those trained at a time when multicultural psychology was less prevalent may never have been taught to grapple with issues of identity with clients and, unfortunately, may never have progressed past their initial training.

Lack of Training

How well are therapists trained to address religion and spirituality in treatment? Across several studies related to clinicians’ experiences with religion and spirituality in treatment, lack of training and inadequacy of training frequently emerged as a theme (e.g., Golsworthy & Coyle, 2001; Kvarfordt & Herba, 2017; Lee et al., 2019). This was true across countries and across the disciplines of psychology, social work, and other mental health professions. According to one group of therapists, the lack of training led practitioners to rely on their own experiences and self-developed methodologies for addressing these issues in treatment (Golsworthy & Coyle, 2001).
In 2007, the American Psychological Association resolved to incorporate religious and spiritual discrimination in trainings related to multiculturalism and diversity. Yet in a survey of doctoral students in APA-accredited programs, 25% of participants reported receiving no training in religious and spiritual diversity (Saunders et al., 2013). For those who did report training in this area, about half referred exclusively to discussions that took place in supervision, rather than specific coursework or training in this area (Saunders et al., 2013). Indeed, less than 10% of respondents reported taking any coursework on religious or spiritual diversity (Saunders et al., 2013).

Corroborating these findings, another study found that where APA-accredited doctoral and internship training programs did provide training on this subject, the methods used were “informal, unmethodical, and unsystematic” (Vogel et al., 2013, p. 164). Trainees seemed most likely to learn about religious and spiritual diversity from unplanned clinical experiences and from religiously or spiritually affiliated peers (Vogel et al., 2013). An apparent contradiction exists in which, based on the APA (2017) Ethical Guidelines, psychologists are expected to be competent in addressing religion and spirituality yet receive little to no formal training in this area. Anticipating the argument that personal experience in this area could replace expertise, Gonsiorek et al. (2009) cautioned that having a particular personal identity (i.e., race, religion, sexual orientation) does not automatically make one professionally competent in that area. They asked, “Are these issues so insubstantial that mere personal experience and reflection suffice as expertise?” (p. 386). Unfortunately, in light of the aforementioned gaps in training, the answer to this question seems to be a resounding “yes.”

Moreover, Wendel (2003) warns that even when clinicians are leaning on their usual clinical training when working with issues of religion and spirituality in treatment, negative
consequences may result. In the model that he proposes for working simultaneously with mental health and religious/spiritual issues, Wendel (2003) suggests considering the relevant issues from both a religious and a spiritual perspective. He warns that a lack of balance in this area could have negative results including “reductionism, tacit superiority of domain, and using one area to achieve the goals of the other” and states that “What is needed is a methodology that offers guidance and protects practitioners from these problems” (Wendel, 2003, p. 172).

In other words, clinicians are not receiving adequate training in this area, and neither general clinical training nor personal experience are enough to compensate for that lack.

**Ideological Differences**

As mentioned previously, Ellis (1985), Freud (2013), and others proposed that there were irreconcilable differences between psychology and religion/spirituality. Though Freud’s and Ellis’ followers found ways to bridge these gaps, there are differences between the two realms that are important to explore. Among these differences are two important ideological divides.

**Political Conflicts.** Interestingly, there are differences across political groups with regard to reported religious affiliation, with 83% of Republicans identifying themselves as religious as compared to only 63% of Democrats, suggesting there may be some association between Republicanism and religiosity (Pew Research Center, 2019). Indeed, the Republican or conservative mindset is often affiliated with traditionalism and hierarchy, both of which are often connected to organized religions (Swigart et al., 2020). In contrast, there is evidence that psychology is heavily dominated by self-identified liberals (Duarte et al., 2015). In an increasingly polarized political landscape, a liberal therapist might balk at the thought of exploring a religious or spiritual way of thinking that seems connected to a right-wing ideology.
Methodological Conflicts. Over time, psychology has struggled to assert itself as a science, in some ways placing an ever-increasing emphasis on research and evidence-based practice. Of course, science and religion have markedly different foundations, and these differences may contribute to the difficulty that many therapists experience with spirituality and religion. Whereas the scientific method privileges the observable, religious and spiritual traditions often emphasize that which cannot be observed, such as the soul, spiritual forces, and the like. Thus, a therapist who seeks to maintain an objective and scientific point of view might struggle to embrace a client’s more esoteric way of thinking. Though the American Psychological Association (2007) acknowledges these differences and recommends respecting them, this advice is easier given than put into practice.

The Current Study

In light of the reported importance of religion and spirituality to many Americans and the contrasting lack of attention that these matters tend to receive in psychological treatment, the goal of the current study was to explore the barriers that prevent clinicians from addressing religion and spirituality in treatment. Underscoring the importance of this issue, Tummula-Narra (2009) writes that integrating spiritual and therapeutic concepts can actually deepen both the therapist’s understanding of their clients and the client’s experience of their most genuine selves.

In reviewing the literature, religion and spirituality most often seemed to be explored in the context of integrating religious/spiritual interventions into treatment or of clinical training/practice in a specifically religious context (e.g., Christian psychology programs). In other words, most studies tended to either address client outcomes in response to religiously/spiritually integrated treatments, propose new models of treatment or integration,
examine the efficacy of existing models, or explore client’s experiences of religion or spirituality in treatment. Very few studies examined therapist’ experiences of religion and spirituality in treatment. The studies that did so tended to be conducted outside of the U.S., and only one of those studies looked at the barriers that clinicians face to addressing religion or spirituality in treatment. Thus, the current study sought to address this gap in the literature by identifying barriers present for clinicians and to do so by speaking with the clinicians directly.

A second goal of this study was to consider therapist factors that may influence the ability to navigate religion and spirituality in the therapy room. Do years of clinical experience have an impact? The therapist’s own religious or spiritual leanings?

To that end, the following research questions were explored:

1) Do therapists approach religion/spirituality differently as an area of client diversity?
   What does this look like in practice?

2) Where barriers to addressing religion/spirituality in session are reported, what is it that gets in the way?

3) Which therapist factors, if any, are correlated with the therapist’s ability to navigate religion and spirituality in treatment?
Method

Qualitative research is often considered the method of choice when attempting to capture people’s experiences (Ashworth, 2008). As the goal of the current study was to better understand therapists’ experiences addressing religion and spirituality with clients, a qualitative research design was used. Semi-structured interviews were conducted and then analyzed using Grounded Theory (Glaser & Strauss, 2008). Grounded Theory has demonstrated utility across a range of settings, including research related to counseling and therapy (Nolas, 2011).

Participants

Participants (n = 8) were all doctoral psychologists in clinical practice. Studies utilizing a Grounded Theory analysis can feature sample sizes ranging from 6-20 participants (e.g., Hipolito-Delgado et al., 2021; Tarshis, 2022; Tursi et al., 2022). As a result, the primary investigator sought to recruit a sample of 10-15 participants. However, due to limited responses to recruitment efforts, the final sample included 8 participants.

To reduce the possibility for results to be contaminated by outside factors, the sample included only doctoral-level (i.e., Psy.D. or Ph.D.) psychologists. This decision was made in an effort to minimize the effects of differences in training approaches (e.g., social work, mental health counseling, etc.) on the data collected. Furthermore, psychologists who worked primarily with children were excluded from the study. This decision was made with the understanding that the treatment of religion and spirituality in sessions could vary considerably between adults and children.

Given the focus of the study on therapists’ clinical experiences with religion and spirituality, only psychologists who were actively engaged in clinical practice were included in the study. When using Grounded Theory approaches to research, it is common to gather a
“purposive” rather than representative sample (Nolas, 2011, p. 26). Instead of aiming to fully represent a given population, Grounded Theory research often seeks to gather a group of participants who will appropriately target the research questions. This focused recruitment approach was adopted for the current study.

Finally, this study sought to recruit a group of participants that was diverse in terms of years of clinical experience, theoretical orientation, gender, race, ethnicity, and religious/spiritual identities and backgrounds. The goal in doing so was to address the research question regarding therapist factors that may contribute to therapists’ experiences with client religion and spirituality.

**Recruitment**

Subjects were recruited using a snowball sampling method in which the researcher distributed recruitment materials and asked individuals to pass those recruitment materials along to their own contacts. To do this, the researcher posted recruitment materials on Facebook and sent them to professional contacts, including former supervisors, graduate and undergraduate professors, colleagues at her internship site, and the director of a former externship site. The researcher’s Director of Clinical Training also distributed the recruitment materials to the alumni listserv for the researcher’s graduate program. Through these channels, an IRB-approved recruitment flier was distributed, and individuals were instructed to contact the principal investigator directly if they were interested in participating in the study. Those who expressed interest were asked to complete a brief demographic survey online. Once the survey had been completed, subjects were invited to participate in an interview.
**Consent**

Participants were asked to provide consent electronically before completing the demographic survey. Subjects who were interviewed were asked to sign a separate online consent form before starting the interview. Consent for audio and video recording was also obtained before interviews were conducted. The principal investigator allotted time before the start of each interview to review consent forms and provide participants with the opportunity to ask questions. The principal investigator also frequently reminded subjects via email that their participation in the study was voluntary and that they could withdraw at any time. (Consent forms can be found in Appendices A and B.)

**Compensation**

Participants were offered compensation for their time in the form of an offer to participate in a raffle drawing for one of two $50 Amazon gift cards. Once the raffle was drawn, the winners were contacted and provided with their gift cards.

**Measures**

Measures for this study included one demographic screening questionnaire and one semi-structured interview protocol (see Appendices A and B). Both measures were developed by the primary investigator.

Interviews are often used in qualitative research to gather meaningful information in response to research questions. According to Nolas (2011), interviews are essentially conversations that can be used for research. The strength of the semi-structured interview format lies in its flexibility. Nolas (2011) advises following the interviewee rather than maintaining rigid adherence to one’s interview questions.
Procedure

In light of safety concerns during the COVID-19 pandemic and to increase ease of scheduling, all interviews were conducted virtually using Microsoft Teams. About 2 hours were scheduled for each interview, though interviews tended to take about 60-90 minutes per participant. Interviews were recorded and transcribed using Microsoft Teams transcription software.

To protect participant anonymity, all participants were assigned a unique ID number. This ID number was used to link participants’ demographic data with their interview data. The code linking participants to their unique ID numbers was stored in a separate location from the rest of the study data and was protected by a password known only to the researcher. Furthermore, all transcriptions were edited to remove any identifying data.

Data Analyses

Frequency Calculations

To understand the significance of participants’ responses to various demographic survey and interview questions, the frequencies of responses were calculated. This was done by simply counting the frequency of a response within the sample and then calculating the percentage of the sample that provided that responses. For example, if three out of eight participants had indicated that they liked apples, it would be reported that 38% of participants reported liking apples. Of note, percentages were rounded to the nearest whole number.

Grounded Theory Analyses

Interview data was cleaned, organized, and then coded using Grounded Theory. Grounded Theory is unique in its reflective and reflexive nature. When using Grounded Theory,
the researcher remains open to being guided by what they find in the data using a “constant comparative method” of analysis (Nolas, 2011; Glaser & Strauss, 2008, p. 103).

The analysis with Grounded Theory begins with reading through the data from start to finish, coding along the way by creating shorthand labels for everything until no new codes can be created (Nolas, 2011). Once an initial set of codes has been created, those codes are subsumed into larger coding categories. The researcher writes memos as they code and categorize the data for the purpose of maintaining a clear record of their thought processes throughout the coding. These memos serve as the beginnings of the theoretical conclusions that the research eventually generates. Thus, the researcher balances between making note of potential theoretical implications and holding those implications lightly. This is to minimize the risk of a researcher imposing hypotheses on the data during the coding process rather than remaining open to being guided by the data. (Nolas, 2011)

Corbin and Strauss (2008) describe this process in terms of “open coding,” generating an exhaustive list of codes based on the raw data and “axial coding,” examining and coding relationships between the categories created in open coding. Once the researcher has their codes, memos, and categories in place, Nolas (2011) recommends searching for patterns in the data, sorting through the analyses until they begin to form theories.

In the current study, open coding was performed by the researcher and a team of three doctoral students who served as research assistants. The researcher oriented these research assistants to the current study and provided brief training in the coding process. Research assistants were each assigned several interviews to code. Once they had completed the coding, the researcher reviewed the codes that they had generated. Axial coding was completed by the researcher. The researcher used the codes developed to start searching for higher-level concepts
related to the research questions. Finally, the researcher searched the analyzed data for patterns and conceptual relationships, eventually leading to the creation of the models and recommendations described below.

**Use of Additional Coders.** The researcher used additional coders during the open coding process. She did so to both expedite the coding process and reduce the impact of her own bias on the coding process. In conducting the interview with participants, the researcher developed impressions of participants and their respective skill levels in addressing religion and spirituality in treatment. To reduce the impact of these impressions on the coding process, in addition to coding interviews herself, the researcher had research assistants code the interviews. These research assistants never found out participants’ names or watched video of participants, making their coding process more objective than that of the researcher herself. Thus, the codes generated by the research assistants provided an objective set of codes against which the primary investigator could check the codes that she had generated when coding the data.

**Coder Training.** To train the research assistants in the Grounded Theory coding process, the researcher held a Zoom meeting with the research assistants. During this meeting, the researcher provided an overview of the research study and Grounded Theory analysis. She described the open coding process, providing examples from an interview she had already coded. Research assistants were encouraged to ask questions during this training and were told to contact the researcher if additional questions emerged during the coding process.

**Exploration of Relationships in the Data**

Given the small sample size, statistically significant correlations could not be assessed. Therefore, to respond to the research question “Which therapist factors, if any, are correlated with the therapist’s ability to navigate religion and spirituality in treatment?” the researcher
identified a number of therapist factors and divided participants into subgroups based on their shared identities, experiences, and/or affiliations. For example, subgroups were created based on therapist gender, religious/spiritual identity, and years of clinical experience. These subgroups are described in greater detail below.

The next task was to examine the relationship between these therapist factors and therapists’ abilities to address religion and spirituality in treatment. To operationalize and examine therapists’ abilities in this area, the researcher gathered together all responses to questions that seemed relevant to the construct of ability to navigate religion/spirituality in treatment. (See Table 1 for overview of the questions analyzed.) The researcher searched for themes among responses to these questions for each of the aforementioned subgroups created. The themes identified are reported in the results section below.
Results

Throughout this section, a number of quotes from participants are presented. To maximize readability of the quotes, the researcher removed common filler phrases such as repeated words and the terms “oh,” “um,” “like,” etc. These changes are represented with ellipses ( . . . ). In this way, the researcher hoped to accurately represent the imperfect nature of human speech and interview responses while also making interview responses easy to read and understand.

Participant Demographics

Self-Described Identities

At the start of the interview, participants were asked to briefly describe aspects of their identities that were salient to them. Their responses are described below.

**RS010.** This participant described himself as being a religious straight white cis-gender male. He also described being a member of the dominant culture as being salient to his identity.

**RS011.** This participant described himself as a white middle-class male, a father, a husband, a psychologist, and an introvert. He also described himself as being one of many human beings and fundamentally an animal.

**RS014.** This participant described herself as a Jewish woman.

**RS015.** This participant described herself as a human, an ethical vegan who does not believe in domination over any other group in nature, someone with a respect for resiliency, an empathic person, a descendant of Holocaust survivors, and someone who has experienced discrimination and exclusion.

