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Advancing the Integration of Religion and Spirituality in Mental Health Care:

Measurement and Current Implementation

By

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DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of
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"Everyone has been made for some particular work,

and the desire for that work has been put in every heart."

Jalal al-Din Muhammad Rumi

Dedication

This dissertation was created with three groups of individuals in mind. First, I dedicate this dissertation to my beautiful daughter, Callie, and her generation. You have such an incredible journey ahead of you, fellow travelers. May your generation stand on the shoulders of those before you, leaving it better for your children. Second, this dissertation goes to every social work practitioner who ever had an instructor unsure of what to say when religion and spirituality came up in class, except "we don't talk about *that* in social work." Forgive them and empower yourself to learn how to ethically and effectively discuss clients' religion and spirituality in practice. Finally, this work is for every client who has bravely told a helping professional his or her religious or spiritual beliefs are an important aspect in their personal healing process, but was quickly met with uncertainty, discomfort, or "we don't talk about *that* in here." My hope is that one day, helping professionals will be well equipped to ethically and effectively discuss this area of your lives – thank you for being patient.

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"To change the world, start with one step. However small, the first step is hardest of all."
David J. Matthews

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Advancing the Integration of Religion and Spirituality in Mental Health Care: Measurement and Current Implementation

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Supervisor: Danielle E. Parrish

Abstract

Research on religion, spirituality, and health indicates that assessing and discussing clients' religion and spirituality (R/S) in practice can improve client outcomes, and that clients prefer such integration. However, few social workers have received this specialized training. This dissertation is the first study to holistically understand social workers' orientation toward religious/spiritually integrated evidence-based practice, including their attitudes, behaviors, perceived feasibility, and self-efficacy. Consisting of three manuscripts, this dissertation includes: 1) a literature review on social work practitioners' integration of R/S; 2) the results from the validation of the Religious/Spiritually Integrated Practice Assessment Scale; and 3) a description of the views and behaviors concerning the integration of clients' R/S among a national sample of LCSWs. Findings highlight a need to expand training for social workers and allied fields on the use of ethical and effective integration of clients' R/S into treatment. Implications for social work education, practice, and research are provided.

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Chapter One: Introduction

Problem Statement

A growing body of evidence on spirituality, religion, and health suggests that religious or spiritual practices contribute to resilience and positive outcomes across a wide range of health and mental health issues (Koenig, King, & Carson, 2012; Koenig, McCullough, & Larson, 2001), yet not all social work practitioners have been educated on this sensitive topic and its application in practice (Canda & Furman, 2010). Religion and spirituality have recently emerged as important additions to the biopsychosocial model in health/mental health treatment (Canda & Furman, 1999, 2010; Koenig, 2005), resulting in the endorsement of a biopsychosocial*spiritual* approach (Canda, & Furman, 1999, 2010). Recent studies have revealed that clients would prefer their health/mental health care provider initiate the discussion of the clients' religious/spiritual beliefs, expressing that such integration supports their health/mental health healing process (Koenig, 2005; Leitz & Hodge, 2013; Rose, Westefeld, & Ansley, 2001; Stanley, et al., 2011; Tepper, Rogers, Coleman, & Maloney, 2001; Weld & Erickson, 2007). Consequently, interventions that integrate this clinical practice component are now being developed for treating anxiety, depression, and addiction (Hodge, 2006; Rosmarin, Pargament, Pirutinsky, & Mahoney, 2010; Smith, Bertz, & Richards, 2007; Armento, Zeno, Barber, Phillips, Oxhandler, Barrera, & Stanley, unpublished).

Social work is currently the largest clinical training profession in the United States, accounting for roughly 45 percent of clinically trained mental health personnel (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010). Social workers offer a unique contribution to mental health services with their strengths-based approach to problems, empowerment model, respect for self-determination, holistic perspective, and sensitivity to

disparate cultures (Saleeby, 2009), all of which requires them to be mindful of clients' biopsychosocialspiritual background.

Historically, social work's accreditation body, the Council on Social Work Education (CSWE), has not consistently required education on religion/spirituality in its Educational Policy Accreditation Standards (EPAS) (Canda & Furman, 2010; Council on Social Work Education [CSWE], 1995, 2008; Marshall, 1991; Russel, 1998, 2006). While three EPAS policies now mention religion/spirituality, only about 40 percent of programs offer a course on this subject (Canda, 2005). With about 60 percent of programs lacking this content, it is clear that the majority of social work students are not receiving adequate instruction on spirituality/religion prior to graduation. In fact, some argue that social work students' exposure to the subject is limited to experiencing religious discrimination in the classroom (Thyer & Myers, 2009). Between the lack of formal training social workers receive (Canda & Furman, 2010; CSWE, 1995, 2008; Marshall, 1991; Russel, 1998, 2006) and the negative messages students have reported receiving in their program on this topic (Thyer & Myers, 2009), the profession is left to wonder what social work practitioners' orientation towards religion and spirituality is, and how these topics are discussed and implemented in practice with clients.

This lack of consistency in training on spiritually sensitive practice suggests a gap in our understanding of current practitioners' self-efficacy, attitudes, perceived feasibility, and behaviors pertaining to the integration of clients' religion/spirituality in practice. To date, few surveys have assessed social work practitioners' attitudes or behaviors in this area, primarily using the Role of Religion and Spirituality in Practice scale (Sheridan, Bullis, Adcock, Berlin, & Miller, 1992) and the Spiritually-Derived Intervention Checklist (Canda & Furman, 1999, 2010). However there is not yet a standardized instrument that measures the above four constructs,

which could be interpreted as practitioners' overall orientation (Parrish & Rubin, 2011b) toward integrating clients' religion/spirituality in practice. This knowledge is critical for social work educators and practitioners to consider as interventions move toward a biopsychosocialspiritual approach and clients express a desire for therapists to bring up the topic in treatment.

Significance of the Problem

Each year, over 26 percent of adults living in the United States receive a diagnosis of mental illness, with 45 percent of those having a dual diagnosis (World Health Organization, 2008). In 2002, serious mental illness was estimated to be prevalent in about 6 percent of the population (1 in every 17 individuals), reportedly costing around 318 billion in 2008 (Insel, 2008), and roughly 2.5 trillion dollars in 2010 in direct and indirect cost (Insel, 2011). Social work is the largest clinically trained profession in the United States (SAMHSA, 2010), and offers a unique contribution to mental health services with its strengths-based approach to problems, empowerment model, respect for self-determination, sensitivity to disparate cultures and backgrounds, and holistic perspective when working with clients (Saleeby, 2009). However, there is a lack of training on the integration of clients' religious/spiritual beliefs into practice in our profession (Canda & Furman, 1999, 2010; Russel, 1998).

Today, over 80 percent of Americans identify with a faith tradition (U.S. Census Bureau, 2010), with 82 percent of adults having reported religion being at least somewhat important to them (PEW Forum on Religion & Public Life, 2008). Consequently, many who seek mental health services may utilize religious coping skills (Pargament, 1997, 2007; Pargament, Kennell, Hathaway, Grevengoed, Newman, & Jones, 1988), causing clients' religious/spiritual beliefs and coping strategies to become a topic that clients may want to talk about with their mental health practitioner. However, often times, clients are unsure of whether or not this topic is acceptable to

discuss in a therapeutic setting (Kahle & Robbins, 2004; Stanley, et al., 2011). In addition, the emerging research suggests that integrating clients' religious/spiritual beliefs into practice may actually *improve* treatment outcomes (Koenig, et al., 2012; Koenig, et al., 2001). A critical issue arises, however, when clients report a preference for their mental health practitioner to initiate the discussion or integrate religion/spirituality in treatment (Koenig, 2005; Leitz & Hodge, 2013; Rose, Westefeld, & Ansley, 2001; Stanley, et al., 2011; Tepper, Rogers, Coleman, & Maloney, 2001; Weld & Erickson, 2007), but the majority (65 percent) of social workers have not received any content addressing religion/spirituality within the practice context during their social work program (Canda & Furman, 2010). While some research has described practitioner views and implementation of specific religious or spiritual techniques (e.g., prayer, meditation) (Canda & Furman, 1999, 2010; Sheridan, 2004; Sheridan, et. al, 1992), there remains a dearth of research concerning social work practitioners' self-efficacy and their perceived feasibility regarding the integration of religion/spirituality in practice. Similarly, practitioners' more global views of integrating spirituality/religion beyond specific techniques, or whether they are currently utilizing extant evidence-based interventions that focus on such integration, has not yet been studied. Consequently, it is critical to understand practitioners' overall orientation to integrating clients' religion/spirituality into treatment beyond specific religious or spiritual techniques or practices to inform future training and dissemination efforts.

Prior to this dissertation, there has not been an instrument to assess the multiple factors that might bear on social workers' acceptance or orientation toward the integration of spirituality/religion in practice, with all levels of validity established. Only three survey instruments have been developed within social work to assess behaviors and attitudes among social work practitioners: the Role of Religion and Spirituality in Practice (RRSP) scale

(Sheridan, et. al, 1992), the Spiritually-Derived Intervention Checklist (SDIC) (Canda & Furman, 1999, 2010), and the Religion and Prayer in Practice Scale (RPPS) (Mattison, Jayaratne, & Croxton, 2000). The Spiritually-Derived Intervention Checklist has primarily been used for descriptive purposes of whether a social worker engages in a particular activity that involves religion/spirituality in practice and whether he/she feels that activity is an appropriate helping activity (Canda & Furman, 1999, 2010). The Role of Religion and Spirituality in Practice Scale (RRSP) (Sheridan, et al., 1992) on the other hand, is the only scale in social work that measures the subject of religion/spirituality in practice among behavioral health providers. The RRSP is unidimensional, and therefore limited to measuring practitioner attitudes regarding the role of religion and spirituality in practice, and has not demonstrated criterion or factorial validity. One aspect of this dissertation proposes to develop a scale, modeled after the Evidence-Based Practice Process Assessment Scale – Short Version (EBPPAS-S), which measures multiple constructs bearing on the overall orientation toward the acceptance of novel practice approaches (Parrish & Rubin, 2011b). In this case, the novel practice approach includes the integration of religion/spirituality into mental health treatment, including attitudes, perceived feasibility, self-efficacy, and behaviors (Parrish & Rubin, 2011b). This dissertation was expected to result in a novel, reliable, and valid instrument that will also be used to describe social workers' views, perceived feasibility, self-efficacy and implementation of spirituality/religion in practice.

A second part of this dissertation describes the prevalence of factors that are expected to play an important role in practitioners' decisions to integrate religion/spirituality as a part of their practice (e.g. feasibility, self-efficacy). Prior studies have shown that these are important variables (that have not yet been addressed in the literature) when assessing new or controversial practice components, such as evidence-based practice (Parrish & Rubin, 2011a, 2011b).

Additionally, Bandura (1977) explains that behaviors are influenced by one's self-efficacy, particularly by avoiding situations that are beyond their capabilities, which seems relevant to this practice behavior with few social workers having been trained on this topic. The information obtained from this dissertation can then be used to inform the development and evaluation of religion/spirituality in practice BSW and MSW curriculum, as well as continuing education efforts. If research continues to emerge demonstrating positive health and mental health outcomes for clients whose religion/spirituality is assessed for and discussed in treatment (Koenig, et al., 2012; Koenig, et al., 2001) it is critical to provide this training to social workers, the largest profession of clinically trained mental health care providers (SAMHSA, 2010), so that clients may have the best possible outcomes.

Literature Review

Religion and Spirituality in Mental Health Care

A recent report from the American Religious Identification Survey (ARIS), stated that while 70 percent of Americans believe in a personal God, 12 percent believe in a higher power (but not a personal God), and 12 percent either did not identify a religion or were atheist or agnostic (Kosmin & Keysar, 2008). Likewise, 82 percent of adults say that religion is at least somewhat important to them (with 56 percent saying it is very important and 26 percent saying it's somewhat important), 83 percent of adults have reported being affiliated with a religious tradition. Of those who were not affiliated, 41 percent still mentioned that religion is at least somewhat important in their lives (PEW Forum on Religion & Public Life, 2008).

Although a difference has been identified between religion and spirituality, the two may be conceptualized as sharing a continuum with interchangeable concepts that an individual may relate to within his/her environment. In fact, Hill and colleagues developed a set of criteria for

these two definitions, with both terms involving "feelings, thoughts, experiences, and behaviors that arise from the search for the sacred" (Hill, et al., 2000, p. 66).

Within social work's literature, spirituality has been defined as "…a universal and fundamental human quality involving the search for a sense of meaning, purpose, morality, well-being, and profundity in relationships with ourselves, others and ultimate reality, however understood… It connotes a process and way of being" (Canda & Furman, 2010, p. 59). Religion, on the other hand, is considered an institutionalized, systemic pattern of values, beliefs, symbols, behaviors, and experiences shared by a community (Canda & Furman, 2010), that relies on a set of scriptures and teachings, and has a moral code of conduct (Koenig, 2008).

There is an emerging body of literature in the field of mental health that suggests clients' religion and/or spirituality may easily be integrated into mental health treatment through individual psychotherapy, motivational interviewing, cognitive behavioral therapy, and addiction recovery interventions (Allen, Fonagy, & Bateman, 2008; Hodge, 2006; Kelly, Stout, Magill, Tonigan, & Pagano, 2011; Rosmarin, et al., 2010; Stanley, et al., 2011; Wachholtz & Pargament, 2008). Additionally, a recent meta analysis of 31 studies on spiritually-oriented psychotherapies found an overall moderately high effect size (.56) across a variety of clinical issues, such as depression, anxiety, and stress (Smith, Bartz, & Richards, 2007). Studies are also emerging that show clients would, in fact, *prefer* that their religious or spiritual beliefs be discussed in treatment to help make meaning of their illness or life situation (Koenig, George, & Peterson, 1998; Stanley, et al., 2011; Tepper, et al., 2001). Common topics related to religion and spirituality that practitioners may discuss with their mental health clients include forgiveness, gratitude, finding meaning in a negative life circumstance, asking questions about ultimate reality, mindfulness/being present in the moment, hope, love, religious/spiritual struggles,

religious/spiritual coping methods (both positive and negative), connection, and/or spiritual transformation (Hodge, 2006; Kabat-Zinn, 2003; Kahle & Robbins, 2004; Koenig, 2005; McCullough, 2000; Pargament, 1997, 2007; Pargament, et al., 1988; Puchalski & Romer, 2000). Additionally, clients' R/S may greatly impact health care decisions, further making it important to consider clients' R/S in treatment planning (Ehman, Ott, Short, Ciampa, & Hansen-Flaschen, 1999; Silvestri, Knitting, Zoller, & Nietert, 2003). Interestingly, not only are clients expressing their openness in discussing these topics in mental health treatment, but one study that examined older adults' preference to integrating their religion/spirituality into treatment found that 58 percent (N=66) stated they would prefer that the *therapist* be the one to initiate the discussion (Stanley, et al., 2011).