**RS016.** This participant described herself as a woman, Jewish, native to her particular city in the Midwest, someone who has moved around and is not provincial, someone who has
been successful in school and is reliant on her intellectual abilities, someone who is interested in community, and someone who has a close network of relationships.

**RS017.** This participant described himself as being married, being a father, being a psychologist, and being Jewish.

**RS019.** This participant described herself as black, African-American, a woman, a first-generation college student, and middle class.

**RS020.** This participant described herself as a black female, a mother, and a Christian.

### Self-Reported Identities

Participants were also asked closed, multiple-choice questions about identity on the demographic survey. Their responses are outlined below and in Table 2.

**Gender Identity.** Three participants (38%) reported identifying as male, while five participants (63%) reported identifying as female.

**Racial/Ethnic Identity.** Six participants (75%) reported White/Caucasian identities, while two participants (25%) reported Black/African American identities.

**Sexual Identity.** All eight participants (100%) reported identifying as heterosexual.

### Professional Identities

Participants provided information about their professional identities through both the demographic survey and the interview. Some of this information is described below.

**Years in Practice.** Four participants (50%) reported being in clinical practice for 10 or more years. Two participants (25%) reported being in practice six to eight years. Two participants (25%) reported being in practice two to six years.

**Practice Settings.** With regard to their primary workplaces, four participants (50%) reported working in private practice. Two participants (25%) reported working at university
counseling centers. One participant (13%) reported working at a Veterans Association. One participant (13%) reported working at a community clinic at both their intensive outpatient and outpatient levels of care.

Three participants (38%) also reported having secondary places of practice. Of those three, one reported working at a county jail and in private practice in addition to their employment at a university counseling center; one participant reported working in private practice in addition to their employment at a university counseling center; and one reported working at a community clinic in addition to their work in private practice.

**Theoretical Orientations.** Six participants (75%) reported using a variety or integration of theoretical orientations in their clinical work. One participant (13%) reported practicing from an Acceptance and Commitment Therapy (ACT) perspective. One participant (13%) reported practicing using a strength-based Cognitive Behavioral Therapy (CBT) approach.

For the therapists who reported using more than one theoretical approach, their reported orientations are described below. One participant described using a blend of crisis management, risk assessment, humanistic, and psychodynamic approaches. One participant reported using a blend of Dialectical Behavior Therapy (DBT) and psychodynamic approaches. One participant reported using a blend that includes trauma therapies and dynamic systems approaches. One participant reported using a directive approach that is informed by systems theory and helps clients to develop skills and tools. One participant reported using an integrative approach and conceptualizing through an attachment lens. One participant reported currently using primarily solution-focused therapy but being foundationally systems-oriented, using person-centered therapy in the past, and having read extensively about Afrocentric therapy.
**Therapist Religious/Spiritual Identities**

**Religious and Spiritual Identities.** Six participants (75%) endorsed having a religious and/or spiritual identity. Two participants (25%) endorsed identifying as agnostic.

Three participants (38%) reported identifying as Jewish. One participant (13%) reported identifying as a member of the Church of the Latter-Day Saints. One participant (13%) reported identifying as Christian. One participant (13%) did not record a specific religious or spiritual identity but explained that they practice religion by reading scriptures, attending church, and praying.

Of the three participants who endorsed identifying as both spiritual and religious, one reported “Jewish” for both their religious and spiritual identities; one reported Mormon for both their religious and spiritual identities, and one reported Chassidic for their spiritual identity and Jewish for their religious identity.

**Religious Background.** Seven participants (88%) reported growing up with some sort of religious or spiritual affiliation. One participant (13%) reported growing up celebrating Christian holidays but stated that they were an atheist as a child. For those who identified growing up with a religious or spiritual background, four participants (50% of the total n) reported being raised within a denomination of Christianity, and three participants (38% of the total n) reported being raised within a denomination of Judaism.

Of those who identified growing up in a Christian home, two participants (25% of the total n) identified being raised as members of the Baptist Church, one participant (13% of the total n) identified being raised in a Lutheran/Presbyterian home, and one participant (13% of the total n) reported being raised as a member of the Church of the Latter-Day Saints.
Of those who identified growing up in a Jewish home, one participant (13% of the total n) reported being raised as a member of the Chabad Chassidic group within Orthodox Judaism, one participant (13% of the total n) reported being raised Conservative Jewish, and one participant (13% of the total n) simply reported being raised Jewish.

**Current Identification with Religious Background.** Six participants (75%) reported being currently affiliated with a religious/spiritual tradition. Two participants (25%) reported not currently being affiliated with a religious/spiritual tradition. Of those who reported currently identifying with a religious/spiritual tradition, five individuals (83%) described identifying with the religious/spiritual tradition in which they were raised. One participant reported transitioning from Conservative Judaism to Reform Judaism. All participants who reported maintaining religious/spiritual identities described their affiliations deepening, becoming more personal, and becoming more voluntary over time.

Of the two participants who reported not currently identifying with a particular religious/spiritual tradition, one reported transitioning from their Lutheran/Presbyterian Christian background to a current identification as agnostic. The other reported being atheist as a child and currently identifying as agnostic.

**Client Demographics**

To better contextualize participants’ responses to the research questions, participants were asked what percentage of their caseload identifies as religious. Nine responses were provided, with one participant differentiating between two different settings in which they practice. Percentages were calculated with 100% representing all nine responses.

All respondents (100%) indicated that 50% or more of their caseload is comprised of clients who identify as spiritual and/or religious. One person (11% of responses) estimated that
90-100% of their caseload is comprised of clients who identify as religious and/or spiritual. Three people (33% of responses) estimated that 80-90% of their caseload is comprised of clients who identify as religious and/or spiritual. One person (11% of responses) estimated that 70-80% of their caseload is comprised of clients who identify as religious and/or spiritual. Four people (44% of responses) estimated that approximately 50% of their caseload is comprised of clients who identify as religious and/or spiritual.

Five participants (63%) identified a clear religious majority within their caseload: clients who identify as members of the Church of the Latter-Day Saints, Jewish clients, Christian clients, and Catholic clients who rate religious and spirituality as being of low importance to them. (Two clinicians identified Christian clients as the religious majority of their caseload, making for a total of five responses.)

**Religion and Spirituality as Areas of Client Identity**

To answer the research question “Do therapists approach religion/spirituality differently as an area of client diversity? What does this look like in practice?” participants were asked a number of questions about their experiences of religion and spirituality in their work with clients. Their responses are described in greater detail below.

**Reactions in Treatment**

When asked what their reactions are when clients bring up religion/spirituality in treatment, six participants (75%) indicated that they have a curious reaction and/or try to better understand the meaning and relevance of religion and spirituality for the specific person in front of them. One participant (13%) reported becoming excited when clients mention religion or spirituality in treatment. One participant (13%) indicated that they specifically try to understand the ways in which religion serves as a strength for the individual. The majority of participants
seemed to indicate that they have generally found the presence of religion or spirituality in clients’ lives to be a positive thing, though they did note some exceptions to this tendency.

One participant identified feeling generally curious when clients bring up religion or spirituality in treatment but wary when learning that participants share his religious identity. (He described being concerned about the assumptions that clients might make about him if they learned that they were members of the same faith.) Another participant reported being generally open to religion and spirituality in treatment but “horrified” when people described trauma that they’ve experienced in religious or spiritual contexts (RS015).

Two participants described especially enjoying discussing religion and spirituality with clients. RS014 stated that she becomes “[v]ery excited. I'm passionate about [it] and it's like my language so when they bring it up I get very excited and it's very meaningful.” Another participant shared:

I enjoy talking about it . . . I am curious about people’s belief systems . . . or even . . . their journey with it. Like how did they get more spiritual? . . . I feel honored that they feel comfortable enough to talk in this environment of anything that's very personal. I think religion or spirituality is a very personal thing. (RS017)

Similarities and Differences with Other Areas of Client Identity

The psychologists interviewed were asked several times and in several ways whether religion and spirituality seem different or similar than other areas of client identity.

Who Brings It Up. Five respondents (63%) indicated that they tend to follow the clients lead regarding religion and spirituality and that this is similar to how they approach other areas of client identity. Two respondents (25%) indicated that they are actually more likely to bring up religion and spirituality in treatment as opposed to other areas of client identity. One of these
participants indicated that they may actually be more comfortable with religion and spirituality than other aspects of client diversity, while the other participant indicated that religion and spirituality feel different from other areas of client identity in that they can actually serve as a protective factor and resource for clients. One participant (13%) did not respond to this question.

**Therapist Reactions.** Four participants (50%) indicated that they have similar reactions to religion and spirituality in treatment as they do to other areas of client identity, while the other four participants (50%) indicated that their reactions to religion and spirituality are different than their reactions to other areas of client identity.

One participant who described similar reactions across areas of client identity explained that they attend to the topic’s salience for the client, regardless of what aspect of identity is being discussed.

Of the participants who described having different reactions to religion and spirituality than other areas of client diversity, two indicated that they especially enjoy speaking about religion and spirituality as compared to other aspects of client identity. One stated that religion and spirituality elicit a different reaction, because it is more hidden than other areas of client identity. One person explained that they react differently to religion and spirituality, because it seems like more of an inherent strength than other areas of client identity.

**Overall Differences.** The clinicians interviewed were also asked if, in general, they have found religion and spirituality to be different than other areas of client identity. Four participants (50%) responded “no,” two participants (25%) responded “yes,” and two participants (25%) responded both “yes” and “no.”

Those who described differences between religion and spirituality and other areas of client identity had a variety of explanations for this observation. Some identified religion and
spirituality as being less visible, more private, and, perhaps as a result, less salient and less likely to lead to rich conversations. The grounded theory analysis indicated that therapists and clients may talk more about *visible* client identities, particularly when there are visible differences between the client and the therapist. This analysis also revealed that different identities may be more salient depending on the client population and the setting in which clinical services are provided.

Some responses indicated that religion and spirituality may be different, not for the therapist, but for the client. Some respondents indicated that clients may be “defensive” about and less willing to share their religious or spiritual identities, because these identities are less “fashionable” in current society than other identities (RS016).

Those who indicated that they’ve experienced religion and spirituality as similar to other areas of client identity indicated that all identities come with challenges and that clients tend to appreciate feeling safe enough to discuss their identities, regardless of what those identities area. The Grounded Theory analysis revealed that, according to these participants, there seems to be a richness that comes with talking about any area of client identity.

**Barriers to Addressing Religion/Spirituality in Treatment**

To answer the question “Where barriers to addressing religion/spirituality in session are reported, what is it that gets in the way?” participants were asked to identify challenges they’ve experienced, both in working with religiously or spiritually identified clients and in addressing issues of religion and spirituality in treatment. Across interview questions pertaining to challenges, participants generated a total of 23 responses. These responses are described in greater detail below and outlined in Figure 1.
Eight responses (35%) indicated that clinicians struggle when they feel their clients are holding problematic beliefs related to religion or spirituality. Four responses (17%) suggested that, at times, therapists find it challenging to withhold their own religious or spiritual beliefs or to otherwise maintain a clinical rather than pastoral role. Three responses (13%) suggested that clinicians experience client guardedness and resistance as a challenge in this area of treatment. Three responses (13%) revealed that clinicians sometimes struggle with client reactions to the therapist’s religious/spiritual identity or presentation. Two responses (9%) indicated that clinician lack of knowledge about particular religious or spiritual beliefs and practices is challenging for some therapists. One response (4%) suggested that therapists may find it challenging to assess client religious or spiritual beliefs that are unconventional. One response (4%) indicated that therapists may experience the challenge of maintaining boundaries when clients ask about their religious or spiritual beliefs. One respondent (4%) reported that he struggled to navigate one client’s reports that the client was engaging in behaviors such as masturbation in a church where he used to practice Christianity.

**Client Problematic Beliefs.**

Respondents reported a number of situations in which clients’ beliefs about religion or spirituality were viewed by the therapist as problematic or potentially problematic. Three responses (13% of total responses) described beliefs that led clients to feel guilty or stuck. Three responses (13% of total responses) described beliefs that the therapist felt were harsh or inaccurate perspectives about a religion shared by the therapist. Two responses (9% of total responses) described client beliefs that were oppressive or persecutory.

**Beliefs Leading to Guilt or Stuckness.** Three responses included examples in which the client’s beliefs about religion or spirituality were causing the client to feel guilty or stuck.
So this person, she's a person in their 60s and she made a pretty serious suicide attempt a few years ago, which left her with some physical limitations . . . her view is that she had a beautiful life that was laid out for her, and that she single handedly . . . ruined the path . . . from my perspective, well, we can . . . try to create another path . . . she's completely stuck and I do sometimes feel like I'm struggling because I don't have that same spiritual perspective she does . . . she's also routinely communicating with various angels and Mother Mary . . . But I guess what's interesting in her case is that none of them are getting her unstuck either, so that also helps me to feel a little bit better, like even angels can't do it. (RS015)

The same respondent also spoke about a client who wanted to use birth control. The therapist shared:

I could kind of tell that most likely all these priests thought he should use birth control, but they couldn't say so and so they would sort of give him these roundabout messages like, well, you know, I think these laws were intended for younger people who . . . hadn't had children and things like that . . . But it was certainly a place where I couldn't really do very much other than sort of support his quest to find information. (RS015)

Finally, one clinician spoke about a gay Christian client who internalized his family’s negative reactions to his sexuality:

He wanted to be part of . . . church and . . . to get more out of out of God and faith, but just being in a family that wasn't accepting of him . . . the messages that you get that you internalize is like ‘Oh, I guess God doesn't love me or I guess . . . it’s this big shameful thing in the church if I show up as a gay male.’ (RS020)
Distortions of Religious/Spiritual Ideals. Respondents provided three examples of times when they found it challenging to address client beliefs that they perceived as a distortion of their own religious or spiritual ideals. One therapist described difficulty navigating anti-LGBTQIA beliefs that are attributed to Christianity. She explained that she does not find these beliefs to be true Christianity. Another Christian identified therapist described difficulty counteracting messages within the Christian community in which individuals are told that they are not praying enough or not being grateful enough. She stated that she will sometimes draw upon examples from the Scripture that indicate that it is normative and okay to have negative emotions. Yet another therapist, this one Jewish-identified, described difficulty working with Jewish clients who felt that G-d hated them and was punishing them. She characterized these clients’ beliefs as “toxic” (RS014).

Persecutory Beliefs. Two clinicians spoke about struggling to address oppressive beliefs held by clients. One Jewish identified therapist described struggling to address an anti-Semitic comment made by a client. Another therapist reported feeling compelled to address a racist comment made by a client who shared the therapist’s ethnic and religious identities.

Maintaining Therapist Role and Boundaries

Four responses described challenges therapists face when either they or the client wish for the therapist to adopt a more pastoral role. Two therapists spoke about sometimes needing to stop themselves from sharing their own religious or spiritual perspectives with clients.

I guess it’s the sensitivity of sometimes wanting to remind them of . . . [G-d]’s role . . . but not being able to . . . like they just need to be validated . . . At the same time, I do think it’s very helpful . . . to . . . give them a bit of a bit step back [from the] pain of the
experience . . . I think the challenge of not wanting to completely leave it out . . . but also not wanting to come off as insensitive, not understanding, invalidating. (RS014)

Two therapists spoke about how they respond to clients who wish to use therapy to discuss religious or spiritual issues.

Well, if I feel like somebody's looking to me to be kind of like a pastoral counselor . . . that starts to feel uncomfortable for me because then I feel like I'm being dishonest in a sense, so it is actually kind of a fine line . . . between saying to someone . . . I'm very glad you're looking to your tradition to get help and . . . I can see how you're getting a lot of support and sense of comfort from God . . . . (RS015).

**Client Guardedness and Resistance**

Three responses described client guardedness when talking about religion or spirituality. Two responses seemed to indicated that client guardedness was due to perceived differences between the client and the therapist. One response suggested that client resistance to exploring spiritual and religious issues is no different than client resistance in other areas.

**Client Reactions to Therapist Religion or Spirituality**

Three therapists indicated that they have struggled with the ways that clients have reacted to the therapist’s religious or spiritual identity. One clinician described struggling when clients make assumptions about a religious identity that they share with the therapist. Another religiously identified clinician described being extra sensitive when working with clients who have a had a negative experience with religion. Finally, one Agnostic identified clinician spoke about a client who had transitioned from Catholicism to Atheism and made statements like, “You can’t possibly understand how difficult this is to have been Catholic and to now try to be Atheist. I’m a bad Atheist . . .” (RS015).
Therapist Lack of Knowledge

Two clinicians identified their own lack of knowledge as a potential challenge. One therapist described a situation in which they inadvertently did something against a client’s religious beliefs.

I remember I was working with [a] Jewish client . . . and wrote ‘God’ and he said, ‘Oh’ . . . [And I said,] ‘I'm sorry, I didn't mean to write the word God on paper’ and . . . ‘How should I handle this? How would you like me to handle this?’ And so we talked about it.

And we were able to kind of move past it. (RS011)

The other therapist described sometimes feeling like she lacked adequate experience in the area of the client’s religious or spiritual tradition:

[I]f it's a religious or a background that I don't share, I may find that if there's things that I don't feel . . . confident in I may see if there's a way in which . . . they would be more suited for someone who did have that . . . background if that was a big part of where they wanted to take therapy. (RS020)

Impact of Therapist Factors on Ability to Address Religion and Spirituality in Treatment

To answer the research question “Which therapist factors, if any, are correlated with the therapist’s ability to navigate religion and spirituality in treatment?” a number of therapist factors were identified and explored to see if they impacted participants’ abilities to address religion and spirituality in treatment. The factors explored were as follows: gender, race/ethnicity, theoretical orientation, current religious/spiritual identity, changes in religious/spiritual identity over time, years in practice, and year graduated.
Gender

For this therapist factor, participants were divided into two groups based on their responses to the demographic survey: male participants \((n = 3)\) and female participants \((n = 5)\).

When asked in the interview to describe challenges they had experienced when working with religiously or spiritually identified clients, two out of three \((67\%)\) members of the male subgroup identified client resistance or guardedness as a challenge. The third member of this subgroup described the challenge of making mistakes with a client due to his own lack of knowledge about the client’s religious practices.

No particular themes or patterns emerged for the female subgroup.

Race

For this therapist factor, participants were divided into two subgroups based on their responses to the demographic survey: White/Caucasian-identified participants \((n = 6)\) and Black/African American-identified participants \((n = 2)\).

In comparison to the White-identified therapists, the Black-identified therapists tended to focus more on shared religion as creating comfort when addressing religion and spirituality with clients. In contrast, the White-identified therapists reported feeling comfortable when providing clients with new perspectives, discussing religious holidays, providing clients with a unique space to explore and express their religion and spirituality, and using religion to discuss grief and loss.

White-identified therapists also tended to speak more about attachment and relationships when describing the ways in which they conceptualize religion and spirituality in treatment. Half of the therapists in the White subgroup \((n = 3, 50\%)\) described looking at clients’ relationships
with G-d, relationships with their families, support systems and general attachments when conceptualizing religion and spirituality.

Meanwhile, both Black-identified therapists described religion and spirituality as a strength or coping tool for many of their clients. Both Black-identified therapists also identified client maladaptive beliefs about religion and spirituality as a challenge they’ve experienced when working with religiously and spiritually identified clients. Finally, both Black-identified therapists described feeling comfortable when working with clients who had similar religious beliefs or experiences to their own.

**Current Religious/Spiritual Identity**

For this therapist factor, participants were divided into two groups based on their responses to the demographic survey: the agnostic group \((n = 2)\) and the group that reported currently identifying with a particular religious tradition \((n = 6)\).

Within the agnostic subgroup, individuals tended to report neutral to negative reactions when clients brought up religion or spirituality in treatment. One participant described trying to understand the relevance of religion or spirituality for the particular client, while the other participant described being generally open but experiencing horror when learning about traumas some clients have experienced at the hands of religion and spirituality. In addition, both members of this subgroup indicated that they do not feel that their experiences with addressing religion and spirituality have been different from addressing other areas of client diversity.

Within the subgroup that identified a particular religious tradition, with the exception of one participant, members tended to report more positive reactions when clients bring up religion or spirituality in treatment. These reactions ranged from excitement to curiosity to connection to appreciation. The one participant in this group who responded differently indicated that he is
generally curious when clients bring up religion or spirituality but tends to feel guarded when working with members of his own faith. (He explained that he worries about the assumptions clients might make about him if they learned about their shared faith.) In addition, four out of six (67%) members of this subgroup reported differences that they noticed in their experiences addressing religion and spirituality in treatment as opposed to other areas of client identity. For the two participants who did not report this experience, one did not provide a response to this interview question and the other indicated that she did not tend to address any area of client diversity until she started working with a client population whose religious identity often matched her own.

**Changes in Religious/Spiritual Identity Over Time**

For this therapist factor, participants were divided into three groups based on their responses to interview questions: participants who specifically reported changing to an agnostic identity \((n = 2)\), participants who reported some categorical change in their religious or spiritual identity from childhood to adulthood \((n = 3)\), and participants who reported maintaining their religious or spiritual identity throughout their lives \((n = 5)\). There was overlap between the first two subgroups, but the researcher felt it important to create two separate groups to ascertain whether differences were due to experiencing any change in religious or spiritual identity or rather, to moving from a more religious or spiritual orientation to an agnostic orientation.

Within the subgroup of participants who reported shifting to an Agnostic identity, no particular themes or patterns were identified.

With the subgroup of participants who reported some categorical change in their identified religion or spirituality over time, when asked for times when they felt comfortable addressing religion or spirituality with clients, two out of three (67%) individuals described
feeling comfortable when providing clients with a unique space to explore their experiences with religion or spirituality. The third participant described feeling comfortable speaking with clients about religion and spirituality in the context of grief and loss.

For the subgroup of participants who reported maintaining their religious or spiritual identities over time, when asked for examples of times that they felt comfortable addressing religion or spirituality with a client, individuals tended to describe either providing clients with a new perspective on the client’s religion/spirituality or connecting with clients about shared religious/spiritual experiences. One therapist in the subgroup did not follow this trend and instead described feeling comfortable when speaking with clients about religious or spiritual holidays. When asked about challenges that they’ve experienced while addressing issues of religion and spirituality in treatment, four out of five (80%) members of this group identified challenges related to the therapist’s beliefs about religion. Two participants indicated that they have found it challenging when clients hold different or seemingly mistaken beliefs about a religion they share with the therapist. One participant indicated that she sometimes finds it challenging not to inappropriately express her own religious beliefs with a client who may not share her perspective or identity. One participant described the challenge of working with a client who holds religious or spiritual beliefs that the therapist views as maladaptive. The final member of this subgroup described client guardedness as a challenge he experiences. Similarly, when asked about a time when they felt uncomfortable addressing religion or spirituality with a client, four out of five (80%) members of this subgroup described feeling uncomfortable when clients either share a religious identity with the therapist and/or have had negative experiences of the therapist’s religion. One participant described feeling generally uncomfortable when working with clients of his faith. Two therapists described feeling uncomfortable when clients have had
negative experiences of a religion that they share with the therapist. One Jewish therapist described feeling uncomfortable when a client expressed anti-Semitic views. The fifth member of this subgroup indicated that they had not really had this experience and attributed this to the tendency of clients to not bring up topics that they feel uncomfortable about.

*Theoretical Orientation*

For this domain, participants were divided into two groups based on their responses to interview questions: participants who identified one specific therapeutic orientation ($n = 2$) and therapists who described utilizing an integrative or eclectic approach to treatment ($n = 6$).

The therapists who identified one specific orientation identified Acceptance and Commitment Therapy (ACT) and Strength-Based Cognitive Behavioral Therapy (CBT), respectively. When asked to describe challenges they have experienced in addressing religion and spirituality in treatment, both members of this subgroup identified challenges related to clients having negative experiences of church and/or religion. Both members of this subgroup also seemed, at times, to view or react to religion and spirituality in treatment in the context of a theoretical framework. The therapist who identified ACT as his primary therapeutic modality spoke elsewhere in the interview about having both an anthropological and behavior analyst perspective. In keeping with these perspectives, this participant described conceptualizing religion and spirituality in treatment from a historical and functional point of view. The therapist who identified strength-based CBT as her primary modality spoke about viewing religion and spirituality as strengths for clients and, in keeping with a CBT perspective, identified maladaptive beliefs about religion and spirituality as a challenge she has come across in treatment.
Meanwhile, the therapists who identified integrative or eclectic treatment approaches tended to identify challenges in working with religion and spirituality that involved the interaction or dynamic between the therapist and client. For example, two members of this subgroup indicated that they have struggled with client reactions to the therapist’s religious identity. Three other members of this subgroup described experiencing challenges and/or discomfort when clients seemed to be pushing beyond the boundaries of therapy or the therapist’s privacy. In addition, within this subgroup, several therapists touched on issues of attachment when describing the ways in which they conceptualize spiritual or religious issues that arise in treatment.

**Years in Practice**

For this therapist factor, participants were divided into three group based on their responses to questions on the demographic survey: participants who had been in practice for 10+ years ($n = 4$), participants who had been in practice for six to eight years ($n = 2$), and participants who had been in practice for two to six years ($n = 2$).

No significant trends or patterns were noted for either the 10+ years of practice subgroup or the 6-8 years of practice subgroup.

For the 2-6 years of practice subgroup, both individuals identified the client’s reaction to the therapist as a challenge they’ve experienced when addressing religion and spirituality in treatment. When asked to describe moments in which they felt uncomfortable addressing religion or spirituality in treatment, both members of this subgroup identified uncomfortable experiences working clinically with members of their own religions. When asked to describe moments in which they felt comfortable addressing religion or spirituality in treatment, both members of this subgroup described being able to provide clients with a new perspective on the client’s religion.
When asked how they conceptualize religion and spirituality in treatment, both members of this subgroup indicated that their conceptualization depends on the individual client. Of note, both members of this subgroup also indicated that they identify as religious and that their religiosity is important to them.

**Year Graduated**

For this therapist factor, participants were divided into two subgroups based on their responses to the demographic survey: individuals who graduated in the 1980s \( (n = 3) \) and individuals who graduated after 2012 \( (n = 5) \).

When asked about times when they feel comfortable talking about religion and spirituality with clients, two members of the subgroup that graduated in the 1980s identified talking about religious holidays. For members of the post-2012 subgroup, when asked about times when they have felt uncomfortable discussing religion and spirituality with clients, three out of five \( (60\%) \) members of this subgroup described situations in which clients had negative experiences of religion. In contrast, zero participants in the other subgroup answered the above question by describing negative experiences that clients described with religion.

**Emergence of Global Themes**

The Grounded Theory analysis of the interviews yielded eight global themes. These themes are identified and expounded upon below and in Table 3.

**Limited Supervision and Training on Religion and Spirituality**

All eight participants \( (100\%) \) in some way mentioned having limited training and supervision in addressing religion and spirituality in treatment. In total, participants made 13 mentions of this theme. RS010 stated that his training in this area “hasn’t been very comprehensive.” RS011 shared that any training he received in this area was “always under . . .
the guise of something . . . much larger” and that broadly he received “very minimal [training] actually.” When speaking about the conceptualization that she had developed to address religion and spirituality in treatment, RS014 remarked, “I wish I had a supervisor or course or something that helped guide me through this, because I could have used it like 10 years ago when I was figuring it all out.”

Since lack of training emerged as the global theme mentioned by the highest number of participants, it is expounded upon below.

**Training in Religion and Spirituality**. All eight participants (100%) reported receiving some sort of diversity training. One participant (13%) stated that they did not receive any diversity training in graduate school, while the other seven participants (88%) did report receiving some diversity training in graduate school. According to participants, these trainings took place through graduate school courses, internship experiences, post-doctoral experiences, continuing education and other post-graduate training, and self-study. Participants indicated that these trainings spanned topics and media such as scheduled seminars, relevant case examples, learning about specific populations and their practices, biases inherent in assessments, multiculturalism classes, family therapy class, and readings on topics such as racial trauma, supporting LGBTQ+ youth, anthropology, and more.

When participants were asked if they had any training specific to religion and spirituality in treatment, two participants (25%) responded that they had. Three participants (38%) reported having some level of training, and three participants (38%) described having no training in this area. For the two participants who reported receiving training in this area, one described receiving this training in a Christian Masters program, while the other reported receiving it through a combination of self-study and training provided by a Jewish agency that she works for.
Below are some quotations from respondents who indicated that they had some level of training in this area:

“There really isn’t a lot out there.” (RS017)

“It’s always under the guise of something that is much larger, for instance . . . like grief.” (RS011)

“. . . hasn’t been very comprehensive, but just talking about [religion and spirituality] . . . not shying away from it [in treatment]. . . .“ (RS010)

**Experiences of Religion and Spirituality in Training.** Five participants (63%) spoke about their experiences as religiously or spiritually identified individuals while receiving their clinical training. Three of these participants (60%) described mixed experiences, while one participant (20%) each reported a negative and a neutral experience.

One of the participants who reported a “mixed” experience in graduate school described experiencing “some interesting dichotomy” between religious beliefs and the “liberal” department housing his training program (RS010). Another participant indicated that, although she never felt “discriminated against or belittled,” she encountered some people and professors who she described as “Treating religion as . . . some kind of a crutch or some kind of an infantile way of coping with the world” (RS016).

The participant who described having negative experiences shared the following:

I think religion is very negatively viewed in the secular world, even in the world of psychology and even with all the [diversity] classes, there wasn't really a space to talk about other perspectives and different views. . . . I think there's also like a lot of leftist politics . . . happening in graduate school and being seen as religious . . . I felt like I had to prove that I was liberal to show like I'm not just religious . . . I didn't realize how hard I
had to balance these identities . . . It [was] only after school did I realize that I really
couldn't like just be open and comfortable with my religious identity. (RS014)

Finally, the participant who described a neutral experience in training indicated that while
in graduate school he was “instructed” that “you don’t talk about politics or religion” (RS017).
However, this participant indicated that he later modified this approach.

Experiences of Religion and Spirituality in Supervision. Participants were also asked
about their experiences of religion and spirituality in supervision when they were supervisees.
Four participants (50%) indicated that religion and spirituality were either not discussed at all or
only discussed minimally. “It was almost absent” RS016 recalled, while RS019 stated, “It was
never really discussed.” Two participants (25%) described having positive experiences of
religion and spirituality in supervision. One stated, “I feel very fortunate. I’ve always had really
good supervisors and every time I’ve wanted to talk about like religion, they’ve been very open
to like what I’m talking about (RS010).” One participant (13%) reported having neutral
experiences, while one participant (13%) reported having mixed experiences.