With such a large number of adults having been diagnosed with a mental illness, these individuals as well as their family and friends may utilize various coping skills to handle or overcome episodes related to the illness, or even every day, stressful life situations. Lazarus has written extensively on the topic of coping as a process that "changes over time and in accordance with the situational contexts in which it occurs" (Lazarus, 1993, p. 235). Pargament has also written on the subject, stating, "situation-specific coping activities serve as a bridge or as mediators between the orienting systems [a general guide or frame of reference that serves as an anchor through unsettling periods] and the outcomes of negative situations" (1997, p. 283). He further extends the idea of coping theory, identifying Religious Coping Theory as a specific mechanism in which individuals use their religion in the midst of crisis with religious coping methods, which, in turn, impacts the outcomes of their negative life events (Pargament, 1997). The diagram below (Figure 1) shows how religious coping methods serve as mediators of the

relationship between one's religious orientation and the outcomes of his/her negative life events (Pargament, 1997, p. 284).

Figure 1: Religious Coping Theory

An examination of the literature on the relationship between religion and health clearly supports Pargament's theory, as a growing body of evidence is finding religious or spiritual practices contribute to resilience and positive outcomes across a wide range of health and mental health issues (Koenig, et al., 2012; Koenig, et al., 2001). Knowing that religion and spirituality may improve client outcomes, it is imperative that this topic be considered when mental health practitioners are working with such individuals and their loved ones.

Mental Health and Social Work: Training & Integration of Religion/Spirituality into Practice

Social work is currently the largest clinically trained profession in the United States, accounting for roughly 45 percent of clinically trained mental health personnel (SAMHSA, 2010). The profession of social work offers a unique contribution to mental health services with its strengths-based approach to problems, empowerment model, respect for self-determination, sensitivity to disparate cultures and backgrounds, and holistic perspective when working with clients (Saleeby, 2009), all of which requires the social worker to be mindful of and work within clients' biopsychosocialspiritual background.

Social Work Education

Historically, social work's accreditation body, the Council on Social Work Education (CSWE), has not consistently required education on religion/spirituality in its Educational Policy Accreditation Standards (EPAS) (Canda & Furman, 1999, 2010; Council on Social Work

Education, 1995, 2008; Marshall, 1991; Russel, 1998, 2006). Currently, there are four EPAS policies that mention religion/spirituality, including Educational Policy 2.1.2 (advising recognition and management of personal values while applying ethical principles to guide practice), 2.1.4 (with religion mentioned under "Engage in diversity and different practice"), 2.1.7 (with spiritual development mentioned under "Apply knowledge of human behavior and the social environment"), and 3.1 (with religion mentioned under "Diversity") (CSWE, 2008). However, many social work programs do not offer a course on this subject, but rather, may integrate the material into a basic Human Behavior in the Social Environment (HBSE) course. Some have argued that this is not an adequate amount of training in the subject and that students would need additional training beyond what is included within a HBSE course (Canda & Furman, 2010; Hodge & Derezotes, 2008). Recent trends are encouraging, yet not sufficient for addressing this important health related variable. Specifically, between 1998 and 2005, the presence of a course on religion/spirituality among accredited MSW programs went from 17 of 114 (15 percent) (Russel, 1998) to 75 of 190 (39.5 percent) (Canda, 2005). Additionally, a Religion and Spirituality Clearinghouse was developed in 2011 in an effort for social work educators to share materials, syllabi, teaching strategies, and other resources with one another to assist in discussing this subject in a current course or create a new course specifically on spiritually-sensitive social work practice (Sherr, Land, Canda, Husain, & Sheridan, 2011). However, with the most recent estimate suggesting that 60 percent of programs are lacking a course in this area, it is clear that the majority of masters-level social work students are not receiving sufficient instruction on spirituality/religion prior to graduating.

Not only is there a dearth in the material covered in the classroom on religion and spirituality, Thyer and Myers (2009) have pointed out that some students' exposure to the subject

in the social work curriculum is limited to students experiencing religious discrimination. Between the demonstrated lack of education that social workers are receiving in the classroom and the mixed or negative messages students have reported receiving from faculty or their program, the profession is left to wonder what current social work practitioners' orientation toward this topic are and how it is it being discussed in clinical practice with clients.

Social Work Practitioners

For practicing social workers in the United States, the National Association of Social Workers (NASW) is the largest organization of social work professionals, with about 145,000 members (National Association of Social Work [NASW], 2011). This organization "works to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies" (National Association of Social Work [NASW], 2008) and has its own Code of Ethics "to serve as a guide to the everyday professional conduct of social workers" (NASW, 2008). Under this Code of Ethics, religion is mentioned in the purpose statement and under five codes (1.05: Cultural Competence and Social Diversity; 1.06: Conflicts of Interest; 2.01: Respect amongst colleagues; 4.02: Discrimination; and 6.04: Preventing domination of, exploitation of, and discrimination against certain demographics) (NASW, 2008) and twice under the Standards for Cultural Competence (NASW, 2001). While spirituality is not mentioned within the Code of Ethics (NASW, 2008), it can be found once in NASW's Standards for Cultural Competence (NASW, 2001) and twice (related to practice) in NASW's Peace Policy Toolkit (NASW, 2007). *Hence, while it may not have always been taught in accredited social work programs, there are current standing expectations for social workers to be competent and able to discuss clients' religion and spirituality as they relate to practice.*

Social workers are also bound by these Codes of Ethics to utilize best practices when working with clients (NASW, 2008). In the field of medicine, Sackett and colleagues have written extensively about this topic and have defined evidence-based practice (EBP) as the "conscientious, explicit and judicious use of current best evidence in making decisions about the care of individuals [clients]" (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71) and "the integration of best research evidence with clinical expertise and [client] values" (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000, p. 1). This evidence-based practice (EBP) model for decision-making is the most widely discussed method for carrying out several of the mandates in social work's Code of Ethics, including relying on research to make practice decisions, evaluating practice, obtaining proper informed consent, self-determination, respect for cultural and social diversity, and competence in the services provided. However, as noted in Sackett's definition and in the documented five-step EBP process (Mullen, 2004, 2006; Shlonsky & Gibbs, 2004; Thyer, 2004), *client characteristics*, *preferences*, and *values* are an integral component of engaging in best practice. If clients express their desire to discuss their religious/spiritual beliefs (Stanley, et al., 2011), a distinct part of their culture (Canda & Furman, 2010), and that they would prefer that the therapists to the ones to initiate the discussion rather than the client (Koenig, 2005; Leitz & Hodge, 2013; Rose, et al., 2001; Stanley, et al., 2011; Tepper, et al., 2001; Weld & Erickson, 2007), then it is consistent with the EBP model to respect the client's self-determination and for the therapist to integrate this area of clients' lives as a part of the intervention process.

In summary, multiple social work organizations, research, and practice models now support the integration of clients' religious or spiritual beliefs, struggles, and/or coping styles with practice. These include the: 1) NASW Code of Ethics (NASW, 2008), 2) CSWE EPAS

(CSWE, 2008), 3) evidence-based practice process (Mullen, 2004, 2006; Shlonsky, 2004; Thyer, 2004), 4) development of manualized interventions that integrate clients' religious/spiritual beliefs into treatment (Hodge, 2006; Rosmarin, et al, 2010; Armento, et al, unpublished), 5) clients' expressing a desire to discuss it and for their mental health practitioner to be the one to bring it up (Koenig, 2005; Leitz & Hodge, 2013; Rose, et al., 2001; Stanley, et al., 2011; Tepper, et al., 2001; Weld & Erickson, 2007), and 6) research emerging to show positive relationships between religion and health/mental health (Koenig, et al., 1998; Koenig, et al., 2012; Koenig, et al., 2001).

Diffusion of Innovations Theory

Diffusion of innovations theory suggests that even if an idea (such as integrating clients' religion/spirituality into practice) has obvious advantages, it typically takes time to be adopted into practice (Rogers, 2003). The Diffusion Process has four main elements (italicized) by which an 1) *innovation*, 2) is *communicated* though certain *channels*, 3) over *time*, 4) among the members of a *social system* (Rogers, 2003, p. 11).

The innovation does not necessarily need to be new knowledge or technology, but rather may be something that is newly considered for adoption or a situation where the adopter has not yet become fully aware of the information. Upon learning of this information, the individual typically begins asking questions about it, how it works, why it works, any consequences, and does a cost-benefit analysis of utilizing the innovation. When individuals perceive an innovation as having less complexity and greater relative advantage, compatibility, trialability (the degree to which an innovation may be experimented with on a limited basis), and observability (degree to which the innovation's results are visible to others), the innovation is adopted more quickly (Rogers, 2003).

Once the knowledge, idea, or technology is deemed as innovative, the message about the innovation is passed along a communication channel, from one individual to another. What is of greatest importance is that most individuals are more receptive to the information when they hear of it from another individual like themselves, with similar qualities and who has already adopted the innovation, as compared to scientific studies (Rogers, 2003). This is a critical step in the diffusion process, especially with the topic of integrating religion/spirituality into practice. Given this has been a topic with little discussion in classrooms historically, there may not be many social work practitioners who have learned how to integrate this into practice. It is at this stage when faculty, field instructors, continuing education speakers, and practitioners play a critical role in educating students on the effective integration of religion/spirituality into clinical practice.

The next element is time, which involves three parts: 1) the innovation-decision process – when an individual moves from being aware of the innovation, to having an attitude toward it, to deciding whether or not to adopt the innovation, to carrying out the adoption or not, and finally, to assess/confirm the decision to adopt the innovation, 2) the innovativeness and adopter categories – how quickly an innovation is adopted by an individual and the type of adopters the other members of the social system are when it comes to innovations, and 3) rate of adoption – the speed in which an innovation is adopted, often in the shape of an S, beginning with a few innovators, then climbing with more individuals within the social system adopting the innovation, and it finally leveling off (Rogers, 2003). While some efforts have been made to adopt the subject of integrating religion and spirituality into social work education and practice [e.g. CSWE including religion/spirituality briefly in its EPAS (CSWE, 2008) and NASW has including religion briefly in the Code of Ethics (NASW, 2008)], it has not been until recently

that these organizations have included this topic. Knowing that overseeing organizations such as NASW and CSWE have recently included attention to this, it is not known how quickly the "social systems" (i.e., practitioners and educators) are to adopting the innovation.

This leads into the fourth element, the social system, which is a "set of interrelated units [individuals, informal groups, organizations, and/or subgroups] that are engaged in joint problem solving to accomplish a common goal" (Rogers, 2003, p. 23). Within the social system, a social structure exists with different levels of ranking among individuals, as well as a communication structure, which is a patterned communication flow in a system (Rogers, 2003). One example of a social structure would be CSWE's policy makers who oversee and determine the education standards, which in turn, causes the Deans of accredited MSW programs to work with others to determine how to meet such standards, which then trickles down to faculty members and finally, to students. A communication structure, on the other hand, is demonstrated by the recent CSWE Clearinghouse that was created for faculty to openly share with one another any materials, syllabi, or advice with regards to how to integrate religion/spirituality into practice (Sherr, et al., 2011). Within the social system, the system's norms are also important to consider and may help or impede the adoption of an innovation (Rogers, 2003). CSWE's EPAS may be considered a norm in this instance, such that, in order for an MSW program to be considered accredited it must meet all accreditation standards (CSWE, 2008). If the accreditation standards include a clear understanding on integrating religion/spirituality in social work education, this may help the innovation disseminate more quickly. On the other hand, if, for example, a mental health services agency does not consider clients' religious/spiritual beliefs as being an important area of clients' lives to assess or discuss, it may be difficult to integrate the innovation of discussing this sensitive topic into practice. Opinion leaders (such as well-known practitioners within an agency

or local area) play an important role in this situation by being able to influence others' attitudes or behavior within the social system by being at the center of the interpersonal communication networks (Rogers, 2003). Like opinion leaders, change agents (e.g. researchers at a university who are interested in or studying the innovation) may also influence members of the social system but are outside of the social system; in fact, change agents often use opinion leaders in the diffusion process (Rogers, 2003). As a result, the innovation may be adopted or rejected by an individual, by the social system as a whole, by someone in power over the social system, or by multiple sources just mentioned. Upon deciding whether or not to adopt or reject the innovation, the consequences are then assessed (Rogers, 2003).

Social Workers' Use of Religion/Spirituality in Practice

It has become increasingly important to better understand the perspectives and practices of *current* social work practitioners in real settings, who may or may not have received education on this subject. As is often the issue, discourse within the literature can be very disconnected to what is occurring among practitioners in the real world, such as the views regarding or integration of clients' religion and spirituality in social work practice.

While a few studies have aimed to understand social work practitioners' attitudes and behaviors regarding the integration of spirituality or religion into health or mental health treatment, there is a dearth in understanding social workers' overall orientation as measured by attitudes, self-efficacy, perceived feasibility, and behaviors. Prior studies have surveyed specific techniques practitioners use with their client or discuss with their client (e.g., praying/meditating with a client, recommending religious texts/books, or helping clients find spiritual meaning in their lives) (Canda & Furman, 1999, 2010; Sheridan, 2004; Sheridan, et al., 1992), and have

measured degrees of agreeableness of when it's appropriate to bring up religion/spirituality in practice (Canda & Furman, 2010).

For example, Canda has used the Spiritually-Derived Intervention Checklist to survey social work practitioners, asking if they have personally done a number of certain techniques that involve religion/spirituality with a client, and also asked whether they feel as if the technique is an appropriate social work helping activity (Canda & Furman, 1999, 2010). In his 2008 administration of the checklist, some of the items practitioners reported engaging in less with clients include meditating with a client (30.4 percent have personally done this, while 60.4 percent feel as though it's an appropriate social work helping activity), praying with a client (27.1 percent have done this, while 44.8 percent felt it to be an appropriate activity), participating in a client's religious/spiritual ritual as a practice intervention (17.5 percent have done this, 32.3 percent felt it would be an appropriate activity), and touching clients for "healing" purposes (14.1 percent have done this, 22.3 percent felt it to be an appropriate activity) (Canda & Furman, 2010). Some of the more commonly engaged in activities included helping clients consider ways their religious/spiritual support systems are helpful (92.2 percent have done this, while 96.2 percent felt it was appropriate), using nonsectarian spiritual language or concepts (84.2 percent have done this, 90.7 percent felt it would be an appropriate activity), recommended participation in a religious or spiritual support system or activity (77.2 percent have done this, 85.3 percent felt it would be an appropriate activity), and discuss the role of religious or spiritual beliefs in relation to significant others (75.3 percent have done this, 88.2 percent felt it would be an appropriate activity) (Canda & Furman, 2010).

After a recent review of the literature, Sheridan stated that "…practitioners and students are utilizing a substantial number of spiritually based interventions, that workers' personal

spirituality is influential in intervention use, that there is no evidence of adherence to specific ethical guidelines, and that the majority of social workers receive little or no instruction on religion and spirituality in their professional programs" (2008, p. 99). If such a lack of instruction on religion and spirituality exists in social work programs, as Sheridan (2008) states, and knowing that practitioners' are utilizing spiritually based interventions without evidence that such interventions adhere to ethical guidelines, a concern clearly arises that educators and continuing educators are responsible to fill this gap. Hence, it was the aim of the proposed research to further identify social work practitioners' current attitudes, behaviors, perceived feasibility and self-efficacy related to integrating clients' religion/spirituality into practice.

Components Of The Dissertation As Articles

This dissertation consists of three articles that examined the integration of clients' religion and spirituality into clinical practice. As stated above, prior research has shown that not only does such integration have the potential to improve mental health outcomes (Koenig, et al., 2012; Koenig, et al., 2001), but clients would prefer that their therapist initiates the discussion (Koenig, 2005; Leitz & Hodge, 2013; Rose, et al., 2001; Stanley, et al., 2011; Tepper, et al., 2001; Weld & Erickson, 2007). However, social workers, the largest group of clinically trained mental health service providers (SAMHSA, 2010) have received a lack in training in this area of clients' lives (Canda & Furman, 2010; CSWE, 1995, 2008; Marshall, 1991; Russel, 1998, 2006).

To improve our understanding of social work practitioners' current orientation toward integrating clients' religion/spirituality into mental health treatment and identify areas for future training, this study sought to first conduct a comprehensive literature review on the measurement of religion and spirituality in social work practice. Additionally, this literature review examined prior studies' findings on social workers' integration of clients' religion and spirituality in

practice, and to compare how social workers compare with other helping professionals. The findings from this were then used to inform the development of a multidimensional scale to measure social workers' self-efficacy, attitudes, perceived feasibility, and behaviors concerning the integration of clients' religion/spirituality into practice, as well as their overall orientation toward the integration of clients' religion/spirituality into practice. This instrument - the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS) - was administered to a random sample of 1,000 licensed social workers from across the country, whose responses were used to assess the reliability, and criterion and factorial validity of the RSIPAS, while also describing social work practitioners' responses to this scale.

In an effort to disseminate the content and findings from this dissertation, three articles have been written and are included as Chapters 2, 3, and 4 of this dissertation. The first article is based on a comprehensive literature review focusing on previous attempts to assess integration of clients' religion and spirituality in social work practice, social work practitioners' beliefs, attitudes, and behaviors around integrating this topic into practice, and to examine how social workers compare with related helping professions. The second article focuses on the development and validation of the RSIPAS. Finally, the third article describes a national sample of Licensed Clinical Social Workers' (LCSWs) responses to the first administration of the RSIPAS. Ideally, this information will be used to inform the development and training evaluation of curricular content for inform BSW and MSW education, field instruction, and continuing education. Each article is further described below with the research questions identified with each article, the methodology that was used, and their plans for dissemination.

Article One: Literature Review

Research Questions. The primary research questions, answered in Article One, are:

1) What (if any) instruments exist to assess social workers' attitudes, beliefs and behaviors regarding the integration of clients' religion and spirituality into practice?
2) Based on the literature, how do social workers' attitudes, beliefs, and behaviors regarding the integration of clients' religion and spirituality into practice differ from other helping professions?

Methodology. Article One is based on a full literature review of religion and spirituality in social work education and practice. After a brief examination of the literature, it is clear that a standardized scale does not exist to measure a full conceptual picture of practitioners' views about integrating spirituality/religion into practice – including attitudes, perceived feasibility, self-efficacy and implementation. While some of these concepts have been explored individually, the instruments used have not yet been validated or have focused less on feasibility issues, self-efficacy, and the use of empirical research on religion and spirituality in practice to guide practice decisions. A short overview on the research around religion and spirituality's effects on treatment outcomes and clients' views on the integration of their spiritual preferences in their treatment is included to assist in contextualizing the article. With social workers being the largest group of clinically trained mental health professionals (SAMHSA, 2010), the social work profession was specifically examined; however, other helping professions are included for comparison. Finally, suggestions and implications for social work education and practice are included.

Dissemination Plan. In August 2013, Article One ("Social work practitioners' integration of clients' religion and spirituality in practice: Measurement and current integration")

was submitted to *Social Work* and was accepted for publication in March 2014. This journal has an impact factor of 1.493 (Leung & Cheung, 2014). In addition to analyses on issues in the profession, this journal focuses on improving practice and advancing knowledge in social work and is widely read by social work practitioners, faculty, and students.

Article Two: Development and Validation of the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS)

Research Questions. After the initial development of the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS), the primary research questions answered in Article Two are:

1) Does the RSIPAS have face, content and criterion validity?
2) Can responses to the RSIPAS be explained by four factors (self-efficacy, attitudes, behaviors, and perceived feasibility)?
3) Can responses to the RSIPAS be explained by four first-order factors (self-efficacy, attitudes, behaviors, and perceived feasibility) and one second-order factor (orientation toward integrating clients' religion/spirituality into practice)?

In order to answer the above questions, Article Two had two distinct phases to it, described below under Methodology.

Methodology. Phase 1: Develop a multidimensional scale to measure social workers' self-efficacy, attitudes, perceived feasibility, and behaviors concerning the integration of their clients' religion/spirituality into practice, as well as their overall orientation to the integration of clients' religion/spirituality into practice.

The RSIPAS was developed based on the existing literature and consultation with experts within the field of religion/spirituality in behavioral health, including Dr. Kenneth Pargament,

Dr. Harold Koenig, Dr. Michael Parker, and Dr. Dan Blazer, who helped to establish face and content validity. In addition, the 2011-2012 Spirituality Research Group at the Institute for Spirituality and Health in the Texas Medical Center provided feedback regarding the scale's content validity. Dr. Danielle Parrish assisted in overseeing the development of the scale items and constructs, which model after the EBPPAS-S (Parrish & Rubin, 2011a, 2011b; Rubin & Parrish, 2010), co-developed by Dr. Danielle Parrish and Dr. Allen Rubin. Drs. W. Andrew Achenbaum and Luis R. Torres also provided feedback on content with their areas of expertise, and helped to oversee methodology.

Following establishment of initial content validity, the scale was pilot tested with 13 social work practitioners to assess whether the scale items are clear, and to determine the length of time it takes to complete the scale. Revisions were made, as necessary, after each administration. The final version was finalized by Danielle Parrish and Holly Oxhandler, and any discussed changes were sent to Kenneth Pargament, W. Andrew Achenbaum, and Luis R. Torres for review and approval.

Phase 2: Assess the internal consistency reliability, factorial validity and criterion validity of this scale.

Research Design. This cross-sectional study utilized an internet survey to validate the proposed Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS) and describe a national sample of licensed clinical social workers' orientation to integrating clients' religion/spirituality into practice. The RSIPAS was developed to achieve the above aim, and was modeled after Rubin and Parrish's (2011b) Evidence-Based Practice Process Assessment Scale – Short Version (EBPPAS - S), which has been shown to be reliable (α = .94) and have face, content, factorial, and criterion validity. The EBP process is a practice process in which social

work practitioners work with clients to achieve the most positive outcomes, while remaining mindful of the clients' values, characteristics, and preferences. Evidence-based practice encompasses the process of integrating clients' religion/spirituality into treatment, as it includes consideration of the clients' values, characteristics, and preferences to obtain positive health or mental health outcomes. In addition, this EBPPAS-S assesses factors related to the adoption of a similar practice behavior, which suggested its overall structure would serve as a useful guide for the development of the RSIPAS. Specifically, this study utilized the general constructs regarding adoption of a practice behavior (e.g. self-efficacy, feasibility, views, and behaviors) from the EBPPAS-S and their sequencing within the scale (Parrish & Rubin, 2011a, 2011b; Rubin & Parrish, 2010) to assess practitioners' orientation of integrating client religious/spiritual beliefs into mental health treatment.

A copy of the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS), along with a demographics section and two open-ended questions, was administered via a Survey Monkey link. Two thousand zip codes were randomly selected from across the country, and entered into HelpPRO.com's search for social workers, with a five-mile radius indicated, to obtain the sampling frame. Only those with an individual profile were included, and from this list, 1,000 social workers were randomly selected to be included in the sampling frame. Upon obtaining the list of licensed social workers in the sample, each was contacted through the email address connected to the individual's HelpPRO profile. The email asked for participants' help with this dissertation study, informed participants of their inclusion in this study, and notified the individuals they will soon receive an email with a link to participate. It also briefly described the project, the chance to win a gift card upon participation, and inform them of the token incentive

included in the mail. Individuals whose email bounced back from the first email (which did not have a link to participate in the survey) were replaced with the next individual in line.

Three business days following this email, the sample received a formal email invitation to participate, with the Survey Monkey link included. Their response to the survey implied their consent to participate in this anonymous study. Those that contacted the principal investigator to be removed from follow-up mailings were sent a confirmation email in response, with the "Non Response" Survey Monkey link to assess for non-response bias.

About two weeks after the this email inviting them to participate, a thank you letter for participation, $1 token incentive, and the Survey Monkey link was sent via mail to remind those who haven't participated to respond to the survey at their convenience. Finally, about two weeks after that, a follow-up email was sent with the survey link to encourage participation, as well as a "Non-Response Survey" link, to assess for non-response bias.

Protection of Human Subjects. An expedited research proposal was approved University of Houston's Committee for the Protection of Human Subjects' Internal Review Board (Appendix H), along with a Request for Waiver of Documentation of Consent (Appendix G), since the survey was anonymous.

Subject Selection/Sampling. According to Tabchnick and Fidell (2007), a minimum of 300 cases is needed to validate the RSIPAS using Confirmatory Factor Analysis (CFA). However, since this was the first administration of the RSIPAS, Comrey and Lee's (1992) guide was used, with 1000 being considered an excellent sample size. Additionally, considering the feasibility of emailing each individual through the website, a sample size of 1,000 seemed to be most appropriate.

The National Association of Social Workers (NASW) partners with HelpPRO (www.HelpPRO.com), a therapist finder website, to provide NASW members the opportunity to advertise their services at a reduced fee (HelpPRO, n.d.). Through this website, site visitors may search for a social worker by entering the desired zip code, selecting the preferred radius in miles, and if desired, any particular practitioner characteristics (e.g., practice specialization, age group, insurance accepted, etc.). Based on the high response rate obtained by Pignotti and Thyer (2009), feasibility for obtaining the names of practitioners and contact information, and ability to track bounce-back emails, similar methods were used for this study.

To obtain the necessary sample size, 2,000 (out of 39,436 as of May 2013) P.O. Box and Standard zip codes were systematically randomly selected, after sorting them in numerical order. For each zip code, a five-mile search radius was determined, and all contacts within that radius were entered. The entire sampling frame of this website is unknown. Individuals' name, address, phone number, fax number, licensure/degree, and whether or not they have a linked email address to their account, were included. Additionally, practitioners are able to identify in their profile whether they address religious or spiritual concerns in practice, which was also collected. Any profiles that are clearly group practices, agencies, schools, or otherwise not an individual's profile, or is repeated in another zip code (as some practitioners have multiple addresses), were excluded. Additionally, eligibility to be included in the sampling frame included having an email address linked to the practitioners' HelpPRO account and a listed mailing address.

Initially, 1,643 unique individual names were identified; however, 1 did not have a social work degree, 197 did not have a mailing address, 56 did not have an email address linked to their profile and 8 did not have either an email address or mailing address. Therefore, 1,000 of the remaining 1,381 were randomly selected to be included in the sample. Prior response rates to

similar, mail-based surveys were between 33-40 percent (Canda & Furman, 2010; Parrish & Rubin, 2011b); however, it was anticipated that this primarily being an email-based survey may decrease the response rate to around 15 percent, based on Parrish and Rubin's (2011b) NASW-Texas sample. However, Pignotti and Thyer's (2009) study using this sample and similar Dillman sampling method procedures (Dillman, et al., 2009) resulted in an impressive 52% response rate. Therefore, a sample size around 346 respondents (based on averaging the above mentioned response rates) was anticipated (see Figure 2 for the Intent to Sample).