Participants were asked whether their supervisors asked about religion and spirituality.
Three participants (38%) indicated that supervisors inquired about client religion and spirituality
when it seemed relevant to the case. Three participants (38%) stated that their supervisors did not
ask about client religion or spirituality. One participant (13%) indicated that their supervisor
often asked about client religion or spirituality. One participant did not have a response recorded
for this question.

Six participants also spoke about the reactions they observed in their supervisors when
religion and spirituality did enter the conversation. Five of these participants (83%) described
observing neutral reactions, while one participant (17%) described observing positive reactions.
Finally, participants were asked what impact, if any, the way their supervisors handled religion and spirituality had on the participants’ willingness to discuss these matters in supervision. Three participants (38%) did not describe any impact. Two participants (25%) described being uncertain what the impact was. One participant (25%) indicated that they had different experiences with different supervisors. One participant (25%) reported increased and decreased willingness, respectively, to discuss religion and spirituality in supervision based on what they observed in their supervisors.

**Religion and Spirituality as a Resource**

Seven out of eight participants (88%) referred to religion and spirituality as a positive resource for their clients. In total, these seven participants made 13 references to this theme. They described the usefulness of religion and spirituality as a coping tool, as a way of navigating grief and loss, as filling psychological and social needs, and as providing community.

RS015, who self-identified as agnostic, shared, “I appreciate the aspect of ritual and coming together and community” available to people who identify as spiritual or religious. RS015 also remarked later in the interview that she was “really glad” that her religious and spiritual clients “have that way of looking at the world.” RS014, who self-identified as religious, spoke about a client who learned to related to G-d as a comforting presence in the midst of her anxiety.

**Attending to Maladaptive Religious and Spiritual Beliefs in Treatment**

Six out of eight participants (75%) described paying attention to their client’s maladaptive religious and spiritual beliefs or attitudes when working clinically with clients. In total, these six participants made eight mentions of this theme. The maladaptive beliefs identified...
included both maladaptive beliefs about religion and spirituality as well as beliefs stemming from religious and spiritual sources.

One person believed . . . in past lives and he used to go to a [?]. You know to tell him who . . . he was in his past life . . . some of the things that this reader would tell him, I think were reinforcing negative aspects self rather than positive . . . I don't think that was good . . . but I also couldn't tell him . . . I think that's . . . a bunch of baloney . . . the challenge is to try to . . . listen, be accepting . . . even though I may not agree with it . . . but also to try to see if it's something that is maladaptive for them and if there's a way that I could approach that. (RS016)

Another participant shared:

I had a client one time that was very Catholic and she wanted to talk about Catholicism . . . She was . . . judging herself very harshly . . . I was talking about . . . Did she really think God would judge her so harshly for something when she was trying hard to . . . do the right thing . . . I feel like I was able to kind of help her see a different perspective of her own faith . . . I think that was a good . . . experience for me to talk to her about her Catholicism . . . (RS010)

**Increased Comfort with Religion and Spirituality Over Time**

Seven out of eight (88%) of participants described experiencing increased comfort over time with addressing religion and spirituality in treatment. They each made one mention of this theme, for a total of seven mentions. Overall, these participants indicated that they were more hesitant or uncomfortable bringing up religion and spirituality earlier in their professional careers.
Yeah, I think that I was probably more reluctant to bring it up at a certain point. I think that kind of comes . . . what I'd call, you know, like new clinicians’ lack of experience. . . . I think that I was worried. (RS010)

In the words of another participant, “I think I encourage this aspect of . . . a person’s life to be . . . part of the therapy process more now than I did in the past” (RS016). Yet another therapist shared, “I would just say that it’s a little bit more in depth and with more passion . . . and with more confidence” (RS020).

**Following Client’s Lead with Areas of Identity**

Six out of eight (75%) participants described tending to follow the client’s lead, not only with bringing religion and spirituality into treatment, but with all aspects of client identity. Each participant mentioned this one time over the course of the interview, for a total of six mentions of this theme. Some clinicians spoke about creating an open and welcoming space in which clients could feel comfortable to explore aspects of their identities.

I think it is usually when the client brings it up, but I think they do so because they know that I'm receptive to it. I think I’ve established that early on. That that's something, that part of their life I want to hear about, that I'm not going to be judgmental. . . And once I know that that's a part of their life, then I will bring that up myself at an appropriate time . . . (RS016)

**Religion and Spirituality as a Shared Language**

Four out of eight (50%) participants spoke about religion and spirituality as sometimes providing them with a shared language with the client. These participants mentioned this theme a total of five times. One participant described being able to use more natural and comfortable language about evolution when speaking with a client who shared the therapist’s agnostic beliefs.
When referring to clients who bring up religion or spirituality in treatment, RS014 commented, “It’s my language.” RS017 described a client who felt comfortable using Yiddish words in the session, because they knew that the therapist was Jewish.

**Looking at Relevance of Religion and Spirituality for the Specific Client**

Three out of eight (38%) participants spoke about viewing religion and spirituality in terms of their relevance for the particular client in front of them. These participants mentioned this theme four times total. RS015 stated, “I think they just become issues like any others . . . what does this particular struggle or issue mean for this particular person, given their history and how important is it? And should we focus on it?”

**Overlap Between Religion/Spirituality and Relationships**

Three out of eight (38%) participants described religion and spirituality as being relevant for clients on a relational level. These participants mentioned this theme four times total. RS014 defined spirituality as “relationship with the divine or relationship with G-d.” She also described conceptualizing religious and spiritual issues in treatment as paralleling the parent-child relationship. Similarly, two other participants both described thinking about religion and spirituality as being related to attachment and indicative of the client’s broader connection to their family of origin.

**“I’m not the judge”**

Two out of eight (25%) participants indicated that they do not feel they get to judge others upon their religion or spirituality. They each mentioned this theme one time for a total of two mentions. RS010 stated, “I’m definitely not the judge, which I’m happy about” in describing how he views clients who hold beliefs that contrast with his own. RS019 described being guided by “the idea that god is love” and stated, “We’re not the judge, he [god] is.”
Other Findings

*Attitudes Toward Religion and Spirituality*

In the interview, participants were asked a variety of questions aimed at better understanding their attitudes toward religion and spirituality. (See Figure 2)

**Associations with the Word Religion.** Participants were asked what associations, if any, they have with the word religion. Two participants (25%) indicated that they have positive associations with the word. Two participants (25%) indicated that they have mixed reactions to the word. Two participants (25%) indicated that they have neutral reactions to the word. One participant (13%) indicated that they have negative associations with the word. One participant (13%) did not report any positive or negative associations with the word.

When asked more specifically about their associations with the word religion, participants had a variety of responses. Some participants described having specific memories of their experiences with religion. Some participants reported thinking automatically about their own religions.

Participants identified a number of potential benefits of religion including its ability to provide community, connection, understanding, comfort, and strength. Participants also identified potential downsides of religion, including its ability to cause trauma, be overly rigid, and be otherwise damaging to people.

**Associations with the Word Spirituality.** Participants were also asked about their associations with the word spirituality. Three participants (38%) reported neutral associations with the word spirituality. Three participants (38%) did not report positive, negative, or neutral responses to the word. One participant (13%) reported a negative association with spirituality, and one participant (13%) reported having both positive and negative associations with the term.
Participants tended to report that spirituality did not seem as well-defined as religion. For those who indicated having some negative associations with the term ($n = 2$), they identified a lack of rationality and a lack of groundedness as potential downsides of spirituality. RS015 explained, “Not to be sort of locked into an entirely rational perspective seems like an interesting way of being to me. . . maybe I find it more amusing . . . ”

**Match Between Client and Therapist Religious/Spiritual Identity**

Participants were asked to describe their experiences working with both clients with whom they did and did not share a religious/spiritual identity.

**Shared Religious/Spiritual Identity.** One participant shared that he worries about assumptions clients may make upon learning that he shares their religious identity. This participant described worrying about incorrectly perceived similarities and indicated that he experiences more discomfort and is less willing to disclose his identity when working with clients of his own faith. Another participant also described being perceived to be more similar to clients than she actually was and indicated that she had to clarify these misconstrued similarities with her clients.

One participant described feeling like he can utilize shared language more comfortably when working with clients who share his perspective on the world. Two participants described experiencing a sense of connection when working with clients who share their religious/spiritual beliefs.

One Christian therapist described a session in which she felt that the demands of the moment stretched beyond her abilities as a therapist and required that she adopt a more Christian role with the Christian client in question. The therapist described praying silently in the session and being inspired to share some Scripture with the client:
My message was to tell him . . . the story of Joseph in the Bible . . . just telling the story 'cause that's what the Holy Spirit put upon me and . . . then the next session . . . he was just like that story you told me about Joseph. That really did something for me. . . .

(RS020)

Different Religious/Spiritual Identity. Five participants (63%) indicated that when religious or spiritual differences are present, they tend to adopt a curious and respectful stance and explore the client’s experience of their own religion or spirituality. Some clinicians spoke about incorporating the client’s religious or spiritual perspective into treatment when appropriate.

I work with a woman who, her Catholicism is incredibly important . . . her mother is dying right now . . . So we've been talking a lot about how her religion . . . has informed her in the past and is informing her now as part of that grief process too and I'll ask her . . . questions . . . . (RS017)

One clinician who reported identifying as agnostic indicated that he has become less judgmental about his clients’ religious and spiritual perspectives over time and has learned to appreciate the value that religion and spirituality can add to people’s lives.

One clinician reported not really speaking about religion and spirituality with clients whose religious or spiritual identities differed from her own.

Moments of Comfort

Participants were asked to identify moments during which they felt comfortable discussing religion or spirituality in treatment with clients. In their responses, four participants (50%) described moments in which they had opportunities to discuss a shared religious tradition with a client. Three participants (38%) described moments in which they felt they provided clients with a new perspective on their own religious or spiritual tradition. Three therapists
(25%) described experiencing comfort when they were able to provide clients with a unique space in which they could speak about their respective religions. Two therapists (25%) spoke about being able to discuss the holidays with clients. One therapist (13%) described using religion or spirituality to explore rituals related to grief and loss. One therapist (13%) reported feeling comfortable when addressing spiritual topics such as mindfulness, appreciation of nature, and ethics with clients.

**Discussing Shared Religion.** Four therapists described having meaningful experiences when speaking with clients about a shared religion. Two examples are highlighted below.

RS020 spoke about a client with whom “most of our conversation was about just God and how God shows up in her life . . . we like really got deep into that and it was . . . really meaningful for her and me.”

Another therapist described drawing upon her own experiences to help a client struggling to find a new religious community:

She moved to Jersey. She wanted to find a home church and so it . . . reminded me so much of me when I kind of moved to Virginia . . . being able to pull on my experiences in understanding where she was coming from. (RS019)

**Providing New Perspective.** Three respondents described feeling comfortable when providing clients with new perspectives on their own religious or spiritual traditions. This was true regardless of whether the therapist shared the particular religious/spiritual tradition with the client. The Grounded Theory analysis revealed that participants tended to report comfort when it seemed to them that the client’s perspective on a particular religious or spiritual matter was initially maladaptive and the therapist felt they had helped the client to find a new, more adaptive perspective on the matter.
Two therapists spoke about helping clients to reach more self-compassionate perspectives on themselves as religious beings:

I feel like I was able to kind of help her see a different perspective of her own faith and that actually felt . . . good. . . . I think that was a good a good experience for me to talk to her about her Catholicism and . . . a different way to maybe interpret what was happening for her. (RS010)

. . . not be so hard on yourself when you're saying these goals . . . I wanna go [to church] every Sunday and that doesn't happen. What does that mean to you? If you don't make it every Sunday, you know? And is that the end of the world? (RS019)

Another therapist described working with a Jewish client for whom she tried to provide a new perspective on sexuality:

With her she actually is struggling with sexuality, in intimacy with her husband . . . I really try to talk to her about how sex is like the most holy of holies . . . that like Hashem [G-d] is there with you. (RS014)

Providing Unique Space. Three therapists spoke about moments in which they were able to provide clients with a unique space to discuss or explore aspects of their own religiosity or spirituality.

One therapist described a religious client for whom the therapist provided a safe space to talk about matters of sexuality and intimacy:

It's a very private topic so it can be very taboo almost to talk about it so to talk about it with someone who is religious and who is spiritual and who is sensitive about it and respects it, I think it is very meaningful. (RS014)
Another therapist identified a time where she provided a religiously identified client with a space to discuss her discomfort with her place of worship:

Over the last four or five years she'd been attending a Catholic Church in her town, and she's actually really politically liberal and the church actually was pretty conservative . . . she started to struggle quite a bit with her church and . . . that was something that I felt very comfortable discussing with her . . . she became not disillusioned with her religion itself, but with the particular congregation. (RS015)

The third therapist described having a meaningful conversation with a Muslim-identified client:

His spiritual beliefs . . . and religious beliefs inform him, and yet he really can't talk to a lot of people about it because people at times equate Muslims with being terrorists . . . We talked just a lot about that . . . I felt very appreciative that he felt comfortable enough to talk about it . . . (RS017)

**Discussing Religious Holidays.** Two therapists identified talking about religious holidays as a way of comfortably connecting with clients over matters of religion and spirituality.

**Conceptualization**

Participants were asked to describe how they conceptualize issues of religion and spirituality that arise in treatment. Each participant described a unique way of conceptualizing these matters. When asked how they arrived at each of their conceptualizations, two participants (25%) indicated that they developed their conceptualizations on their own; one participant (13%) indicated that their conceptualization stemmed from their religious faith leaders; one participant (13%) indicated that his conceptualization was informed by his theoretical home base; one
participant (13%) reported learning their conceptualization in graduate school; and three participants (38%) had no response.

**Influence of Psychology and Religion/Spirituality on Each Other**

Participants were asked how their identities as psychologists have influenced their thinking about religion and spirituality. Responses to this question were quite varied. However, three participants (38%) indicated that they have come to view religion and spirituality as resources for clients. These participants highlighted the roles that religion and spirituality can play both broadly and specifically with regard to grief and loss, communal needs, and social needs. One participant stated:

I know the last couple years . . . I've been talking about death a lot with patients too. . . . we talk about the rituals . . . I know for me personally in dealing with death when my parents have passed, the Jewish rituals around death have been incredibly helpful . . . it's incredibly helpful as a . . . model of . . . what to do, like how to organize such a difficult [experience] . . . I'll also be curious and ask people . . . does their religion . . . spirituality help them during these times too? (RS017)

Two participants (25%) who self-identified as spiritual and/or religious described experiencing significant overlap between psychological and spiritual/religious ideas.

There's just so many things in the Bible that kind of reference psychology and like see these people’s struggles and what the coping skills may be like. So for me . . . they've always kind of gone hand in hand . . . psychology and . . . Christianity. (RS019)

One participant spoke about developing an ability to empathize with others despite differences in religious/spiritual beliefs:
I might not agree with you know certain perspectives or certain ideas that are kind of prevailing in psychology, but . . . that's okay . . . But when the person’s in my office, I'm definitely going to listen to what they have to say. . . I would say in general I'm pro life . . . However, I've treated . . . several clients who have had abortions, and I'm listening to what happened and listening to their perspective, and I still have empathy for their choice and why they did that and why they made that choice. [My perspective] hasn't prevented me from treating them very empathetically and being very open to their experience . . . .