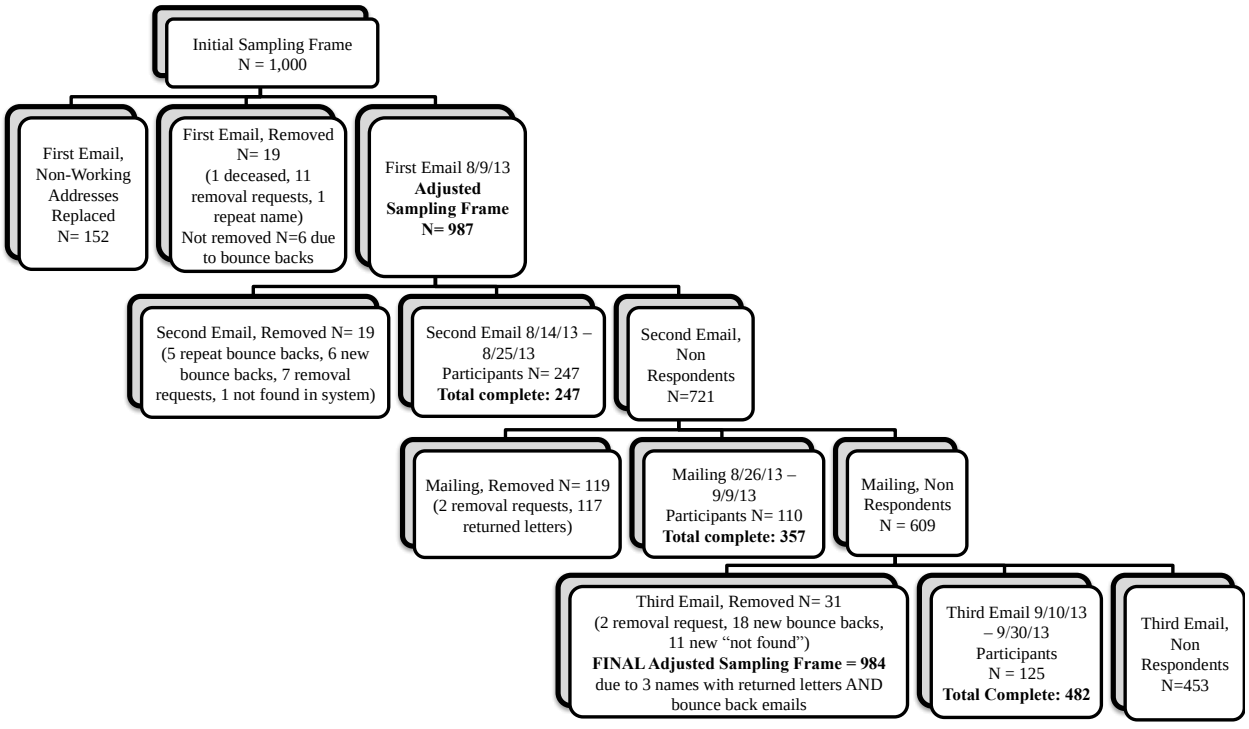
A slightly modified version of the Dillman sampling methods (Dillman, et al., 2009) was used for sampling procedures. The 1,000 randomly selected social workers from HelpPRO received an initial email that informs the individual that he/she was selected for the study and would be receiving an email in the near future that includes a link to participate (Appendix A). About three business days after this initial contact, an email (Appendix B) was sent out inviting the individual to participate in the study via the Survey Monkey link, which included the RSIPAS and a demographic/background section (Appendix E). Details of the project, potential risks/benefits, the anonymous nature of the study, IRB contact information, and a clear explanation that participation implies consent was also included. Participants were offered the opportunity to enter into a drawing at the end of the study for one of five $50 Target gift cards (to help increase response rate) and removed from any future mailings upon emailing the principal investigator.

Two weeks after the initial contact email, a letter (Appendix C) was physically mailed to all individuals in the sample. This letter thanked individuals for their participation and encouraged those who had not participated to do so at their earliest convenience. The link to the survey was also included in this letter. Additionally, based on Dillman, Smyth, and Christian's

(2009) recommendation, a $1 token incentive was included in the letter to encourage participation. Finally, about 2 weeks after this letter was mailed, a third email (Appendix D) was sent with similar language to the second email, with the "Non-Response Survey" link included (Appendix F), to assess for non-response bias.

The online Non-Response Survey included common reasons for non-participation that were identified in Parrish and Rubin's (2011b) study, including lack of time, retired, not relevant to the individual's practice, negative feelings toward the subject matter, and an area for respondents to include any other reasons.

Figure 2: Intent to Sample



Measures. The Religious/Spiritually-Integrated Practice Assessment Scale (RSIPAS) was developed and used to examine social work practitioners' attitudes, self-efficacy, perceived feasibility, and behaviors, (together considered "overall orientation") to integrating clients' religion/spirituality into practice. This scale is modeled after Parrish & Rubin's Evidence-Based Practice Process Assessment Scale – Short Version, which assesses practitioner views toward using evidence-based practice, and has good reliability and validity (Parrish & Rubin, 2011b).

In addition to the RSIPAS, the online survey questionnaire included a background/demographics section that asked about age, gender, ethnicity, prior training and exposure to integrating clients' religion/spirituality into practice, types of degree/licensure, education, number of years in practice, the current setting that he/she works in, religious orientation, spiritual/religious practices, and two items from the General Social Survey that measure perceived spirituality and religiosity (Smith, Hout, & Marsden, 2013). The questionnaire also included the Duke University Religion Index (DUREL), a five-item measure of that assesses three major dimensions or religiosity: organized religious activity (ORA), non-organized religious activity (NORA), and intrinsic religiosity (IR) (Koenig & Büssing, 2010). This brief measure of religiosity was also added for future, secondary analyses (King, 2011). Two open-ended questions were included at the end of the RSIPAS to capture what has assisted or prevented social workers' with integrating clients' religion/spirituality into practice.

Data Analysis. The internal consistency of the RSIPAS and its subscales were assessed using Cronbach's alpha. A Confirmatory Factor Analysis (CFA) was conducted using Mplus 7.0 to assess the factorial validity of the scale with the entire sample. A first-order CFA was used to assess the validity of the four different subscales, and a second-order CFA assessed whether the scale measured an overarching construct of orientation toward integrating religion and

spirituality into practice. Criterion validity was assessed using bivariate measures of correlation and association between subscales and overall scale scores with religiosity and prior education or training regarding the integration or use of religion/spirituality in practice.

Before analyzing the data, the Statistical Package for Social Sciences (SPSS) 20.0 was used to assess missing data and run descriptive statistics. Additionally, SPSS was used to assess multivariate and univariate normality, though Mplus is robust in dealing with issues related to non-normal data. Outliers were also examined using SPSS, though Mplus is also reportedly able to handle outliers and missing data, so all cases with at least some RSIPAS data were kept for the CFA. Finally, linearity and homoscedasticity were examined through scatterplots (Kline, 2005).

Data was assessed by first examining how many individual cases and items are missing data. It has been suggested that there should not be more than 10 percent of missing data for either cases or items (Kline, 1998), although there are no clear guidelines on what constitutes as a "large" amount of incomplete data (Byrne, 2001; Kline 2005). Next, to assess whether potential data are MCAR, MAR or MNAR, t-tests were run to compare the demographic data for the two groups (those with missing data and those without) to assess whether there is a systematic pattern to the missing data. Since data were MCAR and there was adequate power to run the analysis, the weighted least squares means and variance adjusted (WLSMV) approach was used in Mplus, which handles missing data and non-normally distributed categorical items.

Dissemination Plan. Article Two was first submitted to *Research on Social Work Practice,* which has an impact factor of 1.580 (Leung & Cheung, 2014), as the scale focuses on assessing one particular area of social work practice. In addition, this journal often publishes new instruments used in social work research, which fits well with the purpose of this article, and also

published the instrument the RSIPAS was modeled after: the EBPPAS-S (Parrish & Rubin, 2011b).

Due to this scale having evidence for its reliability and validity, in an effort to disseminate the scale itself, it is made available for free, so that agencies or researchers may use it for evaluating practitioners or conducting further research. In addition to the journal article, the scale and its' development and findings will be submitted to be presented at the Annual *Society for Social Work and Research* Conference.

Article Three: A description of social workers' responses to this scale

Research Questions. The primary research questions guiding Article Three, are:

1) What are the attitudes, behaviors, self-efficacy, and perceived feasibility concerning the integration of clients' religion/spirituality into practice among Licensed Clinical Social Work practitioners?
2) Are there any significant relationships between various practitioner background characteristics and RSIPAS variables?

Methodology.

Research Design. The data was collected as described under Article Two's Methodology, using a cross-sectional survey design. Consistent with Article Two, procedures were put in place to maximize response rate and enhance generalizability. Due to the dearth of research in this area, a sampling proportion of 50 percent was used to project the sampling error (Rubin & Babbie, 2011). As mentioned above, in Subject Selection/Sampling under Article Two, the population of NASW members is over 140,000 (NASW, 2011). With this size population, in order to have a margin of error of 5 percent (with a 95 percent confidence interval), a sample size

of 377 is necessary (DSS Research, n.d.), which was very close to the estimated 346, based on previous response rates. However, based on the response rates from Pignotti and Thyer (2009), who used HelpPRO for their study and obtained a 52 percent response rate, it was anticipated that our response rate would be above 35 percent. For a population size of over 140,000, a total of 346 respondents, and a 95 percent confidence interval, the standard error is estimated to be 5.3 percent (DSS Research, n.d.). However, the resulting 442 sample of LCSWs with RSIPAS data resulted in the standard error being estimated at 4.6 percent (DSS Research, n.d.).

To maximize response rate, as mentioned in Article Two, participants received a notice email, an initial email invitation with the link to the study, a letter with a $1 token incentive, and a final follow-up email including the survey link as well as an additional survey link to assess non-response bias. In addition, those who followed the instructions at the end of the survey and emailed the principal investigator were entered into a drawing to win one of the five $50 gift card incentives.

Data Analysis. Questionnaire data was analyzed using the Statistical Package for Social Sciences (SPSS), version 20.0. Descriptive and multiple regression analyses were utilized to explore the relationships between various practitioner background characteristics and RSIPAS variables.

Dissemination Plan. Article Three was submitted to *Social Work*, the official journal of NASW, which has an impact factor of 1.493 (Leung & Cheung, 2014). In addition to analyses on issues in the profession, this journal focuses on improving practice and advancing knowledge in social work and is widely read by social work practitioners, faculty, and students. Additionally, it is our desire to submit it as a follow-up to the first article of this dissertation. In addition to the

journal article, the findings from the social workers' responses will be submitted to present at the Annual Program Meeting of the *Council on Social Work Education*.

Limitations

While a number of strengths exist in this dissertation, it is not without limitations. One possible limitation of this study is that the response rate could be affected by incorrect email addresses, technology issues, emails going into junk mail, or a lack of time available for potential participants to complete the survey, which would impact the generalizability of the findings for article three. However, personalized letters and emails, incentives, and follow-up contacts were used to encourage participation, resulting in a near 50 percent response rate. Specifically, everyone was mailed $1, able to enter into a drawing to win one of five $50 gift cards upon survey completion, and two follow-up emails were administered to boost response rate. The third email also included a link to participate, as well as a link to assess for reasons for non-response. Response bias is another potential limitation to this research, as those interested in the topic may have been more likely to respond than those who have strong feelings against the topic. In addition, the potential for social desirability bias was an added risk, meaning that the respondents would want to present themselves in a favorable light. However, these concerns are reduced, for the most part, by the fact that this is an anonymous survey.

Our sample was also obtained through a therapist finder website (www.HelpPRO.com), so licensed social workers who do not advertise their services on this website were not included in the sampling frame. Additionally, social workers who do not advertise their services on HelpPRO but were in zip codes outside of the 2,000 systematically randomly selected fell outside of the sampling frame. Most respondents were treating mental health issues in solo

private practice, so the results from this dissertation cannot generalize to social workers in other practice settings.

Another potential limitation is that by offering the survey online, there would be no way to monitor who in fact accesses or completed the online survey (e.g., link could have been shared among colleagues). However, an attempt to offset this potential threat to validity included a statement within the cover letter that the participant was specifically selected as one out of 1,000 social workers to participate in this survey. While this may not have completely prevented participants from sharing the survey with others outside of the sample, it may have somewhat prevented or reduce the number of instances where this could have occurred.

Summary

Given the robust literature base demonstrating that the integration of clients' religion/spirituality in mental health care improves outcomes (Koenig, et al., 2012; Koenig, et al., 2001), this dissertation helps to better understand how helping professionals can more widely integrate aspects of clients' spirituality and religion into practice, and what some of the unique barriers or feasibility issues might be concerning such integration. Specifically, this study focuses on social work practitioners', the largest group of mental health providers' (SAMHSA, 2010), to better understand their overall orientation toward this practice issue. In addition, a primary aim of this dissertation was met with the result of a reliable and valid instrument, which may be used for future studies that conduct survey research or the evaluation of training efforts targeting social workers or other mental health practitioners' integration of religion/spirituality in practice.

This dissertation follows the alternative dissertation guidelines, consisting of three articles that examine the integration of clients' religion and spirituality into clinical practice.

Ideally, the information provided in the articles will be used to inform the development and training evaluation of curricular content to inform BSW and MSW education, field instruction, and continuing education.

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Chapter Two: Article 1

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Holly K. Oxhandler, MSW, PhD Candidate and lead author, contributed to the conception and design of this literature review, acquisition of articles, and the synthesis and interpretation of this review. She drafted the article, worked with her dissertation committee on revisions, and gave final approval of the version to be published.

Kenneth I. Pargament, PhD, Dissertation Committee Member and coauthor, contributed to the design of this review, provided literature in the field of psychology and critical revisions, and gave final approval of the version to be published.

Social work practitioners' integration of clients' religion and spirituality in practice: Measurement and current integration

Key words: religion; spirituality; social work; practice; education

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Abstract

Emerging research on religion, spirituality, health, and mental health has begun to catch the attention of helping professionals. Additionally, clients are beginning to express a desire for their health and mental health practitioners to initiate discussion of their religious or spiritual beliefs as they relate to practice. Social workers are the largest group of mental health personnel, so it is important to understand their attitudes, views, and behaviors regarding integrating clients' religion and spirituality into practice. Few studies have assessed social workers' integration of clients' religion and spirituality in practice, primarily focusing on practitioner characteristics and use of specific helping activities to integrate clients' religion and spirituality in treatment. This article discusses how religion and spirituality have been integrated into social work practice and education, and reviews instruments used to assess social workers' integration of religion and spirituality in practice. Additionally, the findings from previous studies examining social workers' integration of clients' religion and spirituality are compared with those of other helping professions. Finally, implications for education and practice are discussed.

Social work practitioners' integration of clients' religion and spirituality in practice: Measurement and current integration

A growing body of evidence on spirituality, religion, and health suggests religious or spiritual practices contribute to positive outcomes across a wide range of health and mental health issues (Koenig, McCullough, & Larson, 2001; Koenig, King, & Carson, 2012). Clients have also expressed a preference for health care providers to initiate the discussion of their religious and spiritual beliefs, stating such integration supports their healing process (Koenig, 2005; Stanley, et al., 2011; Tepper, Rogers, Coleman, & Maloney, 2001). Additionally, religious struggles or coping mechanisms may emerge in practice (Pargament, 1997), making it important that practitioners address the religious dimension of life challenges and traumas.

Social workers are currently the largest group of clinically trained professionals, accounting for 45% of mental health personnel (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010). Despite research showing the importance of considering clients' religion and spirituality (R/S) in health and mental health treatment, 65% of social workers report not having received education on how to integrate clients' R/S in practice, and 25% do not have the skills to assist clients in religious or spiritual matters (Canda & Furman, 2010). Among the other 75%, the quality of their skills is not known.

This paper presents a review of the literature on three areas concerning R/S: 1) issues and considerations in health and mental health treatment, 2) the degree of integration in social work practice and education (including assessment, discussion of clients' R/S in practice, and use of empirically-supported practice behaviors that integrate clients' R/S), and 3) prior attempts to measure social workers' integration of R/S in practice. Additionally, social workers' views and

behaviors around integrating R/S will be compared with other helping professions, implications for education and practice will be discussed, and suggestions for future studies will be made.

Religion and Spirituality in Health and Mental Health Treatment

Defining religion and spirituality. Definitions of R/S vary across helping professions. Hill and colleagues (2000) identify that both terms involve "feelings, thoughts, experiences, and behaviors that arise from the search for the sacred" (p. 66). *Religion* is defined as an institutionalized, systemic pattern of values, beliefs, symbols, behaviors, and experiences shared by a community (Canda & Furman, 2010) that relies on a set of scriptures, teachings, moral code of conduct, and rituals (Koenig, 2008). *Spirituality*, is a fundamental human quality (Canda & Furman, 2010), involving a personal search for the sacred (Pargament, 2007), and "moves the individual toward knowledge, love, meaning, peace, hope, transcendence, connectedness, compassion, wellness, and wholeness" (Summit on Spirituality, as cited in Miller, 2003, p. 6). Further, *positive spirituality* is "a developing and internalized personal relation with the sacred or transcendent that is not bound by race, ethnicity, economics, or class and promotes the wellness and welfare of self and others," integrating both religion and spirituality (Crowther, Parker, Achenbaum, Larimore, & Koenig, 2002, p. 614). Although these terms can be differentiated conceptually, they are often interconnected in practice. R/S can be integral to many clients' lives and are important to consider in social work practice, much like culture. In fact, Canda and Furman (2010) define religion, and Robbins, Chatterjee and Canda (2012) define culture as both being shared by a community or social group, transmitted over time, and include a pattern of values, beliefs, and behaviors. The National Association of Social Workers' (NASW) Code of Ethics (2008) includes religion under the umbrella of diversity topics requiring cultural competence, and NASW's Standards for Cultural Competence (2001) "require culturally

sensitive and culturally competent interventions…[that] include addressing…the importance of religion and spirituality in the lives of clients" (p. 8). Regardless of clients' R/S beliefs, social workers should consider it an aspect of client diversity.

Prevalence of Religion and Spirituality within the United States. Social workers are trained to be culturally competent, to maintain a holistic perspective, and remain mindful of where a client is (Saleeby, 2009). Thus, it is important to consider salient aspects of a client's life, including his/her R/S, especially with 80% of U.S. adults reporting religion being at least *somewhat* important (58% of which said *very* important) (PEW Report, 2012). Over the last five years, those unaffiliated with a religion increased by 4.3%, yet a third of this group reports religion as at least somewhat important, over half consider themselves either religious or spiritual but not religious, and 68% believe in "God or universal sprit" (PEW Report, 2012). Therefore, though unaffiliated with a faith tradition, this group is not completely secular. Citizens also place priority on private, individualized faith (Achenbaum, 2012; Wuthnow, 2010), with over half experiencing weekly spiritual peace and well-being, and a third claiming to have experienced divine healing or receiving monthly answers to prayer requests (PEW Report, 2008).

Integrating Religion & Spirituality into Practice. Various helping professionals integrate R/S in health and mental health treatment by using standardized assessment tools, such as the CSI-MEMO (Koenig, 2002) or FICA Spiritual History (Puchalski & Romer, 2000), or discussing forgiveness, gratitude, mindfulness, presence, hope, meaning, connection, spiritual transformation, ultimate reality, and positive/negative spiritual coping mechanisms with clients (Hodge, 2006; Kabat-Zinn, 2003; Koenig, 2005; McCoullough, 2000; Pargament, 1997, 2007). Particular effort has been made to integrate clients' R/S into cognitive-behavioral therapy (CBT) by utilizing religious or spiritual images or words during progressive muscle relaxation (PMR),

deep breathing, or cognitive restructuring (Armento, et al, unpublished; Barrera, Zeno, Bush, Barber & Stanley, 2012; Hodge, 2006; Rosmarin, Pargament, Pirutinsky, & Mahoney, 2010). Rogers' (1951) client-centered therapy and Allen's mentalization (Allen, Fonagy, & Bateman, 2008) also support R/S in practice. A recent meta-analysis of 31 studies on spiritually-oriented psychotherapies found an overall moderately high effect size (.56) across a variety of clinical issues (e.g., depression, anxiety, stress), suggesting spiritually-integrated therapies benefit clients with these clinical issues (Smith, Bartz, & Richards, 2007). Likewise, Wachholtz and Pargament (2008) found that those randomized to practice spiritual meditations ("God is good") 20 minutes/day for 30 days had fewer headaches, less anxiety, and higher pain tolerance than those who practiced internal secular meditations ("I am good"), external secular meditations ("Grass is green."), or PMR.

Recently, Rosmarin, et al. (2010), had 125 participants (77% female, with an average age of 42 years), who self-identified as Jewish, randomized to an internet-based spiritually integrated treatment (SIT), an internet-based progressive muscle relaxation (PMR) program, or a waitlist (WL) group, and complete all assessment points of the study. At 6-8 weeks post-treatment, those in the SIT condition had significantly lower levels of worry, stress, depression, and intolerance to uncertainty compared to the PMR and WL. The effect sizes for SIT, PMR, and WL, respectively, include: stress (-1.90, -1.10, -.88), worry (-1.90, -1.10, -.04), depression (-0.89, -0.65, -0.65), and intolerance to uncertainty (-1.40, -0.47, -0.39). The effect sizes across conditions (SIT, PMR, WL) for positive religious coping at 6-8 weeks post-treatment were 0.60, -0.24, -0.05, respectively (Rosmarin, et al., 2010).

Current Integration of Religion and Spirituality in Social Work Education and Practice

Historically, R/S have not always been included in the social work curriculum. The professionalization of social work (1920s-1970s) paralleled a trend toward its separation in other helping professions. As related helping professions moved toward a scientific, medical model to practice, and with R/S material not being scientifically grounded at the time, R/S content was removed from social work's curriculum guidelines (Marshall, 1991; Russel, 1998; Canda & Furman, 2010). However, a resurgence of interest in spirituality in the 1980s resulted in the Counsel on Social Work Education's (CSWE) 1995 guidelines, which returned attention to R/S as a part of client diversity (Russel, 1998). Currently, three policies from CSWE's Educational Policy Accreditation Standards (EPAS, 2008) mention R/S, encouraging learning from diverse sources of instruction (Policy 3.1), honoring the role culture (including religion) plays in one's identity and life experiences (Policy 2.1.4), and understanding spiritual (along with biological, social, cultural, and psychological) development (Policy 2.1.7).

To date, many social work programs do not offer a course on R/S, but weave religious traditions into the Human Behavior in the Social Environment content and textbook readings. However, due to R/S being more experiential in nature, some have argued a specialized course is needed to help foster an understanding of the role R/S has in clients' lives (including positive and negative coping strategies) that may not be obtained solely by required readings or in one or two brief lectures (Hodge & Derezotes, 2008; Canda & Furman, 2010). Additionally, clients' R/S may greatly influence health care decisions (Ehman, Ott, Short, Ciampa, & Hansen-Flaschen, 1999; Silvestri, Knitting, Zoller, & Nietert, 2003), further making it important for social workers to learn to assess and discuss clients' R/S. In 1998, only 17 of 114 (15%) social work programs had a course on spirituality (Russel, 1998), which increased to 75 of 190 (40%) (Canda, 2005).

In 2011, a CSWE clearinghouse emerged to disseminate R/S teaching strategies (Sherr, Land, Canda, Husain, & Sheridan, 2011). Despite these efforts, the degree to which these changes are actually impacting current social work education and reaching practitioners is limited. As a result, curricular content has not kept pace with path breaking research, which shows important connections among religion, spirituality, and health (Koenig, et al. 2001; Koenig, et al., 2012). Additionally, it is important to examine how R/S interfaces with social work education, especially since some students have reported experiences of religious discrimination in the classroom (Thyer & Myers, 2009), which may stifle their learning process.

Under NASW's (2008) Code of Ethics, religion is mentioned in the purpose statement and under five standards (1.05, 2.01, 4.02, 6.04, and 1.06). These guidelines advise practitioners against discrimination, to respect diversity, and to avoid conflicts of interest (e.g. practicing to further religious interests). Social workers are expected to understand social diversity (including religion) under Standard 1.05, but understanding client diversity is not the same as knowing *how* to appropriately apply and integrate such knowledge into practice. Further, spirituality is not mentioned in the Code of Ethics (NASW, 2008), though it is mentioned in NASW's Standards for Cultural Competence (2001), acknowledging the importance of spirituality for many clients, and potential use of such support systems (e.g. spiritual leaders). Assessing for and understanding this area of clients' lives better positions social work practitioners to identify and address both the positive and negative impact that R/S may have in clients' lives.

For current practitioners, the evidence-based practice (EBP) process is one of the most widely recognized decision-making processes by identifying and integrating "best research evidence with clinical expertise and [client] values" (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000, p.1). *Client characteristics*, *preferences*, and *values* (including R/S) are integral

components of engaging in best practice (Mullen, 2006; Shlonsky & Gibbs, 2004). Since clients prefer to discuss their R/S beliefs, at their practitioner's initiative, social workers' views and integration of R/S into practice are worth exploring.

Current social work practitioners' integration of clients' R/S. To date, few studies have sought to understand social workers' views and integration of clients' R/S into practice. Upon reviewing the social work literature, three scales appeared to have been developed and used to specifically measure social workers' integration of clients' R/S in practice, though others may exist. These scales include the Role of Religion and Spirituality in Practice Scale (RRSP) (Sheridan, et al., 1992), the Religion and Prayer in Practice Scale (RPPS) (Mattison, Jayaratne, & Croxton, 2000), and the Spiritually Derived Intervention Checklist (SDIC) (Canda & Furman, 1999; 2010). Previous studies have primarily examined social workers' use of R/S helping activities or interventions (e.g., praying/meditating with a client) and whether the social worker agrees the activity is appropriate to use in practice. Each instrument is described below.

Role of Religion and Spirituality in Practice Scale (RRSP). In 2008 Sheridan noted "practitioners and students are utilizing a substantial number of spiritually based interventions… that there is no evidence of adherence to specific ethical guidelines, and that the majority of social workers receive little or no instruction on religion and spirituality" (p. 99). This disconcerting observation came 13 years after CSWE's renewed emphasis on R/S and 16 years following the development of the RRSP (Sheridan, et al., 1992).

The RRSP is a 19-item scale (alpha = .81) designed to assess attitudes toward R/S in practice, practitioners' ideology, past and current religious affiliation, extent of and satisfaction with education and training in R/S, and certain clinical practice behaviors (e.g. "Know clients' religious or spiritual backgrounds," "Pray privately for a client") (Sheridan, et al., 1992). In the

original study, Sheridan and colleagues (1992) found that compared to social workers and psychologists, licensed professional counselors (LPCs) had the highest involvement and affiliation with organized religion, higher attitudes and use of religion and spirituality in practice, and were more likely to report their clients presented issues involving R/S. In 1994, Sheridan, Wilmer, and Atcheson surveyed social work educators using the RRSP. Results indicated high scores on the RRSP, and a majority of educators supporting a course on spirituality, despite only about 15% of programs having a course in 1998 (Russel, 1998).

Despite the wealth of information provided by this scale (Sheridan, et al., 1992; Sheridan, et al., 1994; Sheridan, 2004; Sheridan & Amato-von Hemert, 1999), the RRSP is limited by not having demonstrated criterion or factorial validity and is unidimensional, only measuring attitudes toward the role of R/S in practice. While this dimension is important, by itself, it does not assess a comprehensive understanding of practitioners' views and integration of clients' R/S by overlooking potentially relevant practice behaviors, self-efficacy, and the question of whether such integration is even feasible.

Spiritually Derived Intervention Checklist (SDIC). The 21-item SDIC was developed to survey NASW members' use of specific religious or spiritual helping activities with clients, and whether the helping activity was appropriate in practice (Canda & Furman, 1999, 2010). Many of the items mirror those in the RRSP (e.g. use or recommend religious or spiritual books or writings, recommend participation in a religious or spiritual support system or activity) (Canda & Furman, 1999, 2010). The SDIC assesses attitudes (specifically towards how appropriate the helping activity is) and behaviors related to R/S in practice. Three subscales emerged in the 1997 study and were replicated in 2008, including religion items (alpha = .97), spirituality items (alpha = .97), and religion/spirituality items (alpha =.98) (Canda & Furman, 2010). In both studies,

more respondents agreed each helping activity was appropriate in practice than those who had actually done the activity. While the SDIC has provided much information (Canda & Furman, 1999; 2010), it does not shed light on why more practitioners feel certain R/S helping activities are appropriate for practice, but do not engage in these helping activities. To this end, measuring self-efficacy or perceived feasibility of engaging in the activities may help to fill this gap.

Religion and Prayer in Practice Scale (RPPS). In 2000, Mattison, et al. developed the RPPS (alpha = .80). Like Canda and Furman (1999, 2010), they asked NASW members if the indicated religious or spiritual practice activities were appropriate and whether they had used the activity with clients. Activities included: 1) discuss religious beliefs with client, 2) pray with the client at the client's request, 3) request client to pray with you, 4) use serenity prayer, 5) initiate laying of hands as a technique, and 6) recommend religious form of healing. The item which social workers felt was the most appropriate (34%) was the use of the serenity prayer, with the least appropriate (3%) being requesting the client to pray with you. Most interestingly, while only 14% felt "discuss your religious beliefs with client" was an appropriate helping activity, 45% had done this activity at least once. This study corroborates Sheridan's (2008) observation, that a practitioner may view an activity as inappropriate in practice, but still engage in the activity. Combined with Canda and Furman's (1999, 2010) findings, a clear disconnect exists between what is perceived as appropriate for practice and what is actually done. What is not clear, however, are the reasons for this disconnect and how to address them.