(RS010)

Participants were also asked whether they’ve experienced any particular overlap or tension between their ideas about psychology and their ideas about religion and spirituality. One participant described tension between the Freudian view of humanity and their own Jewish view of humanity, explaining that Freud views people as driven by sexual impulses, whereas Judaism does not view these impulses as part of what it essentially means to be human.

One participant described experiencing some tension regarding LGBTQ+ communities and issues. This participant described needing to intentionally reconcile some of their learned stigmas and beliefs about LGBTQ+ communities in order to arrive at a new perspective. In a similar vein, one participant described an incident in which he felt psychology was making assumptions about the beliefs that religious individuals might hold:

[T]he teacher gave me a very awkward assignment. She's like treat this person who's coming to you for issues about their sexuality as if you were very religious and I was like, ‘Well I am very religious.’ . . . as I was doing this exercise . . . I was saying things that I would imagine people from my background would say it was making me very
uncomfortable . . . I was like . . . I don't really don't subscribe to these ideas anymore, and so it's very uncomfortably for me to talk like this. (RS010)

One participant described sometimes feeling limited by their CBT orientation and stated, “I find that . . . I need to put the CBT solution focus aside . . . and really get to . . . speaking more about just spiritually what’s happening with you” (RS020).

Regarding the overlap between the two fields, however a few participants identified both as being healing, both as related to living with ambiguity, and both as providing in-depth exploration.

Experiences of the Interview

Before concluding their interviews with the writer, participants were asked what it was like for them to partake in the interview. Seven participants (88%) indicated that participating in the interview had provided them with food for thought. The final participant (13%) stated that they appreciated the opportunity to discuss the topic. RS015 shared, “I think it’s interesting to . . . bring into awareness an area that I’m certainly aware of but don’t really focus on . . . I’m thinking . . . I could bring it to the surface a little bit more.” RS019 stated, “Oh it’s been eye opening. I haven’t talked about religion in forever, I mean . . . in context of psychotherapy and psychology.”

Finally, another participant shared:

[I]t's . . . allowing me to be mindful . . . even in my sessions with clients but even talking more about my supervision and classes too. And I think just for me just to continue educating myself on it. (RS017)
Discussion

The current study was conducted to better understand barriers therapists face in addressing religion and spirituality in treatment. To this end, participants were recruited to participate in semi-structured interviews about their experiences addressing religion and spirituality in treatment. Eight doctoral-level psychologists were included in the sample.

Participants responded to both a demographic survey and a number of interview questions. The questions asked were aimed at gathering information about the participants’ demographics, their own attitudes toward religion and spirituality, their experiences with religion and spirituality in treatment with clients, and their experiences with religion and spirituality in training and supervision. Participants were also briefly asked about their experiences during the interview itself.

The data gathered were analyzed using a combination of Grounded Theory analysis and frequency calculations. Results were organized and reported for the purpose of answering the initial research questions:

1) Do therapists approach religion/spirituality differently as an area of client diversity? What does this look like in practice?

2) Where barriers to addressing religion/spirituality in session are reported, what is it that gets in the way?

3) Which therapist factors, if any, are correlated with the therapist’s ability to navigate religion and spirituality in treatment?

Are Religion and Spirituality Different?

Results from the current study did not support the literature that suggests that issues of religion and spirituality are often avoided or neglected in treatment (Frazier & Hansen, 2009;
Moleiro et al., 2018). In the current sample, every participant was able to provide ample evidence that they have, in fact, addressed religion and spirituality with a number of clients. However, 25% of the sample did suggest that they are more likely to do so with members of their own faith than with other clients. This corroborates findings from McMinn et al. (2012) who suggest that shared faith between client and therapist can be both a powerful source of connection and the basis for significant blind spots. This aforementioned 25% of the sample also reported a number of settings and times in their careers when they did not tend to address client religion or spirituality at all. Nevertheless, even these therapists were able to share a number of recent examples of times when they explored issues of religion and spirituality with clients. Moreover, the remaining 75% of the sample did not report avoiding religion or spirituality with their clients at all.

However, participants did identify some differences between religion/spirituality as compared to other areas of client diversity. Broadly speaking, where differences were reported, participants actually described being more likely to address religion and spirituality in treatment and to have a positive response to these topics when they arose. This suggests that psychologists’ comfort levels with religion and spirituality tend to be equal or greater to their comfort levels in addressing other areas of client identity. Moreover, it seems that psychologists view religion and spirituality more positively than other areas of client identity. Indeed, several participants described viewing religion and spirituality as an inherent strength and resource as compared to other client identities which may be associated with hardship and oppression. Similarly, Delaney et al. (2013) found that 82% of psychologists in their sample perceived a positive relationship between religion and mental health.
Participants also noted similarities between religion/spirituality and other areas of client identity, indicating that there is a depth of meaning and connection that may be present when a client feels comfortable enough to explore any aspect of their identity with the therapist. This echoes Tummula-Narra’s (2009) assertion that exploring religion and spirituality in treatment can deepen both the therapist’s experience of the client and the client’s experience of themselves.

**How are Religion and Spirituality Addressed?**

Interestingly, though participants reported feeling more comfortable discussing religion and spirituality than other areas of client identity, they tended to wait for the client to bring these topics up in treatment. The participants who described directly asking clients about religion and spirituality reported asking about this on their intake interviews and/or when conducting risk assessments. Otherwise, based on the current sample, it seems that clinicians are most likely to follow the client’s lead in this area. Indeed, the literature indicates that psychologists are trained to follow the client’s lead in therapy (Russel & Yarhouse, 2006; Winkeljohn Black et al., 2021) and that this is especially important in choosing which cultural factors are discussed in treatment (Owen et al., 2016).

Some participants noted that they might be more likely to directly address visible aspects of client identity, particularly where there are clear differences between the client and therapist. For example, a therapist might be more likely to point out differences between their race and that of the client as opposed to differences between their religious or gender identity and that of the client. Hagler (2020) explains that, because it may not be visible, sexual identity is less likely to be discussed in supervision than other, more visible identities. It stands to reason that the same would hold true for other hidden identities, such as religious or spiritual identity.
This presents several possible difficulties. First, as one participant noted, clients may be less likely to bring up religion and spirituality as compared to other areas of their identity due to their perception that therapists may not be open to or respectful toward religious or spiritual beliefs and practices (e.g., Hathaway, 2016). Thus, if clinicians are following the client’s lead, and the client is operating based on an assumption of non-acceptance, religion and spirituality may never enter the therapy room, despite perhaps being important to the client. Second, if therapists are attending to religion and spirituality based on clients’ reported religious/spiritual levels on intake, what of those clients who hold atheistic, agnostic, or other non-religious/spiritual belief systems? As described in the literature cited above (e.g., Sahker, 2016), exploring religious and spiritual concepts may be as important for non-religious clients as it is for their religiously and spiritually identified counterparts. Clinicians may not be aware of this reality and may miss out on addressing important topics with clients who do not endorse holding religious or spiritual beliefs.

Summary

The current study did not find that religion and spirituality are neglected in treatment. In fact, participants sometimes reported being more likely to address religion and spirituality as compared to other areas of client diversity and to feel more positively about doing so. In addition, participants equated religion and spirituality to other areas of client identity with regard to the richness of conversation that these topics may provide. Finally, clinicians reported adopting similar approaches to all areas of client identity, most often following the clients lead regarding which areas of identity, if any, will be explored in treatment. This reported tendency to follow the client’s lead may cause important aspects of client identity to be neglected in treatment.
What Barriers are Present?

Rorty (1999 as cited in Rosenbaum, 2009) famously called religion a “conversation stopper” (n.p.). The current interview data was analyzed to discover barriers that prevent religion and spirituality from entering the therapy conversation. With the exception of two participants, clinicians in the current sample did not tend to report avoiding religion and spirituality in treatment. Nevertheless, several barriers to addressing religion and spirituality in treatment were identified.

Participants were also asked about challenges they have faced in addressing religion and spirituality in treatment with clients. Thus, the majority of the discussion below is focused on barriers that therapists experience when they are already addressing religion and spirituality in treatment rather than barriers to addressing these topics in the first place.

Barriers to Addressing Religion and Spirituality in Treatment

Despite the limited number of participants who reported avoiding religion and spirituality in treatment, the following barriers were identified: perceived differences between client and therapist, inadequate training and supervision, client guardedness, and ideological differences.

One participant indicated that she did not bring up any aspect of client diversity in treatment until she started working in a treatment setting where she shared a religious background with many of her clients. Another participant indicated that she is less likely to bring up religion or spirituality with clients who do not share her religious identity. Both of these participants indicated that they are more comfortable addressing and more likely to address religion and spirituality with members of their own faith than with clients of other faiths. Thus, for these participants, perceived differences between their religious/spiritual identities and those of their clients served as a barrier toward addressing issues of religion and spirituality in
treatment. This is similar to findings presented by Winkeljohn Black et al. (2021) in which a therapist-client dyad who had overlapping spiritual beliefs seem to experience more comfort in treatment than a therapist-client dyad who did not have overlapping spiritual beliefs.

One of the aforementioned participants stated elsewhere that she did not have space to speak about her own religious identity during her graduate training. Though she did not state this explicitly, it seems possible that this modeling trickled into her behavior as a therapist, manifesting as her reported tendency not to address issues of diversity with her clients. In fact, Russel and Yarhouse (2006) imply that internship training directors may view religion and spirituality as unimportant due to their own education and training, suggesting that attitudes toward religion and spirituality can trickle down to therapists through their training experiences. Moreover, one participant reported being explicitly told during their graduate training not to talk with clients about politics or religion. This participant stated that they have since changed their own personal approach. However, it is important to note that these attitudes have been present in psychology training programs and may be continuing to serve as a barrier, preventing therapists from adequately supporting clients by addressing religion and spirituality in treatment.

Participants indicated that clients are sometimes guarded, defensive, or even resistant regarding their own religious or spiritual identities. Thus, it may be the client’s guardedness rather than a particular attitude or behavior on behalf of the therapist that serves as a barrier, preventing discussion of religion and spirituality in treatment. Indeed, the literature suggests that clients may withhold from disclosing important information about their religious or spiritual lives both with therapists who do and do not share the client’s belief system (McMinn et al., 2012).
Ideological Differences. Though participants did not directly identify ideological differences as a barrier to addressing religion and spirituality in treatment, some interesting findings on this topic did emerge.

As was the case in a study conducted by Delaney et al. (2013), most participants in the current study tended to describe a positive relationship between their identities as psychologists and their perspectives on religion and spirituality, with 38% of the current sample noting that they tend to view religion and spirituality as resources for their clients. The majority of participants did not report tensions between their ideas about psychology and their ideas about religion and spirituality. However, there were several reports of stigma that the therapists themselves had experienced in the psychology community against religion, spirituality, and/or religiously or spiritually identified individuals. Thus, it seems that therapists feel that the mental health world may stigmatize and even discriminate against religious and spiritual populations, but individual therapists tend not to report that this phenomenon inhibits their ability to address religion and spirituality in treatment.

In addition, three therapists described situations in which either they or clients had to navigate being religiously identified in a politically liberal context or being politically liberal in a religious context. In all three of the situations described, these different identities were perceived as conflicting with each other. Further supporting the possibility of a perceived relationship between political and religious/spiritual identity, Margolis and Sances (2016) indicate that Republicans tend to have stronger religious identity than Democrats, as measured by church attendance. Thus, clients and therapists alike might perceive religiosity/spirituality as a barrier toward aligning with politically liberal ideas and vice versa. It is interesting to consider the
impact that this perceived relationship could have on the extent to which therapists can fully explore religious, spiritual, and political issues and identities with clients in treatment.

Moreover, the participants who described having negative associations with the term spirituality indicated that they may struggle to understand or appreciate the notion of adopting a non-rational or super-rational perspective. Likewise, one of the participants in a study conducted by Woodhouse and Hogan (2019) suggested that spirituality may be ignored in mental health training precisely because it defies explanation. This finding lends preliminary support to the possibility that psychology, which can be seen as a science, and spirituality, which does not pretend to be scientific in nature, may be perceived as being at odds with each other. This may serve as a barrier for clinicians who maintain a scientific perspective and are trying to explore matters of spirituality with clients.

**Barriers Faced While Addressing Religion and Spirituality in Treatment**

Analysis of the interview responses revealed a number of challenges that therapists may face when addressing client religion and spirituality in treatment: maladaptive client beliefs, difficulty maintaining the therapist role, therapist lack of knowledge, and client assumptions about the therapist.

Participants reported sometimes struggling when clients held maladaptive beliefs related to or stemming from religion and spirituality. This suggests that while religion and spirituality did not present problems for clinicians in their own rights, clinicians were appropriately applying their assessment skills to the intersection between client’s religion/spirituality and their mental health and overall functioning. This finding indicates that conflicts between a client’s religious/spiritual beliefs and their psychological wellbeing may pose a challenge for the therapist seeking to address both. Rosenfeld (2011) cautions that therapists must balance
between respecting client autonomy and appropriately assessing and treating harmful beliefs and practices. In other words, therapists must balance the ethical values of self-determination and autonomy with their value for non-maleficence (Rosenfeld, 2011).

Therapists also described sometimes experiencing difficulty withholding their own beliefs about a religious tradition they shared with the client. Moreover, even when the therapist and client followed different religious or spiritual paths, therapists described sometimes feeling pulled by clients to adopt a role that was more pastoral than clinical. In other words, one challenge faced by therapists when addressing religion and spirituality in treatment seems to be maintaining a clinical role even while discussing religious and spiritual concepts. Gonsiorek (2009) identifies and cautions against falling into this trap.

In addition, participants described sometimes being challenged by their own lack of knowledge about the client’s spiritual or religious tradition. It is likely for this reason that McMinn et al. (2012) suggest that therapists possess at least basic knowledge about world religions and also be prepared to understand the personal relevance of a religious tradition for the particular client in front of them. In the current study, some therapists reported struggling to understand whether client’s beliefs were normative or irregular for members of their religious or spiritual background. While one therapist described working through this lack of knowledge with the client, another therapist indicated that they might refer a client out to someone who shares their religious or spiritual background if this background was something the client wanted to focus on in therapy. These responses suggest that, while there are therapists who feel comfortable navigating religious and spiritual differences in session, there are others who may feel that these differences are insurmountable. This could certainly pose problems for clients who may not be able to find a therapist who is affordable to them, has availability, has the clinical
expertise the client needs, and also has knowledge about the client’s religious or spiritual identity.

The literature reviewed earlier (Moleiro et al., 2018; Watts-Jones, 2010) indicates that it is important for therapists to acknowledge both their own identities and the ways in which those identities interact with their client’s identity. As an example, McMinn et al. (2012) notes that clients may react to a therapist who shares their faith by withholding information about their struggles with the shared faith. A number of participants in the current study seem to demonstrate awareness of the significance of these factors, noting in the interviews that sometimes the barrier in treatment is actually the client’s reaction to the therapist’s religious or spiritual identity. This seemed especially true when the client either shared or had negative experiences of the therapist’s religious identity. Based on their abilities to report this phenomenon during the interview, participants seemed to be appropriately aware of the ways in which their identities might interact with their clients’ identities. One participant reported being especially wary of disclosing his faith to other members of his faith for fear of the assumptions his clients might have about him.