Considering that allied helping professions often face similar practice issues as social workers, other professions may have identified important ideas or approaches for integrating R/S into practice settings. As research and practice move toward an interdisciplinary approach to treatment, recognizing neighboring professions' integration of R/S is critical.

Comparing the Integration of Clients' Religion and Spirituality in Social Work with Related Professions

Social work is not the only profession that wrestles with the role of R/S in practice. It is only within the past few decades R/S has reclaimed helping professionals' attention, despite their common roots in ministry (Koenig, et al., 2001). As with social work, various professions have recently attempted to better understand practitioners' views and integration of R/S in practice.

Religion and spirituality in allied professions. Like social work, each helping profession has its own Code of Ethics. Religion is often woven into the topic of discrimination in most ethical codes, including those under the American Psychological Association (APA) (2002), the American Association for Marriage and Family Therapy (AAMFT) (2012), and the American Counseling Association (ACA) (2005). The ACA and American Nurses Association's (ANA) Code of Ethics also mentions consideration of religion during assessment (ACA, 2005) and treatment planning (ANA, 2001). While most helping professions include some attention to this area of clients' lives, there is variability in clarity and degree of its importance.

Psychology & Counseling. A number of studies have been done to assess psychologists' integration of R/S in clinical practice. Although most studies show psychologists to be less religious than the population they serve and only 1 in 4 believe R/S is relevant to practice, research suggests psychologists are more open to this topic in practice. For example, half report asking clients about their R/S during assessment, and an overwhelming 82% believe a positive relationship exists between religion and mental health (Delaney, Miller, & Bisonó, 2007; Shafranske & Cummings, 2013). Psychologists have also expressed the importance of being aware of the role R/S has in clients' lives as well as in their own lives (Crook-Lyon, et al., 2012).

Marriage and Family Therapy (MFT). Studies have found many MFTs express interest in incorporating R/S in therapy (Prest, Russel, & D'Sousa, 1999; Carlson, Kirkpatrick, Hecker, & Kilmer, 2002), regardless of the therapist's religious orientation (McNeil, Pavkov, Hecker, & Killmer, 2012). Similar to Crook-Lyon, et al. (2012), McNeil, et al. (2012) found MFTs report awareness of their R/S beliefs is important, and tend to have positive views toward integrating R/S in practice. Using an adapted version of the RRSP, Carlson, et al. (2002) found a majority of AAMFT members agreed that asking clients about their religion was appropriate. While half felt talking with the client about God was appropriate, 17% felt it was appropriate to discuss their own religious beliefs – similar to the 14% of social workers in Mattison, et al. (2000). Qualitative data revealed MFTs should "let clients know that we are willing to talk about their spiritual lives" (Carlson, et al., 2002, p. 168), matching clients' desire for practitioners to bring up the topic of R/S (Koenig, 2005; Stanley, et al., 2011).

Nursing. Despite its religious roots, the nursing profession has not consistently integrated clients' R/S into practice. In 2000, the Joint Commission on Accreditation of Healthcare Organization began requiring a spiritual history on every hospital, nursing home, or home healthcare patient (Koenig, 2008), with nurses often collecting such information. Today, ANA's Code of Ethics includes clients' R/S in treatment planning, as mentioned above. With regard to current practice, 29% of nurses offer spiritual counseling, 71% had offered, suggested, or provided prayer to patients, and nearly all would offer, suggest, or provide spiritual help to patients who had requested it and were about to die (Grant, 2004). Nurses have described spirituality as a source of strength, connection, and a supporting practice that promotes health (Cavendish, et al., 2004). Nurses also report using R/S for personal coping, stating R/S provides

meaning to their work and serves as a protective function from job-related stress (Ekedahl & Wengstrom, 2010; Pesut, 2013) – an insight not widely examined by other helping professions.

Comparing social work with other helping professions. Because social workers account for almost half of all mental health personnel (SAMHSA, 2010), understanding current social workers' orientation toward integrating clients' R/S into practice is important. Across studies, certain practitioner characteristics appear to affect practice behaviors. For example, more religious or older practitioners are more likely to consider religious activities to be appropriate for use in practice, hold positive attitudes towards R/S, and make greater use of interventions that integrate clients' R/S in practice (Larsen, 2010; Mattison, et al., 2000; Sheridan, 2004; Stewart, Koeske, & Koeske, 2006), similar to the findings in psychology and MFT. Additionally, there is a common thread across professions, with practitioners desiring more discussion of R/S in their training (Crook-Lyon, et al., 2012; Prest, et al., 1999; Canda & Furman, 2010).

Few studies have compared helping professions on their views and use of R/S in practice. In Berger and Jensen's (1990) study, MFTs were the most religious, with beliefs similar to the general public, as compared to psychologists, psychiatrists, and social workers. Regarding integrating R/S into practice, LPCs had the most positive attitudes, compared to social workers or psychologists (Sheridan, et al., 1992). While a growing discourse is apparent in social work literature, the profession has much to learn about integrating clients' R/S, especially since most social work practitioners have not received education on this topic (Canda & Furman, 2010), and may not know what to do when faced with a majority religious population.

Discussion & Next Steps

While the literature is growing on social workers' attitudes and use of specific religious or spiritual techniques in practice, further study is needed. Prior studies have examined

practitioners' use of specific R/S behaviors in practice, yet for some of these practice behaviors, there is little evidence to support their use (e.g. touching clients for healing purposes). In the spirit of the EBP process, using the best research evidence available, future studies might assess how practitioners can best integrate R/S within the widely recognized EBP process. For example, it would be worth knowing if practitioners are reading about evidence connecting R/S and health (e.g., using standardized R/S assessment tools, empirically-supported practice behaviors mentioned above, or empirically-supported interventions such as the one used in Rosmarin, et al.'s 2010 study) to guide their practice decisions. Likewise, due to few social workers having received this content in their education, it may be worth identifying where (and if) practitioners are learning how to ethically and effectively assess for and discuss clients' R/S in practice, such as by reading research articles, through continuing education, or through supervision. Future studies may also assess whether practitioners involve clients in deciding if their R/S beliefs are integrated into treatment, especially considering the EBP process includes integrating appraised evidence with practitioner expertise and clients' culture and preferences (Sackett, et al., 2000).

Social work research has also not thoroughly assessed other factors, including practitioners' perceived feasibility and self-efficacy with integrating R/S into practice, which may impact social workers' orientation to this area of practice. For example, agency support (or lack thereof) and/or time constraints may impact whether practitioners feel it is even feasible or acceptable to ask about clients' R/S, or how their R/S relates to treatment. Additionally, with few social workers having received training on R/S, their self-efficacy may be affected, potentially impacting engagement with this area of practice. If a practitioner has not received adequate training on assessing for or discussing this area of clients' lives, or has received negative or discriminative messages in his/her graduate program about R/S (Thyer & Myers, 2009) how

likely is he/she to engage in these practice behaviors? Likewise, practitioner knowledge (or lack thereof) on how to address clients' R/S struggles or coping methods (either positive or negative) may also impact treatment planning and outcomes (Pargament, 2007).

Meanwhile, social work practitioners who have not received this content in their graduate training may consider seeking continuing education, supervision, or peer consultation on strategies for ethically and effectively integrating clients' R/S into practice. Additionally, much in the way personal biases with regard to cultural differences are explored in MSW programs, social work practitioners are encouraged to continuously explore their perceptions of working with a variety of R/S belief systems. Practitioners may also want to consider having a list of spiritual leaders to refer clients to, if the client desires. Finally, it is recommended that practitioners consider the evidence-based practice process (Sackett, et al., 2000) for identifying current, empirically supported methods for integrating clients' R/S in practice. Such methods include standardized assessment tools, manualized interventions, empirically supported practice behaviors that are appropriate with the client characteristics and preferences, and evaluating client outcomes.

Conclusion

While the authors acknowledge the complexity of examining practitioners' integration of clients' R/S in practice, there is much to learn. There appears to be a need to empower practitioners to ethically and effectively assess for and address any issues related to R/S in practice. As research on R/S and health emerges, with social workers being the largest group of clinically trained helping professionals, and with a majority of the population reportedly religious or spiritual, it is important for our profession to understand social workers' views and behaviors around integrating R/S in practice to inform future training and educational efforts.

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Chapter Three: Article 2

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Holly K. Oxhandler, MSW, PhD Candidate and lead author, contributed to the conception and design of the project, initial development of the Religious/Spiritually Integrated Practice Assessment Scale, acquisition of data, and the analysis and interpretation of results. She drafted the article, worked with her dissertation committee on revisions, and gave final approval of the version to be published.

Danielle Parrish, PhD, Dissertation Chair, contributed to the conception and design of the project and the interpretation of the data. She provided critical revisions and gave final approval of the version to be published.

The Development and Validation of the Religious/Spiritually Integrated Practice Assessment Scale

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Key words: psychometric study; religion; spirituality; scale; practitioner

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Abstract

Objective: This manuscript describes the development and validation of the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS). The RSIPAS is designed to assess social work practitioners' attitudes, behaviors, perceived feasibility, and self-efficacy concerning the assessment or integration of clients' religious and spiritual beliefs in clinical practice. **Methods:** After establishing content validity of the RSIPAS with a group of nationally known experts in the area of religion/spirituality and behavioral health, a national sample of master's social workers (N = 482) was randomly selected to assess the scale's internal consistency, criterion validity, discriminant validity, and factorial validity. **Results:** Findings support the scale's reliability (α = .95), criterion validity, discriminant validity, and factorial validity. **Conclusions:** The RSIPAS may be a useful instrument for elucidating current views and training needs among social work practitioners, or to evaluate the outcomes of training or educational programs that provide content on religion and spirituality in the practice context.

The Development and Validation of the Religious/Spiritually Integrated Practice Assessment Scale

Emerging research on the relationship between religion, spirituality and health suggests that assessing for and discussing clients' religion and spirituality (R/S) in clinical practice may result in positive health and mental health outcomes (Koenig, McCullough, & Larson, 2001; Koenig, King & Carson, 2012). Considering most (80%) U.S. adults report religion is at least somewhat important in their lives (PEW Forum on Religion & Public Life, 2012), it is not surprising that the large majority of clients seeking behavioral health services have expressed a preference that their R/S beliefs be discussed in treatment, and that helping professionals be the ones to initiate the discussion about the role of religion and spirituality (R/S) in their lives (Koenig, 2005; Leitz & Hodge, 2013; Rose, Westefeld, & Ansley, 2001; Stanley, et al., 2011; Tepper, Rogers, Coleman, & Maloney, 2001; Weld & Erickson, 2007).

Social workers are currently the largest group of clinically trained behavioral health helping professionals (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010). As such, it is alarming that nearly two-thirds (65%) of social workers have not received specific educational content on incorporating an assessment of or attention to clients' R/S in practice (Canda & Furman, 2010). This may be partly due to a trend in social work and allied fields during the 1920s to 1970s toward a medical model that did not include R/S (Marshall, 1991; Russel, 1998; Canda & Furman, 2010).

The consequence of this trend is that the potential of clients' R/S as a strength or coping strategy, challenge or life conflict, or important aspect of culture is often ignored in practice settings. Moreover, stories of religious discrimination within the social work classroom abound, suggesting that a respect for such diversity is not consistently modeled for our students (Thyer &

Myers, 2009). However, the National Association of Social Workers' (NASW) Code of Ethics (2008) recognizes the importance of clients' R/S in five of its standards (1.05, 1.06, 2.01, 4.02, and 6.04), calling social work practitioners to recognize R/S as an important aspect of client culture. The incongruence between the limited professional training provided on R/S in social work, the NASW Code of Ethics, and the important role religion and spirituality plays in clients' lives suggests a need to bolster training in this area.

To address the lack of attention to R/S in social work practice and education, the Council on Social Work Education (CSWE) recently developed a clearinghouse for educators to exchange teaching materials on important concepts related to R/S and practice for social work students (Sherr, Land, Canda, Husain, & Sheridan, 2011). Additionally, CSWE's most recent Educational Policy Accreditation Standards (EPAS, 2008) included three policies (3.1, 2.1.4, and 2.1.7) that suggest R/S is an important part of social work education. Advocates for increased education on the consideration of clients' R/S in practice have recommended that social work programs offer a specialized R/S course to enhance understanding (Canda & Furman, 2010; Hodge & Derezotes, 2008). Some of these efforts seem promising, as 40 percent of graduate social work programs had a course on spirituality in 2005 (Canda, 2005), an increase from the 15% of programs with a course in 1998 (Russell, 1998). However, the quality of the course, or content discussed in the classroom, are unknown.

While encouraging, these efforts are not designed to reach current social work practitioners in the field, and very few continuing education efforts available to address these needs are known. However, research-supported interventions that specifically integrate clients' R/S in practice are emerging. One example of this includes Rosmain and colleagues' internet-based spiritually integrated treatment, which resulted in significantly lower levels of worry,

stress, depression, and intolerance to uncertainty as compared to a progressive muscle relaxation group or waitlist group (Rosmarin, Pargament, Pirutinsky, & Mahoney, 2010). Standardized assessment tools are also being disseminated, such as the CSI-MEMO (Koenig, 2002) and the FICA Spiritual History (Puchalski & Romer, 2000). Moreover, research-supported spiritually-oriented psychotherapies for a variety of clinical issues are being developed (Smith, Bartz, & Richard, 2007). These are all promising developments, yet the profession is left to wonder whether social work practitioners (and allied fields) are adequately prepared to assess clients' R/S as an aspect of their culture, and provide R/S research-supported treatments should they become the best available intervention for a particular population. As such, there is a need to develop measurement instruments to assess efforts to educate and train social workers and allied fields to address R/S issues in real practice settings.

To date, three instruments have been designed to measure social work practitioners' integration of clients' R/S in practice (Oxhandler & Pargament, in press): 1) the Role of Religion and Spirituality in Practice Scale (Sheridan, Bullis, Adcock, Berlin, & Miller, 1992); 2) the Spiritually Derived Intervention Checklist (Canda & Furman, 1999, 2010); and 3) the Religion and Prayer in Practice Scale (Mattison, Jayaratne, & Croxton, 2000). The Role of Religion and Spirituality in Practice Scale (RRSP) is a 19-item scale (alpha = .81) that measures practitioners' attitudes toward R/S, practitioners' ideology, prior training in R/S, practitioner religious affiliation, and social work practice behaviors (Sheridan, et al., 1992). The Spiritually Derived Intervention Checklist (SDIC) is a 21-item instrument that measures the practitioners' assessment of the appropriateness of certain R/S helping activities in practice. It contains three subscales: religion items (alpha = .97), spirituality items (alpha = .97), and religion/spirituality items (alpha = .98) (Canda & Furman, 2010). The SDIC contains many of the items from the

RRSP, but also compares practitioners' attitudes towards a practice behavior with their actual use of that practice behavior. Finally, the Religion and Prayer in Practice Scale (RPPS) is a unidimensional instrument (alpha = .80) that includes six practice activities, and like the SDIC, compares practitioners' attitudes about an item with whether the practitioner actually engages in that behavior (Mattison, et al., 2000).