Summary

The following barriers toward addressing religion and spirituality in treatment were identified:

1. Therapist perception of differences between their own religious or spiritual identity and that of the client
2. Inadequate training, supervision, and modeling in graduate school
3. Client defensiveness or guardedness about matters of religion or spirituality
4. Ideological differences between psychology and religion/spirituality
The following were identified as barriers that pose difficulty when clinicians are already addressing religion and spirituality in treatment:

1. Clients holding maladaptive beliefs stemming from or related to religion or spirituality
2. Maintaining a clinical role even while discussing religious and spiritual concepts
3. Lack of knowledge about the client’s spiritual or religious tradition
4. Clients’ reactions to their therapists’ religious or spiritual identity

**Therapist Factors in Addressing Religion and Spirituality in Treatment**

In the review of the literature, a number of possible therapist factors were identified that might serve as barriers for therapists to addressing religion and spirituality in treatment: therapist religiosity, therapist experience, ideological differences between therapists and clients, and lack of training. In the current study, participants’ reports of their experiences in treatment were analyzed in the context of various therapist factors. In addition to the factors noted above, the factors analyzed included therapist gender, race, changes in religious or spiritual identity, and therapeutic modality.

**Therapist Gender**

Interestingly, the male therapists in the sample were more likely than the female participants to identify client guardedness and resistance as a challenge in navigating religion and spirituality in treatment. The reasons for this phenomenon are unclear. Perhaps clients respond differently to male therapists than they do to female therapists. Indeed, a paper by Bhati (2014) suggests that therapist-client pairs with a female therapist tended to report better therapeutic alliance than therapist-client pairs with male therapists. Of note, all three male therapists in the current sample reported identifying as White, cis-gender, and heterosexual. Perhaps, in the current sociocultural climate, these White male therapists have had to become
more attuned to or wary of client guardedness than their female counterparts. In fact, Weir (2021) has an entire paper on his experience as a White male therapist seeking to navigate cultural issues. Regardless of the reason, if male therapists experience more resistance from clients to exploring religion and spirituality in treatment, it may be somewhat more difficult for male therapist to address these topics in treatment than it is for female therapists.

**Therapist Race**

In this study, White and Black identified therapists differed in their descriptions of addressing religion and spirituality in treatment with clients. As compared to Black-identified therapists, White-identified clinicians were more likely to discuss attachment and relationships in their conceptualizations of religious and spiritual matters in treatment. They were also less likely to identify shared religion or spirituality as providing comfort in treatment, instead identifying more clinically-based events as providing comfort (e.g., providing new perspective, creating space for exploration, etc.). On the other hand, Black-identified therapists were more likely than White-identified therapists to report feeling comfortable when working with clients who had similar beliefs to their own. Black-identified therapists were also more likely to describe religion and spirituality as a resource for clients and to describe maladaptive beliefs about religion and spirituality as a challenge in treatment.

While neither racial identity seems to serve as a barrier toward addressing religion and spirituality in treatment, it seems possible that there are differences in the ways that Black and White-identified therapists approach and react to religion and spirituality in treatment. The researcher could not locate any existing literature on this subject. Further exploration would be necessary to fully explore and understand this phenomenon.
Therapist Religious or Spiritual Identity

Unsurprisingly, religiously identified participants tended to report being more excited about religion and spirituality in treatment than Agnostic-identified participants. This aligns with findings from Cumming et al. (2014) and Frazier and Hansen (2009). Religiously identified participants in the current study were also more likely to report differences between religion/spirituality and other areas of client identity, while Agnostic participants tended to report no differences. It is possible that religiously identified participants differentiated religion and spirituality from other areas of identity simply because the former was more salient and exciting to them than the latter. Indeed, where differences were reported, religion and spirituality were often viewed more positively by these participants than other areas of client identity. Another possibility, however, is that therapists for whom religion and spirituality are not personally salient, are less likely to acknowledge or attend to the differences in how these issues present in treatment as compared to other, perhaps more salient, areas of client identity. Further research would be necessary to determine whether lack of therapist religiosity or spirituality in any way inhibits the therapist’s ability to navigate these topics in treatment.

Changes in Therapist Religious or Spiritual Identity Over Time

In general, participants who had maintained a particular religious identity over time tended to report more difficulties managing their own religious beliefs in session. For example, they described challenges related to needing to hold back from inappropriately expressing their own religious or spiritual beliefs to clients. In addition, therapists who reported maintaining the same religious identity over time were more likely to report experiencing discomfort when clients either shared the therapist’s religious identity and/or had negative experiences with the
therapist’s religion. Thus, maintaining a single religious identity over time may present some unique challenges for therapists as they address issues of religion and spirituality in treatment.

In contrast, participants who described changing their religious identities over time were more likely to identify times when they provided clients with space for exploration as times when they felt comfortable addressing religion and spirituality in treatment. The literature suggests that for therapists to truly create safe spaces for their clients to explore a topic, the therapist must be sufficiently comfortable with the topic in question (Watts-Jones, 2010). Perhaps in the current sample, the personal experience of exploring one’s own religious or spiritual identity and choosing to make changes left the therapists who had done so especially well-equipped to explore these matters with clients.

**Therapist Therapeutic Modality**

Therapists who identified one particular therapeutic modality tended to report using cognitive behavioral approaches to treatment. These therapists tended to speak less about the therapist-client dynamics that emerged in treatment around issues of religion and spirituality as compared to therapists who described having integrative or eclectic approaches to treatment. It is possible that therapists practicing from purely cognitive behavioral orientations may pay less attention to dynamic, relational, and interactional aspects of treatment, leaving them less likely to notice the interaction between their own religious or spiritual identity and that of the client. Indeed, Parpottas (2012) argues that cognitive behavioral therapists need to integrate more of a relational focus into their treatment. Keeping in mind Watt-Jones’ (2010) emphasis on the importance of acknowledging the therapist’s identity and its intersection with the client’s, maintaining an approach to treatment that does not attend to the process aspects of therapy may actually serve as a barrier to fully addressing client religion and spirituality in treatment.
Years in Practice

There were a number of similarities noted in the response patterns for therapists who reported 2-6 years of clinical practice as compared to therapist with six or more years of clinical practice. It is unclear whether these trends were related to the amount of time these participants had been in practice, the fact that these participants both reported identifying as religious and indicated that their religion is important to them, or a completely separate factor.

Regardless of the reason, participants in the 2-6 years subgroup reported sometimes experiencing discomfort when working with members of their own faiths and sometimes experiencing challenges related to the how clients react to them as therapists. They also indicated that they enjoyed being able to provide clients with new perspective on the client’s religion. Finally, these participants stated that their conceptualization of religious and spiritual matters in treatment is highly dependent on the specific individual in front of them.

However, across experience levels, 88% of participants indicated that they experienced increased comfort over time in addressing religion and spirituality in treatment. This is interesting in light of significant research that the therapist’s level of experience does not seem to predict client outcomes (e.g., Erekson et al., 2017; Norton et al., 2014; Vos et al., 2022). However, given results from the current study, increased experience as a therapist may significantly impact the therapist’s comfort level and overall internal experience of providing treatment.

Summary

The following factors may have some impact on the ways in which therapists address religion and spirituality in treatment with clients. However, further research is needed to
definitively demonstrate correlations between these factors and therapists’ abilities to navigate religion and spirituality in treatment with clients:

1. Therapist gender
2. Therapist race
3. Therapist religious or spiritual identity
4. Therapist changes in religious or spiritual identity over time
5. Therapist therapeutic modality
6. Years in clinical practice

**Religion and Spirituality in Treatment**

Though the findings presented from here onward do not directly answer the research questions, they are important in more broadly understanding clinicians’ experiences addressing religion and spirituality in treatment. Moreover, these findings significantly contributed to the emerging models described below for addressing religion and spirituality in training programs, supervision, and clinical practice.

Strikingly, every participant in this study reported that, at minimum, 50% of their caseload is made up of by clients who identify as spiritual and/or religious. This, together with the Pew Research Center’s (2019) report that 72% of the U.S. population identifies as religious, suggests that it is crucial for psychologists and other therapists to be adept at addressing issues of religion and spirituality that may arise in treatment. Many participants described attending to the particular meaning of religion and spirituality for the specific client in front of them. This suggests that, rather than imposing their own beliefs about religion or spirituality on clients, therapists tend to stay mindful of exploring the client’s unique experience.
Religion and Spirituality in Clinical Training

Of the global themes generated by the Grounded Theory analysis, limited supervision and training was the most frequently mentioned and was mentioned by 100% of participants. This echoes findings reported by others (e.g., Golsworthy & Coyle, 2001; Kvarfordt & Herba, 2017; Lee et al., 2019; Saunders et al., 2013).

Only one participant described receiving specific training during graduate school in religious and spiritual diversity, and stated that this took place at a Christian Master’s program that they attended. One other participant reported receiving training through a combination of self-study and her work place, which she indicated is a Jewish agency. Otherwise, participants tended to report little to no training in this area despite being trained in other areas of diversity. Where training was provided, it tended not to be very comprehensive according to participant reports. Moreover, when describing the attitudes they experienced and perceived toward religion and spirituality from their training programs, participants tended to report neutral to negative attitudes held by professors and faculty members with religion and spirituality either being ignored or viewed outright negatively. Nedumaruthumchalil (2009) states that an unspoken understanding has existed that religion is outside of the purview of psychology and explains that this has led religion to be absent from psychological treatment.

Participants’ experiences in supervision tended to be less negative and more neutral, with many participants indicating that supervisors seemed open to discussing religion and spirituality but did not tend to bring it up unless it was directly relevant to the case at hand. Indeed, findings suggest that for many participants religion and spirituality were either completely absent or minimally present in supervision. Many participants described developing their conceptualizations of religious and spiritual issues on their own, and one participant reported
wishing that she had had guidance from supervisors and mentors in doing so. Saunders et al. (2013) likewise found that psychology trainees seemed to generate their own approaches to addressing religion and spirituality in treatment despite their lack of training in this area.

In summary, in contrast to the clinical realm, where religion and spirituality do not seem to be treated differently than other areas of client identity, in the realm of training, religion and spirituality seem to get less attention than other areas of client diversity. This suggests that, while trends in the field of psychology have tended toward increasing the focus on issues of diversity, there is still much work to be done in this area.

Other Findings

Though all interview questions asked about both religion and spirituality, participants tended to speak much more about religion than about spirituality. Woodhouse and Hogan (2019) found that even when they explicitly asked their participants about spirituality, many participants reported thinking about religion instead. This may be due to what participants in the current study reported: that spirituality does not feel as well-defined as religion. This may, in turn, make it harder to identify if and when spirituality is being addressed in treatment. Moreover, this may indicate that therapists are more likely to address religion in treatment than spirituality.

In addition, from eight interviews worth of data, only a few mentions of non-religious or non-spiritual clients emerged. Participants were far more likely to describe addressing issues of religion and spirituality with religiously or spiritually identified clients than their secular, agnostic, and atheistic counterparts. However, the literature indicates that it is important for therapists to explore, not just religion and spirituality, but the lack of religion and spirituality with clients (Aron, 2004; Rosmarin et al., 2015; Sahker, 2016). While mention of these
discussions were not absent from the current data, this study provides preliminary evidence that there is more work to be done in this area.

**Proposed Models and Treatment Recommendations**

*Rationale*

Therapists in the current sample indicated that between 50%-100% of their current clients identify as spiritual or religious. Moreover, 88% of the current sample indicated that religion and spirituality can serve as positive resources for clients. Like the literature cited above (Rosmarin, 2018; Woodhouse & Hogan, 2019), these findings further support the notion that religion and spirituality are important constructs for clinicians to be able to navigate in mental health treatment.

One participant suggested that she might refer a client out if she felt that her lack of knowledge about the client’s religious or spiritual tradition was inhibiting her ability to work well with the client. While it is always important for therapists to be aware of the boundaries of their competence, the more boundaries present, the less access to care the individual clinician can provide. Much research has been done about the barriers to mental health care present for a number of minority groups (e.g., Aggarwal et al., 2016; Horwitz, 2020). So as not to add additional barriers to treatment for clients who may already struggle to find appropriate therapy services, it would seem important for clinicians to be trained to be as competent as possible in addressing areas of client identity in which they feel incompetent.

Overall, participants tended to report feeling reasonably able to address issues of religion and spirituality in treatment. Clinicians seemed to have learned to apply general therapy skills to the specific domains of religion and spirituality. For example, in addressing religion and spirituality in treatment, participants reported attending to maladaptive client beliefs, maintaining
an open and respectful stance, and trying to understand client beliefs and practices in the context of the individual client. Indeed, based on the global themes generate by the Grounded Theory analysis, it seems that clinicians are particularly adept at noticing when clients hold maladaptive beliefs related to religion and spirituality. Based on the above, one might assume that clinical training programs are doing a good job of preparing clinicians to address religion and spirituality in treatment. However, corroborating the existing literature (e.g., Evans & Nelson, 2021, Magaldi-Dopman, 2014; Saunders et al., 2013; Vogel et al., 2013), lack of adequate training was the global theme that was most prevalent in the interview data. In fact, participants tended to report developing their conceptualizations and abilities regarding religion and spirituality in treatment on their own rather than in the context of a training program. Only one of eight participants reported developing their conceptualization of religious and spiritual issues in treatment in graduate school, and this graduate school was actually a Christian Master’s program. Though clinicians seem to be doing a decent job extending their broader graduate training to the topics of religion and spirituality, many indicated that they were less comfortable or even outright uncomfortable addressing these topics earlier in their professional lives. Woodhouse and Hogan (2019) similarly found that participants reported experiencing discomfort in response to client expressions of spirituality. In the current study, however, participants reported increased comfort with religion and spirituality in treatment over time, and this emerged as another Global Theme from the study data. While training programs and clinical supervisors may be providing clinicians-in-training with good foundational skills for therapy and even, perhaps, addressing client diversity more broadly, with regard to religion and spirituality, it seems that there is more work to be done.
Not only did participants indicate that they were not adequately trained to address religion and spirituality in treatment, some of them also described difficulties navigating their own religious or spiritual identities with psychology faculty, colleagues, and supervisors. Experiences in this area ranged from positive to neutral to outright negative, with some participants feeling that they could only express their religious or spiritual identities to a limited extent in professional contexts. This is similar to what Hagler (2020) found regarding psychology trainees’ experiences feeling discriminated against for their sexual identities over the course of their training.

In light of the above findings and based on the data generated by this study, tentative models for addressing religion and spirituality in both training programs and clinical supervisory contexts are presented below. Recommendations for clinicians are also provided.

**Model for Training Programs**

Based on the current study, time and experience seem to be significant factors in reducing therapist discomfort with addressing religion and spirituality in treatment with clients. It stands to reason then that starting this process earlier would help clinicians to feel more comfortable with these topics earlier in their careers. Cumming et al. (2014) make it clear that personal experience alone cannot render a therapist competent in addressing religion and spirituality in treatment with clients. It is therefore recommended that training programs make an active effort to provide clinicians-in-training with opportunities to meaningfully address these topics early in their training. It is important for clinicians-in-training to recognize that religion and spirituality can be important topics to explore with clients and to have some basic tools for doing so. Gonsiorek (2009) suggests that a combination of coursework and readings, among other things, to increase competency in addressing religion and spirituality in treatment. While there is no way
to prepare clinicians for every situation that they might experience in therapy, training programs can provide their students with skills for cultural humility, self-reflection, and meaningful assessment of client cultural context. Within this foundation, training programs can integrate opportunities to discuss specific areas of client identity and diversity, making sure to specifically mention, not only race, ethnicity, and sexuality, but also less-explored domains like socioeconomic status, religious or spiritual identity, and ability level.

Indeed, the current study suggests that even a single opportunity to explore the relevance of religion and spirituality can prompt meaningful reflection for clinicians and clinicians-in-training. Participants tended to report positive experience of the study interview, specifically stating that the interview had both caused them to reflect upon matters they did not often think about and had left them with food for thought beyond the allotted interview time. Thus, while it impossible to fully plumb the depths of every important topic that might arise in a clinical context, it seems only fair to both clinicians-in-training and their future clients to make space early in training for potentially important aspects of client identity, such as religion and spirituality. Indeed, participants in a study conducted by Woodhouse and Hogan (2019) indicated that their awareness of religious and spiritual issues in treatment increased as a result of receiving training in this area.

In addition to preparing their students to address religion and spirituality in clinical settings, the current study suggests that training programs could be doing a better job of providing their students with opportunities to express, reflect upon, and embrace their own religious or spiritual identities. Indeed, therapist self-awareness is just as important with religious and spiritual issues as it is with other areas of cultural diversity (McMinn et al., 2012). Despite this, of the participants in the current study who described their experiences as religiously or
spiritually identified individuals in graduate school, none reported overwhelmingly positive experiences. Instead, experiences tended to range from negative to neutral to mixed. Some participants described finding it difficult to balance between their therapist and religious identities and values. Other participants described hearing overtly negative perspectives on religion and spirituality expressed by training program faculty members.

As training programs work to follow current trends in multicultural psychology, increasing their focus on issues of diversity and identity, it is recommended that they reflect upon and address attitudes they and their faculty members may hold about religious or spiritual subgroups. This is especially important in light of the finding that trainee perception of trainer judgement can inhibit the trainee’s exploration within a training context (Woodhouse & Hogan, 2019). Moreover, it is recommended that training programs at least occasionally create spaces in which students can take a meaningful look at and discuss aspects of their own identities that are salient to them, including religious and spiritual identities. In the words of McMinn et al. (2012), “[I]t is imperative that therapists explore their own religious and spiritual beliefs, and potential biases and limitations, when it comes to working across faith traditions” (p. 266).

**Model for Clinical Supervisors**

Experiences with individual supervisors seemed to slant more positive than reported experiences in training programs, with 25% of participants reporting positive experiences of religion and spirituality in supervision. This aligns with findings from other studies that suggest that psychology trainees tend to described religion and spirituality as being addressed more often in supervision than in classroom or other didactic settings (Saunders et al., 2014; Schafer et al., 2009). However, 50% of participants in the current study still reported that religion and spirituality were hardly discussed in supervision. While 50% of the sample indicated that religion
and spirituality were discussed when relevant or even most of the time, it seems like there is room for supervisors to pay additional attention to client religion and spirituality. Indeed, several clinicians indicated that they ask about religion and spirituality during their intake process. In the same vein, it would seem helpful for supervisors to inquire about client religion and spirituality, at least at the start of supervision for a particular case. Moreover, depending on the supervisor’s style, it may be appropriate for a supervisor to disclose their own religious/spiritual identity at the start of a new supervisory relationship and to discuss its implications for and interactions with the religious/spiritual identity of the supervisee. Hagler (2020) describes a similar approach to addressing sexual identity in supervision, sharing that supervisor self-disclosure and openness to discussing cultural issues left him, as the supervisee, more comfortable to speak about his own identity. Following this approach, supervisors could model openness to issues of religion and spirituality from the start of supervision.

**Recommendations for Therapists**

Findings from the current study generated a number of recommendations for clinicians as they navigate issues of religion and spirituality in treatment:

1. Like therapists in other studies (e.g., Woodhouse & Hogan, 2019), therapists in the current sample tended to speak more about religion in sessions than about spirituality and to report having more biases about the latter than the former. Thus, it is recommended that clinicians maintain awareness of biases they hold against spirituality in order to catch those biases when they might prevent the clinician from exploring a potentially important area of a client’s life.

2. In keeping with the recommendations of Aron (2004), Rosmarin et al. (2015), and Sahker (2016) and in light of findings from the current study that therapists may not address
religion and spirituality with non-religious/spiritual clients, it is further recommended that therapists remain mindful of the possible importance of exploring religious or spiritual concepts even with clients who do not self-identify as spiritual or religious.

3. Given reports that people at times associate being politically conservative with being more religious and being politically liberal with being less religious (e.g., Cumming et al., 2014), it is recommended that therapists stay aware of assumptions they might have about a client’s religiosity/spirituality based on the client’s political leanings and vice versa.

4. Where the therapist lacks knowledge about a particular spiritual or religious tradition, it is recommended that the therapist provide the client with informed consent and, if the client does not wish to be referred elsewhere, obtain a better understanding of the tradition in question through dialogue with the client (e.g., McMinn et al., 2012).

5. For therapists who have adhered to a single religious or spiritual tradition throughout their lives, it is recommended that therapists pay attention to if/when they feel closed off to exploring an area of religion or spirituality with a client. It is important that clinicians are able to support client exploration in this area, even if the exploration will lead to perhaps uncomfortable reckoning for the therapist (e.g., Watts-Jones, 2010).

6. Finally, it is recommended that clinicians maintain awareness of when they feel tempted to adopt a role that is more pastoral than clinical (e.g., Gonsiorek, 2009).

Limitations

Self-Report

The interview-based format of the current study means that the data most likely revealed therapists’ own assessments of their abilities to navigate religion and spirituality in treatment.
While self-report is a useful way of gathering information and exploring individual experiences, it does introduce tremendous potential for bias. For example, therapists being interviewed may have been practicing impression management, trying to show the interviewer the best of their clinical abilities while downplaying areas of weakness or uncertainty. Furthermore, it is possible that therapists might not be aware of their weaknesses in this area, particularly if there have been moments in sessions that they have missed or unconsciously shied away from.

**Sample Size**

While the eight participants who participated generated a trove of valuable information, there is no way that eight clinicians can adequately represent the range of experiences across clinicians. Thus, the small sample size in the current study served as a limitation, minimizing the generalizability of the information gathered.

The small sample size also reduced the statistical power of the study, making it impossible to generate statistically significant correlational data.

**Lack of Representation**

The limited representative power of this sample is compounded by the limited demographic categories represented in the sample. Only psychologists were represented, not other mental health professionals. Of psychologists, only those with doctoral degrees were included in the sample. Racially and ethnically, only White and Black individuals participated in the study, with the vast majority of participants identifying as White. As mentioned previously, all participants were heterosexual; thus, there was no diversity of sexual orientation in the sample. Religiously and spiritually, only Agnostic, Jewish, and Christian identities were represented.
Most significantly, perhaps, all subjects were individuals who voluntarily responded to a recruitment flier asking for people to participate in an interview about working with religiously and spiritually diverse clients. Thus, it is likely that many participants had pre-existing interest in this topic, which may explain why many of the reported associations with religion and spirituality skewed neutral to positive. Moreover, clinicians who did not feel that they had either significant experience or sufficient skills for working with religiously or spiritually diverse clients likely would not have respond to the recruitment flier.

**Directions for Future Research**

To continue to meaningfully contribute to the research on religion and spirituality in mental health treatment, it would be important to repeat this study with a larger and more representative sample. Specifically, future research should seek participants who are as diverse in their gender identity, sexual orientation, religious/spiritual identity, and racial/ethnic identity as the general population of therapists. In addition, it would be interesting to conduct a study that asks both therapists and their clients about their experiences of religion and spirituality in treatment. This would provide a sort of check on the therapist self-reports and also incorporate another important perspective, that of the therapy client.

Given preliminary findings in this study in support of the relevance of therapist factors in addressing religion and spirituality in treatment, it is recommended that future research seek to further explore possible correlations between specific factors and therapists’ abilities to address religion and spirituality in treatment. Specifically, the therapist factors of gender, race, changes in religious/spiritual identity over time, and years in practice should be further explored.

Finally, it is suggested that the proposed models for training and supervision be implemented, researched, and refined. Indeed, while conducting this study, the author became
aware of an exciting initiative called The Spiritual and Religious Competencies Project. According to their website, they have a $5.1 million grant in support of the mission “to improve mental health care and promote human flourishing by ensuring every mental health professional possesses the basic competencies to attend to their clients’ religious faith or spirituality in clinical practice.” The Spiritual and Religious Competencies Project has subprojects aimed at improving graduate education, conducting research, increasing competency training for professionals, and understanding the current state of graduate training in religious and spiritual competencies. Though the work of multiculturalism is never done, it is encouraging to see that progress is being made (The Spiritual and Religious Competencies Project, 2022).
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### Table 1

**Questions Analyzed as Domains of Therapist Ability**

<table>
<thead>
<tr>
<th>Question Code</th>
<th>Question Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>QT3</td>
<td>When spirituality or religion come up in treatment, who usually brings it up—you or the client?</td>
</tr>
<tr>
<td>QT4</td>
<td>What is your reaction when a client brings up religiosity or spirituality in treatment?</td>
</tr>
<tr>
<td>QT5</td>
<td>What challenges, if any, have you experienced in working with spiritually/religiously identified clients?</td>
</tr>
<tr>
<td>QT6</td>
<td>What challenges, if any, have you experienced with addressing issues of spirituality/religion in treatment with clients?</td>
</tr>
<tr>
<td>QT7</td>
<td>Can you give an example of a time when you felt uncomfortable discussing religion/spirituality with a client?</td>
</tr>
<tr>
<td>QT8</td>
<td>Can you give an example of a time when you felt comfortable discussing religion/spirituality with a client?</td>
</tr>
<tr>
<td>QT12</td>
<td>How do you tend to conceptualize spiritual or religious issues that arise in treatment?</td>
</tr>
<tr>
<td>QT13</td>
<td>In your experience, has addressing this area of identity (r/s) with clients been different than addressing other areas of client diversity?</td>
</tr>
</tbody>
</table>
### Table 2

### Participant Demographics

<table>
<thead>
<tr>
<th>Demographic Category</th>
<th>N</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td><strong>Gender Identity</strong></td>
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<td></td>
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<tr>
<td>Male</td>
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<td>38</td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
<td>63</td>
</tr>
<tr>
<td><strong>Racial/Ethnic Identity</strong></td>
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<td></td>
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<tr>
<td>White/Caucasian</td>
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<td>75</td>
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<tr>
<td>Black/African American</td>
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<td>25</td>
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<tr>
<td><strong>Sexual Identity</strong></td>
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<td></td>
</tr>
<tr>
<td>Heterosexual</td>
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<td>100</td>
</tr>
<tr>
<td><strong>Religious/Spiritual Identity</strong></td>
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<td></td>
</tr>
<tr>
<td>Jewish</td>
<td>3</td>
<td>38</td>
</tr>
<tr>
<td>Agnostic</td>
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<td>25</td>
</tr>
<tr>
<td>Christian</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Latter-Day Saints/Mormon</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td><strong>Religious Background</strong></td>
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<td></td>
</tr>
<tr>
<td>Baptist Church</td>
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<td>25</td>
</tr>
<tr>
<td>Lutheran/Presbyterian</td>
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<td>13</td>
</tr>
<tr>
<td>Church of the Latter-Day Saints</td>
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<td>13</td>
</tr>
<tr>
<td>Chabad Chassidic</td>
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<td>13</td>
</tr>
<tr>
<td>Conservative Jewish</td>
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<td>13</td>
</tr>
<tr>
<td>Jewish</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Christian Holidays</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td><strong>Current Identification w/Religious Background</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Background Maintained</td>
<td>5</td>
<td>63</td>
</tr>
<tr>
<td>Changed from Background</td>
<td>3</td>
<td>38</td>
</tr>
<tr>
<td><strong>Years in Practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10+</td>
<td>4</td>
<td>50</td>
</tr>
<tr>
<td>6-8</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>2-6</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td><strong>Primary Practice Setting</strong></td>
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<td></td>
</tr>
<tr>
<td>Private Practice</td>
<td>4</td>
<td>50</td>
</tr>
<tr>
<td>University Counseling Center</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>Veterans Association</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Community Clinic</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td><strong>Therapeutic Modality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrated/Eclectic Approaches</td>
<td>6</td>
<td>75</td>
</tr>
<tr>
<td>Acceptance and Commitment Therapy</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>Strength-Based Cognitive Behavioral Therapy</td>
<td>1</td>
<td>13</td>
</tr>
</tbody>
</table>
Table 3

*Global Themes from Grounded Theory Analysis*

<table>
<thead>
<tr>
<th>Global Themes</th>
<th>Number of Participants Who Mentioned Theme (%)</th>
<th>Number of Times Theme was Mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited Supervision and Training on Religion and Spirituality</td>
<td>8 (100%)</td>
<td>13</td>
</tr>
<tr>
<td>Religion and Spirituality as a Resource</td>
<td>7 (88%)</td>
<td>13</td>
</tr>
<tr>
<td>Attending to Maladaptive Religious and Spiritual Beliefs in Treatment</td>
<td>6 (75%)</td>
<td>8</td>
</tr>
<tr>
<td>Increased Comfort with Religion and Spirituality Over Time</td>
<td>7 (88%)</td>
<td>7</td>
</tr>
<tr>
<td>Following Client’s Lead with Areas of Identity</td>
<td>6 (75%)</td>
<td>6</td>
</tr>
<tr>
<td>Religion and Spirituality as a Shared Language</td>
<td>4 (50%)</td>
<td>5</td>
</tr>
<tr>
<td>Looking at Relevance of Religion and Spirituality for the Specific Client</td>
<td>3 (38%)</td>
<td>4</td>
</tr>
<tr>
<td>Overlap Between Religion/Spirituality and Relationships</td>
<td>3 (38%)</td>
<td>4</td>
</tr>
<tr>
<td>“I’m not the judge”</td>
<td>2 (25%)</td>
<td>2</td>
</tr>
</tbody>
</table>
Figures

Figure 1

*Reported Challenges Addressing Religion and Spirituality in Treatment*

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Frequency of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navigating Concerning Behaviors</td>
<td>1</td>
</tr>
<tr>
<td>Maintaining Boundaries</td>
<td>2</td>
</tr>
<tr>
<td>Unconventional Client Beliefs</td>
<td>3</td>
</tr>
<tr>
<td>Therapist Lack of Knowledge</td>
<td>4</td>
</tr>
<tr>
<td>Client Reactions to Therapist Religion/Spirituality</td>
<td>5</td>
</tr>
<tr>
<td>Client Guardedness and Resistance</td>
<td>6</td>
</tr>
<tr>
<td>Maintaining Therapist Role and Boundaries</td>
<td>7</td>
</tr>
<tr>
<td>Client Problematic Beliefs</td>
<td>8</td>
</tr>
</tbody>
</table>

Figure 2

*Reported Associations with the Words Religion and Spirituality*

<table>
<thead>
<tr>
<th>Association</th>
<th>Religion</th>
<th>Spirituality</th>
</tr>
</thead>
<tbody>
<tr>
<td>None Reported</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Negative</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Neutral</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Mixed</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Positive</td>
<td>2</td>
<td>0</td>
</tr>
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</table>
Appendix A: Consent for Demographic Survey

CONSENT TO TAKE PART IN A RESEARCH STUDY

TITLE OF STUDY: Addressing Client Identity Factors in Mental Health Treatment
Principal Investigator: Aliza Lasky, Psy.M.