These instruments have a number of limitations (Oxhandler & Pargament, in press). For example, their primary focus is on practitioners' attitudes and use of specific religious/spiritual practices with clients, like praying with a client or touching the client for healing purposes, which may or may not have evidence to support their use in clinical practice. The RRSP and RPPS are also unidimensional, only measuring practitioners' attitudes toward the role of R/S in practice. They do not gather additional data regarding feasibility and self-efficacy.

Feasibility and self-efficacy, in addition to attitudes and implementation, have been identified as important factors to consider in evaluating practitioners' orientation toward a particular area of practice (Parrish & Rubin, 2011; Rubin & Parrish, 2010, 2011). For example, if a practitioner has not received training on how to assess or discuss clients' R/S, which many current social work practitioners have not (Canda & Furman, 2010), she may not feel efficacious in discussing this area of clients' lives. Likewise, if a practitioner's agency does not support the discussion of clients' R/S, or if practitioners do not feel there is enough time to include an assessment of the client's R/S, their perceived feasibility of incorporating R/S in practice may be affected.

Finally, all three scales have limited validity and reliability, and have not demonstrated factorial validity. The RRSP and SDIC have established content validity and criterion validity (but not RPPS), the RRSP has convergent and divergent validity, and the SDIC suggests

discriminant validity based on how atheists' and agnostics' responses compare with Christians' responses. As such, an instrument that measures practitioners' actual integration of clients' R/S in practice and establishes factorial validity has not yet been developed.

With the widespread adoption of the evidence-based practice process in social work and allied fields (Sackett, et al., 2000), future efforts to survey practitioners' integration of R/S in practice may want to focus less on the use of specific, unsupported R/S practice behaviors. Instead, the focus should be more on practitioners' efforts to address clients' R/S values to guide the EBP process and select research-supported R/S strategies or interventions when they are a good fit for the client. The Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS) was developed to address this concern, as well as develop a scale with additional dimensions (self-efficacy, feasibility) to develop a better understanding of practitioners' overall orientation to addressing religious or spiritual issues in practice. If the reliability and validity of the RSIPAS is supported, its future administration can potentially provide useful information to inform and evaluate educational or training efforts on the integration of R/S into practice.

The purpose of this current study was to develop and test the reliability and validity of the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS). Three research questions guided this study: 1) Does the RSIPAS have content and criterion validity?; 2) Can responses to the RSIPAS be explained by four factors (self-efficacy, attitudes, behaviors, and perceived feasibility)?; and 3) Can responses to the RSIPAS be explained by four first-order factors (self-efficacy, attitudes, behaviors, and perceived feasibility) and one second-order factor (orientation toward integrating clients' religion/spirituality into practice)? If found to have evidence for reliability and validity, the RSIPAS would be the first instrument with factorial validity for

assessing practitioners' integration of clients' R/S in practice, including assessment of self-efficacy and perceived feasibility surrounding this practice behavior.

Scale Development

Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS)

The RSIPAS consists of 43 items, measured using a five-point Likert scale. To handle potential acquiescent response bias, five items (ATT5, ATT9, ATT14, FEAS3 FEAS4) were negatively worded, and reverse scored. The original scale consisted of 4 subscales and 43 items: (a) Self-Efficacy with Regard to Integrating Clients' R/S in Practice (13 items), (b) Attitudes Toward Integrating Clients' R/S in Practice (14 items), (c) Perceived Feasibility to Engage in R/S Integrated Practice (6 items), and (d) Behaviors Related to Integrating Clients' R/S in Practice (10 items).

The scale was developed based on our experience with the existing literature in social work and related helping professions (i.e., psychology, medicine) on addressing clients' R/S within a practice context. A few items in the instrument were also obtained from prior scales and questionnaires measuring R/S in social work practice (Canda & Furman, 1999, 2010; Sheridan, et al., 1992). Additionally, one of the developers attended a five-day research course in 2012 on R/S and health and had experience with developing a manualized cognitive-behavioral intervention that integrates clients' R/S in treatment for older adults with anxiety and depression (Armento, et al., unpublished). Since the lead author was interested in studying attitudes, behaviors, perceived feasibility and self-efficacy on the integration of clients' R/S in practice, the instrument was modeled after Parrish and Rubin's Evidence-Based Practice Process Assessment Scale – Short Version (Parrish & Rubin, 2011; Rubin & Parrish, 2010, 2011), which also

measured practitioners' self-efficacy, attitudes, perceived feasibility and implementation of another practice skill - the evidence-based practice process.

To establish content validity and pilot the instrument with practitioners, four phases of scale development were utilized. The first phase consisted of an in-person meeting with 13 members of the 2011-2012 Spirituality Research Group at the Institute for Spirituality and Health in the Texas Medical Center. This group consisted of experts in the areas of religion, spirituality and health, who reviewed and provided feedback in person in March 2012, resulting in a revised version. The second review phase consisted of consultation with experts within the field of behavioral health and R/S, including Kenneth Pargament, Harold Koenig, Dan Blazer, and Michael Parker, to further establish content validity. Each expert received a copy of the revised scale via email and responded with recommended changes to the scale by email, which were then compiled into a second revised version.

Following the initial establishment of content validity, the third review phase involved piloting the instrument with practitioners. The revised version from phase two was then piloted with 12 social work practitioners in person, and one by phone, during November 2012. These 13 practitioners provided feedback on the time it took to complete the instrument, the wording of the items, and the content as it relates to their practice experience. Each recommendation provided by these practitioners was considered and minor edits were made throughout this review phase. As a fourth and final review phase, the coauthors met to discuss the final instrument, and sent any final edits to Kenneth Pargament via email for final content review.

Method

Sample

The University of Houston's Institutional Review Board approved this study. The sampling frame included social work practitioners in the United States who publicly advertised their services through the therapist finder website, HelpPRO (http://www.helppro.com). HelpPRO has partnered with NASW since 2005 (HelpPRO, n.d.) to develop the National Social Worker Finder (www.HelpStartsHere.org) as "the premier resource for referral information about licensed social workers nation-wide" (HelpPRO, n.d.). While other sampling frames were considered for this study, HelpPRO was selected because it was possible to obtain a random sample of social workers across the U.S. with both mail and email addresses, and because other researchers have previously been able to obtain very successful online response rates using this resource (Pignotti & Thyer, 2009). HelpPRO has a "Social Worker Finder Basic Search" option to locate individuals who met the study criteria (Licensed Clinical Social Worker). It also allows site visitors to email the therapist directly through the website, and provides other information, including therapist's professional website, address, problem areas served, populations served, fees, treatment methods, and other optional information provided by the therapist.

One limitation of the search option in HelpPRO was the ability to search only for social workers by zip codes. In order to maximize our chances of a representative sample, 2,000 standard and P.O. Box zip codes were systematically randomly selected from across the United States and entered into the National Social Worker Finder on HelpPRO with a five mile radius. Only individual practitioners were included in the sample; therefore, 137 non-individuals (including group practices, agencies, or schools) were excluded, as it was unknown who would receive the invitations to participate. A total of 1,643 unique individuals were identified; however 261 (15.8%) of these individuals were excluded due to missing a mailing address and/or no email address linked to their profile, and one due to not having a degree in social work. Since

the were planning to utilize sampling methods previously used by Pignotti and Thyer (2009) that resulted in a 52% response rate, 1,000 individuals were randomly selected of the remaining 1,381 eligible for the sampling frame, as a sample of approximately 400 for the proposed analyses was necessary.

Data Collection

Using an adapted version of Dillman, Smyth, and Christian's (2009) survey methods, 1,000 social workers were sent: 1) a pre-invitation email, informing participants about the survey; 2) the initial invitation email with the survey link five days later; 3) a thank you/reminder letter with a $1 token incentive two weeks after the initial invitation; and 4) a final follow-up email two weeks after the letter that included the survey link and a separate link to a question that assessed for non-response bias. Upon completing the instrument, participants were asked to email the lead author, thereby entering to win one of five $50 Target gift cards and being removed from follow-up email contacts.

After sending the pre-invitation email, 152 emails bounced-back and were replaced with a random selection from among the remaining 381 individuals on the list. However, one name was later found to be a duplicate, resulting in an initial sampling frame of 999. From the pre-invitation email, 10 asked to be removed, one was deceased, and one was unable to participate due to technology issues. Since these individuals were not given the survey link, they were removed from the sampling frame and not replaced, reducing the sampling frame to 987. After sending the initial email invitation with the survey link, 27 individuals had the first email invitation and/or final email bounce back, but their letters were not returned to the investigator, suggesting that they may be at the same address but no longer have the same email address or it was delivered to their trash or junk email box. Additionally, 113 individuals had their letter

returned to the investigator, but the email did not bounce back, suggesting they had moved their physical address, but may maintain the same email address. Thus, 140 individuals only received the invitation to participate by either email or mail alone. Twelve individuals were no longer found in HelpPRO by the final email, though it is unknown if they participated in the survey. Three individuals had both invitation emails bounce back and returned letters, meaning they never received any form of invitation to the survey, reducing the sampling frame to 984. Though 832 received both the email and letter and were in HelpPRO throughout the entire study, some may have participated with only receiving one contact. Therefore, the final sampling frame is 984. A total of 482 responded to the survey, including one completing it by mail, yielding a 49% response rate.

Data Analysis

The Statistical Package for Social Sciences (SPSS) 20.0 was used to run descriptive statistics and assess missing data and assumptions for the confirmatory factor analysis (CFA). Cronbach's alpha was used to assess the internal consistency reliability of the scale and each subscale. Criterion validity was assessed by running point-biserial correlations between scale and subscale scores and participants' prior experience taking educational courses as a student (yes/no) or continuing education courses (yes/no) that focused on R/S in practice, as well as their knowledge of any empirically-supported interventions that integrate clients' R/S in practice. Our rationale for this was that if the practitioner had received education on this area, he/she would likely be more favorable to the topic of R/S and practice and score higher on the RSIPAS. Additionally, practitioner religiosity (as measured by religious affiliation, participation in religious or spiritual services, and involvement in personal R/S practices) has been shown to predict practitioners' use of spiritually-based interventions (Kvarfodt & Sheridan, 2009).

Therefore, the Duke University Religious Index, a reliable and valid instrument (Koenig & Büssing, 2010), was added to assess practitioners' frequency of organizational religious activity (ORA) and non-organizational activity (NORA), as well as their degree of intrinsic religiosity (IR). Spearman's rho correlations were run between scale and subscale scores and participants' ORA and NORA. Pearson's r correlations were also run between intrinsic religiosity scores on the DUREL (with higher scores indicating higher intrinsic religiosity) and the overall scale and subscale scores to further assess criterion validity. The results are displayed in Table 1. All correlations were significant, except for the correlation between the Perceived Feasibility with ORA. Intrinsic religiosity had the highest correlations to RSIPAS scores.

Mplus 7.0 (Muthen & Muthen, 2012) was used to run the first-order and second-order hypothesized confirmatory factor analyses. As recommended by Kline (2005), the following goodness of fit indices were used for acceptable levels of fit: χ^2; root mean square error of approximation (RMSEA) with a 90% confidence interval with acceptable values between 0.05 and 0.08; and Comparative Fit Index (CFI) and Tucker-Lewis Index (TLI) values over 0.90; and weighted root mean square residual (WRMR) as close to 1 as possible, though Muthen (2010) suggests the WRMR value is not worth concern if the other fit indices look good.

Results

Sample Characteristics

Sample characteristics and demographics are reported in Table 2. Of the 482 who responded to the survey, 12 cases were removed for not having any RSIPAS scale data, resulting in a sample size of 470. The majority of participants were female (80%) and White (87%). The mean age was 57 years (SD = 11.00), with an average length of practice experience at 23 years (SD = 11.28). Consistent with Canda and Furman's (2010) findings, few practitioners had

received education (either in the form of a course or simply in their field instruction) on integrating clients' R/S in practice, though just under half (45%) reported some prior continuing education on the topic.

Missing Data and Assumptions

Missing data was examined using SPSS 20.0 missing data analysis on the 470 cases for which there was RSIPAS scale data. Missing data for the attitudes, perceived feasibility, and self-efficacy subscales were below the suggested 5% by Tabachnick and Fidell (2007). However, the Behavior subscale had between 5%-5.8% missing data, which is not surprising given its placement at the end of the scale and survey questionnaire. Based on Tabachnick and Fidell's (2007) suggestion, independent t-tests were run to compare those with over 5% missing RSIPAS data and those without missing RSIPAS data, and no significant differences were found. Data were then assessed to determine whether they were missing completely at random (MCAR) or missing at random (MAR) using Little's MCAR test, and indeed, the data was MCAR (X^2 = 2102.02, df = 2066, p = .285). Independent samples t-tests were also run to compare those with and those without any missing data and there were not significant differences with regard to age, length in practice, perceived burnout, or self-identifying as a religious or spiritual person. Chi-square tests of independence also did not identify significant differences between respondents with and without missing data with regard to gender, region, race/ethnicity, religious affiliation, whether the respondent had taken prior courses on R/S in their MSW program, or attended continuing education workshops, and whether the respondent was aware of any empirically supported interventions that integrate clients' R/S. A difference was detected between those with a master's degree and those with a doctorate (X^2 = 5.56, df = 1, p = .02), indicating more practitioners with a doctorate skipped at least one item in the RSIPAS. Masters and doctoral

level practitioners were then compared regarding missing entire subscales, and no differences were found. Chi square tests of independence were also run with ethnicity, religious affiliation, and highest education degree, and there was no difference; however, the assumption of having at least 5 expected frequencies in each category was violated. Missing data were handled using the Mplus Weighted Least Squares with Robust Estimates approach (Asparouhov & Muthen, 2007), given its ability to generate model modification indices for incomplete data files.