This online consent form is part of an informed consent process for a research study and it will provide information that will help you decide whether you want to take part in the study. It is your choice to take part or not. Ask questions if there is anything in the form that is not clear to you. If you decide to take part, instructions at the end of document will tell you what to do next. Your alternative to taking part in the research is not to take part in it.

Who is conducting this research study and what is it about?
You are being asked to take part in research conducted by Aliza Lasky, Psy.M. who is a graduate student in the Graduate School of Applied and Professional Psychology at Rutgers University. The purpose of this study is to explore clinicians’ experience addressing client diversity in clinical treatment. We anticipate that 10-15 subjects will take part in the research.

What will I be asked to do if I take part?
You will be asked to complete a brief 5-10 minute online survey. If you decide to continue to participate in this study, you will also be asked to participate in an interview. Separate consent will be obtained for the interview process.

What are the risks and/or discomforts I might experience if I take part in the study?
Breach of confidentiality is a risk of harm but a data security plan is in place to minimize such a risk. Also, some questions may make you feel uncomfortable. If that happens, you can skip those questions or withdraw from the study altogether. If you decide to quit at any time before you have finished the survey your answers will NOT be recorded.

If you experience significant discomfort in response to this survey, please utilize the Crisis Text Line by texting CONNECT to 741741.

Are there any benefits to me if I choose to take part in this study?
There no direct benefits to you for taking part in this research. You will be contributing to knowledge about clinicians’ experience addressing client diversity in treatment.

Will I be paid to take part in this study?
You will not be paid to take part in this study. However, those who are chosen to participate in the next portion of this study will be entered into a raffle to win one of two $50 Amazon gift cards.

How will information about me be kept private or confidential?
All efforts will be made to keep your responses confidential, but total confidentiality cannot be guaranteed.

- We will use Qualtrics to collect and forward your responses to us. We will not know your IP address when you respond to the online research. We will ask you to include demographic information when you complete the survey. However, instead of your name, you will be asked to enter the ID code provided to you by the researcher. In this way, no identifiable information will be stored with your responses.
- The key code linking your ID code to your name will be securely stored in a separate password protected file which will be destroyed after data analysis is complete and study findings are professionally presented or published.

No information that can identify you will appear in any professional presentation or publication.
What will happen to information I provide in the research after the study is over?
• After information that could identify you has been removed, de-identified responses may be used by or
distributed to investigators for other research without obtaining additional informed consent from you.

What will happen if I do not want to take part or decide later not to stay in the study?
Your participation is voluntary. If you choose to take part now, you may change your mind and withdraw later. In
addition, you can choose to skip questions that you do not wish to answer. If you do not click on the ‘submit’ button
after completing the form, your responses will not be recorded. However, once you click the ‘submit’ button at the
end of the form, your responses cannot be withdrawn as we will not know which ones yours are. You may also
withdraw your consent for use of data you submit, but you must do this in writing to the PI, Aliza Lasky, Psy.M.

Who can I call if I have questions?
If you have questions about taking part in this study, you can contact the Principal Investigator:
Aliza Lasky, Psy.M.
The Graduate School of Applied and Professional Psychology
Rutgers University
Email: aliza.lasky@rutgers.edu

You can also contact my faculty advisor Nicole Cain, PhD at nicole.cain@rutgers.edu

If you have questions about your rights as a research subject, you can contact the IRB Director at:
Arts and Sciences IRB (732) 235-2866 or the Rutgers Human Subjects Protection Program at (973) 972-1149 or
email us at humansubjects@ored.rutgers.edu.

Please print out this consent form if you would like a copy of it for your files.

If you do not wish to take part in the research, close this website address. If you wish take part in the research, follow
the directions below:

By beginning this research, I acknowledge that I am 18 years of age or older and have read and understand the
information. I agree to take part in the research, with the knowledge that I am free to withdraw my participation in the
research without penalty.

Click on the "I Agree" button to confirm your agreement to take part in the research.

I Agree  I Do Not Agree
Appendix B: Consent for Interview and Audio/Video Recording

TITLE OF STUDY: Addressing Client Identity Factors in Mental Health Treatment
Principal Investigator: Aliza Lasky, Psy.M.

This consent form is part of an informed consent process for a research study and it will provide information that will help you decide whether you want to take part in this study. It is your choice to take part or not. After all of your questions have been answered and you wish to take part in the research study, you will be asked to sign this consent form. You will be given a copy of the signed form to keep. Your alternative to taking part in the research is not to take part in it.

Who is conducting this research study and what is it about?
You are being asked to take part in research being conducted by Aliza Lasky, Psy.M. who is a graduate student in the Graduate School of Applied and Professional Psychology. The purpose of this study is to explore clinicians’ experience addressing client diversity in clinical treatment.

What will I be asked to do if I take part?
The interview will take about 90 minutes to complete. The interview will consist of open-ended questions related to your training background, cultural identity, and experiences addressing client identity factors in treatment. We anticipate that about 15 subjects will take part in the study. All interviews will be video recorded.

What are the risks and/or discomforts I might experience if I take part in the study?
As is the case in studies of this nature, breach of confidentiality is a possible risk. However, a data security plan is in place to minimize such a risk. Also, some of the interview questions may lead you to feel uncomfortable. If that happens, you can skip those questions or withdraw from the study altogether. If you decide to quit the interview your responses will NOT be saved.

Are there any benefits to me if I choose to take part in this study?
There are no direct benefits to you for taking part in this research. You will, however, be contributing to knowledge about religion and spirituality as areas of client diversity.

Will I be paid to take part in this study?
Everyone who participates in this study will be entered into a raffle to win one of two $50 Amazon gift cards. Winners will receive their gift cards via email within two weeks of the completion of the last interview for this study.

How will information about me be kept private or confidential?
All efforts will be made to keep your responses confidential, but total confidentiality cannot be guaranteed.

- We will ask you to provide your name and email address for the purpose of this consent form and the Amazon gift card raffle. This identifiable information will not be stored together with your interview responses. Instead, your responses will be assigned a subject # which will be stored separately from your identifiable information so others will not know which responses are yours. We will securely store the key code linking your responses to your identifiable information in a separate password-protected file which will be destroyed after data analysis is complete and study findings are professionally presented or published. No information that can identify you will appear in any professional presentation or publication.

What will happen to information I provide in the research after the study is over?

- After information that could identify you has been removed, de-identified responses may be used by or distributed to investigators for other research without obtaining additional informed consent from you.

What will happen if I do not want to take part or decide later not to stay in the study?
Your participation is voluntary. If you choose to take part now, you may change your mind and withdraw later. In addition, you can choose to skip interview questions that you are not comfortable answering or stop the interview at any time. You may also withdraw your consent for use of responses you provided during the interview, but you must do this in writing to the PI, Aliza Lasky, Psy.M.

Who can I call if I have questions?
If you have questions about taking part in this study, you can contact the Principal Investigator:
Aliza Lasky, Psy.M.
The Graduate School of Applied and Professional Psychology
Rutgers University
Email: aliza.lasky@rutgers.edu

You can also contact my faculty advisor Nicole Cain, PhD at Nicole.cain@rutgers.edu

If you have questions about your rights as a research subject, you can contact the IRB Director at:
Arts and Sciences IRB (732) 235-2866 or the Rutgers Human Subjects Protection Program at (973) 972-1149 or email us at humansubjects@ored.rutgers.edu.

Please keep this consent form if you would like a copy of it for your files.

AGREEMENT TO PARTICIPATE

1. Subject consent:
I have read this entire consent form, or it has been read to me, and I believe that I understand what has been discussed. All of my questions about this form and this study have been answered. I agree to take part in this study.

Subject Name (printed): __________________________

Subject Signature: __________________________ Date: __________

2. Signature of Investigator/Individual Obtaining Consent:
To the best of my ability, I have explained and discussed all the important details about the study including all of the information contained in this consent form.

Investigator/Person Obtaining Consent (printed): __________________________

Signature: __________________________ Date: __________
You have already agreed to take part in a research study entitled: Addressing Client Identity Factors in Mental Health Treatment conducted by Aliza Lasky, Psy.M.. We are asking your consent to allow us to video record you as part of the research. Video recording is required for all those who choose to take part in this research study.

The recordings will be used for analysis and transcription by the research staff.

The recordings may include the following information that can identify you. You will likely be visually identifiable in the video recording. However, the videos will not be stored with your name, and no one other than the research staff will have access to the videos.

The recordings will be stored in a secure cloud location using a subject ID # that contains no identifiable information and will be retained in this secure cloud location indefinitely.

The recordings may be used by this research team for other research without obtaining additional informed consent from you. However, the recordings will not be shared with anyone outside of the research team.

Your signature on this form permits the investigator named above to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written consent.

**AGREEMENT TO BE RECORDED**

Subject Name (Print):______________________________________________________________

Subject Signature ________________________________   Date ______________________

Investigator/Person Obtaining Consent Name (Printed):___________________________________

Signature ________________________________________ Date _______________________
Appendix C: Demographic Questionnaire

1) Do you have a PsyD or PhD?
   a. Yes
   b. No
      i. “I’m sorry. You are not eligible for participation in this study. Thank you for your time.”

2) What year did you receive your PsyD/PhD? ______________

3) Are you currently engaged in clinical work?
   a. Yes
   b. No
      i. Why not?
         1. Family leave
         2. COVID
         3. Other temporary leave from clinical work
         4. Other
            a. “I’m sorry. You are not eligible for participation in this study. Thank you for your time.”

4) Do you primarily work with children?
   a. Yes
      i. “I’m sorry. You are not eligible for participation in this study. Thank you for your time.”
   b. No

5) How many years have you been in clinical practice for?
   a. 0-2 years
   b. 2-4 years
   c. 4-6 years
   d. 6-8 years
   e. 8-10 year
   f. 10+ years

6) Which of these therapeutic modalities best describes your clinical work? (check all that apply)
   a. Cognitive and/or behavioral approach
   b. Psychodynamic or psychoanalytic approach
   c. Systems-based approach
   d. Other: ______________

7) How would you describe your therapeutic modality in treatment? ______________

8) Which of these most closely matches your gender identity?
   a. Female
   b. Male
   c. Non-binary
   d. Prefer not to say
   e. Other: ______________

9) Which of these most closely matches your sexual identity?
   a. Asexual
b. Bisexual
c. Heterosexual
d. Homosexual
e. Prefer not to say
f. Other: __________

10) Which of these most closely matches your race and/or ethnic identity?
   a. Asian/Pacific Islander
   b. Black or African American
   c. Hispanic or Latino
   d. Native American or American Indian
   e. White
   f. Prefer not to say
   g. Other: __________

11) Which of these most closely matches your spiritual or religious identity? (check all that apply)
   a. Religious
      i. Which religious tradition, if any, do you most closely identify with?
         ___________________________
   b. Spiritual
      i. Which spiritual tradition, if any, do you most closely identify with?
         ___________________________
      ii. ___________________________
   c. Agnostic
   d. Atheistic
   e. Prefer not to say
   f. Other: ______________________

Thank you for filling out this survey! If you are eligible to participate, you will be contacted by the principal investigator for this study.

12) Your name: __________________
13) Email address: ____________________
14) If you prefer to be contacted using a method other than email, please provided alternative contact information: __________________________

I understand that by submitting this survey, I give the researchers permission to contact me regarding my eligibility for the study. I further understand that I can withdraw from the study at any time.
Yes ___  No____
Appendix D: Interview Protocol

Therapist Demographics
1. What additional training have you received since completing your formal clinical training?
2. Have you received any sort of diversity training?
   a. Can you tell me more about that?
3. How would you describe the sort of therapy you practice? Do you identify with a particular theoretical orientation?
4. What sort of a setting do you practice in?
5. Can you briefly list the parts of your identity that are salient to you? (If prompt is needed: Some people include things like gender, race, ethnicity, profession into this category.)

Therapist Attitudes Toward Religion/Spirituality
1. What comes to mind for you when you hear the word religion? (From Maichuk, 2011-How would you define religion?)
   a. If needed, prompting for: Do you have any negative/positive associations with the word religion?
2. What comes to mind for you when you hear the word spirituality? (From Maichuk, 2011-How would you define spirituality?)
   a. If needed, prompting for: Do you have any negative/positive associations with the word spirituality?
3. (Questions adapted from Maichuk (2011) dissertation)
   a. Can you tell me about your own spiritual/religious background?
      i. (If not addressed in the initial answer: )
         1. Can you tell me about if or how your relationship with spirituality or religion has changed over time?
         2. How much do you currently identify with your spiritual/religious background?
         3. How would you describe your current relationship with religion/spirituality?
4. If relevant: What has your experience been being a spiritual/religious person in the world of psychology? (e.g., training programs, conferences, clients, supervisions)
5. How has your identity as a psychologist influenced your thinking about religion/spirituality?
   a. Have you experience overlap between your ideas about religion and your ideas about psychology? Tensions between the two?

Treatment with Clients
1. Have you had any training in addressing issues of spirituality or religion with clients?
   a. Can you tell me more about that?
2. Approximately what percentage of your caseload is made up of clients who identify as spiritual or religious?
a. For those clients who are spiritually or religiously identified, how would you describe their spiritual/religious identity?

3. When spirituality or religion come up in treatment, who usually brings it up—you or the client?
   a. (Adapted from Stewart, 2019 dissertation:) Is this similar to how you approach other areas of diversity and client identity? What is similar? What is different?

4. What is your reaction when a client brings up religiosity or spirituality in treatment?
   a. (Adapted from Stewart, 2019 dissertation:) Is this a typical reaction for you when a client brings up an area of their identity? What is similar or different?

5. What challenges, if any, have you experienced in working with spiritually/religiously identified clients?

6. What challenges, if any, have you experienced with addressing issues of spirituality/religion in treatment with clients?

7. Can you give an example of a time when you felt uncomfortable discussing religion/spirituality with a client?

8. Can you give an example of a time when you felt comfortable discussing religion/spirituality with a client?

9. Can you tell me about a time when you worked with a client whose spiritual or religious background was similar to your own?

10. Can you tell me about a time when you worked with a client whose spiritual or religious background was different from your own?

11. Could you describe to me if and how the way you address spirituality/religion in treatment has changed over time?

12. How do you tend to conceptualize spiritual or religious issues that arise in treatment?
   a. How have you developed this conceptualization? (e.g., supervisors, theoretical home base, personal experience)

13. In your experience, has addressing this area of identity (r/s) with clients been different than addressing other areas of client diversity?
   a. Why do you think that’s the case?

14. All therapists have clients who are easier and harder for them to work with. With regard to religion and spirituality, who have these clients been for you?

Religion and Spirituality in Supervision

1. Can you tell me what your experience has been of religion/spirituality in supervision when you were receiving your training?
   a. Have your supervisors asked about your clients’ religious/spiritual identities?
   b. How have religiosity/spirituality been treated when they’ve come up in supervision?

2. How did this influence your willingness to discuss or not discuss religion/spirituality in supervision?
Concluding Questions (adapted from Stewart, 2019 dissertation)
1. Is there anything that we haven’t spoken about that you would like to share with me?
2. What has it been like for you to take part in this interview?