Univariate normality was assessed using frequency distributions, histograms, and the skewness and kurtosis indices (Abu-Bader, 2010; Tabachnick & Fidell, 2007). After reverse scoring ATT5, ATT9, ATT14, FEAS3, and FEAS4, all subscale items were negatively skewed, except for a few of the Behavior items, which approached violating the assumption of normality. A reflected logarithm transformation was used to reduce issues of skewness and kurtosis to test for reliability in SPSS (Abu-Bader, 2010; Tabachnick & Fidell, 2007). Despite these issues with normality, the weighted least squares means and variance adjusted (WLSMV) approach in Mplus was used, which is robust in dealing with any potential issues of non-normality in the data. The assumption of linearity was tested using bivariate scatter plots, and was adequately met.

Confirmatory Factor Analysis

A confirmatory factor analysis (CFA) was conducted in Mplus to test the proposed model's validity, and identify whether or not slight adjustments to the instrument were needed for future studies.

First Hypothesized Model: Baseline CFA Model. The baseline model is displayed in Figure 1. This model tested whether responses to the RSIPAS can be explained by four factors that measure self-efficacy, attitudes, perceived feasibility, and behaviors. Item loadings that were less than fair, falling below .45 (Comrey & Lee, 1992) were considered for deletion. Upon

running the initial CFA, Attitude item 9 (ATT9) had a loading of .39, and Behavior item 9 (BEH9) had a loading of .40, warranting deletion. The resulting baseline model had adequate fit and can be found in Table 3.

Second Model: Final CFA Model. Modification indices were then examined in the original baseline model to see if any theoretically based adjustments could be made to improve the model, which is displayed in Figure 2. Modification indices (MIs) suggested correlating ATT10 and ATT5's error terms, which resulted in the item loading for ATT5 dropping to .39. As such, ATT5 was removed from the model. Additionally, 10 error term correlations were added to similarly worded items [e.g., ATT7 (Attending to clients' religious/spiritual needs is consistent with the principles of meeting the client where he/she is at.) and ATT11 (Attending to clients' religious/spiritual beliefs is consistent with my profession's code of ethics)] with high MIs. These include: FEAS1 with FEAS2, FEAS1 with FEAS4, ATT2 with ATT4, ATT3 with ATT4, ATT6 with ATT14, ATT 7 with ATT11, BEH1 with BEH2, BEH2 with BEH3, BEH3 with BEH5, and SE10 with SE7.

Second Hypothesized Model: Second Order CFA Model. The second hypothesized model tested whether an overarching, second-order construct (orientation toward religious/spiritually integrated practice) existed after establishing the first four-factor model of the RSIPAS. The final CFA model, displayed in Figure 3, was used to test this hypothesis. The second hypothesized model also had adequate fit and improvement in fit from the final CFA model (described in Table 3): $\chi^2 diff$ (2, N=470) = 100.83, p <.001

Factor Loadings and Correlations. As mentioned above, items with standardized factor loadings that fell below .45, which is considered a fair factor loading (Comrey & Lee, 1992), were examined and deleted. The standardized factor loadings of the remaining 40 items in the

final model, which is the suggested model for future studies, were good to excellent, except for three items that were considered fair (.45 - .54). Twenty-six of the 40 items were considered excellent, loading above .71 (Comrey & Lee, 1992). The four subscale standardized factor loadings in Mplus were excellent, ranging from .87 to .92, supporting the scale's convergent validity (Kline, 2005). Additionally, the four subscale correlations were inspected using Mplus and ranged between .73 and .83, supporting the scale's discriminant validity by not being excessively high (>.85; Kline, 2005), except for one correlation. Self-Efficacy and Feasibility had a slightly higher correlation of .88, and were further explored for what percent of the variance was unique. Kline's (2005) suggestion of .85 would mean 28% unique variance not explained by the other latent variable. With a correlation of .88, 23% of the explained variance is unique to each variable. Due to the slight 5% difference between the suggested correlation cutoff and this correlation, the 23% unique variance still present between Self-Efficacy and Feasibility, and the theoretical development of the two constructs, the two latent variables were kept.

Reliability and Item Analysis. Internal consistency for the revised model was assessed in SPSS 20.0, using Cronbach's α on the final sample that excluded missing data by listwise deletion. Cronbach's α for the 40-item scale was .95, which is considered excellent (Kline, 2005). As shown in Table 4 Cronbach's α for the subscales ranged from .84 to .91, which is considered very good to excellent (Kline, 2005). The 5-point Likert scale was converted to a 1-5 score, with Strongly Disagree (or Never in the Behaviors subscale) = 1 and Strongly Agree (or Very Often in the Behaviors subscale) = 5. Items within the 40-item scale that require reverse scoring prior to summing each subscale include ATT14, FEAS3, and FEAS4.

Factor scores for the four subscales and the overall scale were also calculated in Mplus to check if scoring is consistent, by checking the correlation between the Mplus scores with scores

in SPSS. The four subscale factor scores and overall scale score all correlated above .95 ($p < .01$), suggesting that factor scores may be estimated by simply summing subscale's items for the subscale scores, and summing the four subscales to obtain the overall scale score.

The 40-item scale mean was 153.53 (SD=21.05), suggesting a higher mean (3.83) than the mid-point of 3 on a 1-5 Likert scale. The final CFA model's coefficient α, mean score, and standard deviation (SD) for each subscale and the overall scale are located in Table 4.

Discussion

The purpose of this study was to develop a valid instrument to measure social work practitioners' attitudes, behaviors, perceived feasibility, and self-efficacy regarding integrating clients' R/S in practice. The findings from this study supported the reliability, content validity, criterion validity, and factorial/construct validity of the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS). The internal consistency of the final model was .95, which is considered excellent. The confirmatory factor analyses for both the first and second-order analyses had adequate fit, supporting the factorial validity of each subscale and the overarching scale construct of overall orientation to integrating clients' R/S in practice.

Overall, these findings suggest the RSIPAS is ready for distribution and use with social work practitioners. The initial 43 items included in the original hypothesized model are presented in Appendix A; however, for future studies, it is recommend that the 40 items in the final CFA model be used (also noted in Appendix A). The authors freely grant permission for the use of this instrument to conduct surveys of social work practitioners concerning their views of and current integration of clients' R/S in practice. Specifically, mental health services organizations could use the RSIPAS to assess their social work practitioners' views and implementation of clients' R/S in practice, and identify potential training needs among their employees. Additionally, given

that CSWE includes religion and spirituality within its Educational Policy Accreditation Standards (2008), social work educators may be interested in identifying the degree with which their students are developing self-efficacy and openness to assessing and considering clients' religious and spiritual preferences. Educators may also want to evaluate how their alumni's responses to the RSIPAS change post-graduation, and possibly what contributes to such change. In addition, social work programs may consider using the RSIPAS to assess their field instructors' orientation toward integrating clients' R/S in practice, as field education is the signature pedagogy in social work and serves as an important training ground for learning these important skills (CSWE, 2008). The RSIPAS can also be used to evaluate continuing education training efforts to provide additional training on religious and spiritual issues in direct practice, with a specific focus on increasing self-efficacy, feasibility and the use of research-supported techniques and interventions.

Though this study has a number of strengths, there are also limitations. While the results suggest this scale is supported by an adequate model, future validation studies should be conducted to assess whether the revised scale results in a better fit in a new sample. In addition, though the sample largely reflects that of licensed social workers in the United States by being predominantly older, female and White, (Center for Health Workforce Studies, 2006), there are potential questions regarding its psychometric validity with samples that may not reflect these primary demographics. For example, recent studies suggest that younger individuals are less likely to identify as religious or to see R/S as important and may respond differently to the RSIPAS (PEW Forum on Religion & Public Life, 2008, 2010). There is also some evidence of a gender divide, with males generally less likely to identify with a religious tradition (PEW Forum on Religion & Public Life, 2008). At the same time, individuals from minority backgrounds,

especially those from more traditional cultural backgrounds (e.g., Hispanics, African Americans) continue to state that R/S is more important to them than Whites (PEW Forum on Religion & Public Life, 2008). As such, it would be important to validate the RSIPAS with samples that include younger and more diverse respondents, as well as social work students, to determine whether the psychometric properties of the scale hold.

This study provides a validated instrument for use in assessing social work practitioners' self-efficacy with, attitudes toward, perceived feasibility of, and actual integration of their client's religious and spiritual beliefs in practice. The authors hope that this scale will be used widely to support educational and training efforts to increase the social work profession's competence and comfort in addressing this important cultural issue. Additionally, the authors hope that those who use this scale will contribute to the literature by sharing their results regarding the validity of this instrument.

Appendix A: Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS)

(Authors' Note: Items with an R after the number were reverse scored, including ATT5, ATT9, ATT14, FEAS3, and FEAS4. For future administration of the RSIPAS, the following items should be removed: Attitude 5, 9, and Behavior 9.)

Purpose: The purpose of this scale is to assess your familiarity with and views about integrating clients' religion and spirituality into clinical practice, which is also called religious/spiritually integrated practice.

Definitions to guide interpretation of scale items (Please read):

1. *Religion* is "a systematic set of beliefs and practices observed by a community, supported by rituals that acknowledge, worship, or communicate with the Divine and usually relies on a set of scriptures, teachings, and offers a moral code of conduct" (Koenig, 2008).

2. Spirituality is "the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and formation of community" (Koenig, et al, 2000).

In addition, while religion and spirituality have two distinct definitions (as shown above), the two terms are commonly used interchangeably to describe an important area in many people's lives. For the purpose of this scale, please consider the terms religion and spirituality as interchangeable as you respond to the items.

Instructions: The scale contains four sections. Please follow the instructions under each section.

Religious/Spiritually-integrated practice has not been widely disseminated in many clinical training programs. Therefore, like many other practitioners, you may know little about this concept. Nevertheless, please answer all items to the best of your ability, even if you are unsure of your answer, have no opinion, or have had little to no experience with this in practice.

All responses are anonymous; please answer each item according to how you really view religious/spiritually integrated practice. Thank you!

Section I. Self-Efficacy with Religious/Spiritually Integrated Practice

Please indicate the response to the right that best fits how much you agree or disagree with the statements regarding religious/spiritually integrated practice.

[Level of Agreement and scoring: Strongly Disagree (SD) = 1, Disagree (D) = 2, Neutral (N) = 3, Agree (A) = 4, Strongly Agree (SA) = 5)

1. I know how to skillfully gather a history from my clients about their religious/spiritual beliefs and practices.
2. I am able to recognize when my clients are experiencing religious/spiritual struggles. (e.g. tension or conflict with his/her Higher Power, religious/spiritual community, spiritual beliefs, etc.)
3. I know what to do if my client brings up thoughts of being possessed by Satan or the Devil.
4. I consider the unique needs of diverse clients with different religious/spiritual backgrounds in my practice

5. I am able to recognize when my clients utilize positive religious/spiritual coping strategies. (e.g. trying to find a spiritual lesson in the presenting issue, etc.)
6. I am able to ensure my clients have access to religious/spiritual resources if they see this as an important aspect to their healing process. (e.g. religious/spiritual reading materials, pastoral counseling, contact information to local clergy, or a prayer room/place of worship).
7. I feel as though I have the skills to discuss my clients' religious/spiritual strengths.
8. I feel confident in my ability to integrate my clients' religious/spiritual beliefs into their treatment.
9. I know when it is beneficial to refer my client to pastoral or religious counseling.
10. I feel as though I have the skills to discuss my clients' religious/spiritual struggles.
11. I am able to recognize when my clients utilize negative religious/spiritual coping strategies. (e.g. viewing the presenting issue as punishment from his/her Higher Power, etc.)
12. I know what to do when my client has religious/spiritual beliefs that I am unfamiliar with.
13. I am comfortable discussing my clients' religious/spiritual struggles in therapy.

Section II. Attitudes About Religious/Spiritually Integrated Practice
Please indicate the response to the right that best fits how much you agree or disagree with the statements regarding religious/spiritually integrated practice.
[Level of Agreement and scoring: Strongly Disagree (SD) = 1, Disagree (D) = 2, Neutral (N) = 3, Agree (A) = 4, Strongly Agree (SA) = 5)

1. It is essential to assess clients' religious/spiritual beliefs in practice.
2. Integrating clients' religious/spiritual needs during treatment helps improve client outcomes.
3. Practitioners who take time to understand their clients' religious/spiritual beliefs show greater concern for client well-being than practitioners who do not take time to understand their clients' religious/spiritual beliefs.
4. Integrating clients' religious/spiritual beliefs in treatment helps clients meet their goals.
5. (R) Referring my clients to religious or pastoral counseling is harmful.
6. I am open to learning about my clients' religious/spiritual beliefs that may differ from mine.
7. Attending to clients' religious/spiritual needs is consistent with the principles of meeting the client where he/she is at.
8. Sensitivity to clients' religious/spiritual beliefs will improve one's practice.
9. (R) Clients' religious/spiritual beliefs are not an important part of their culture.
10. I am open to referring my clients to religious or pastoral counseling.
11. Attending to clients' religious/spiritual beliefs is consistent with my profession's code of ethics.
12. Empirically-supported religious/spiritually integrated therapies are relevant to my practice.
13. There is a religious/spiritual dimension to the work I do.
14. (R) I refuse to work within my clients' religious/spiritual belief system if it differs from my own.

Section III. Feasibility for You to Engage in Religious/Spiritually Integrated Practice
Please indicate the response to the right that best fits how much you agree or disagree with the statements regarding religious/spiritually integrated practice.
[Level of Agreement and scoring: Strongly Disagree (SD) = 1, Disagree (D) = 2, Neutral (N) = 3, Agree (A) = 4, Strongly Agree (SA) = 5)

1. I have enough time to assess my clients' religious/spiritual background.
2. I have enough time to identify potential strengths or struggles related to my clients' religion/spirituality.
3. (R) My primary practice setting does not support the integration of religion/spirituality into practice.
4. (R) I don't have enough time to think about incorporating a religious/spiritually integrated approach to practice.
5. Given the many issues that must be addressed in treatment, I still find time to integrate my clients' religion/spirituality if they communicate a preference for this.
6. I have been adequately trained to integrate my clients' religion/spirituality into therapy.

Section IV. How Often Do You Currently Engage in Religious/Spiritually Integrated Practice?
For this section, please indicate the response that best fits the *frequency* with which you currently engage in religious/spiritually integrated practice.
[Frequency and scoring: Never (1) = 1, Rarely (2) = 2, Some of the time (3) = 3, Often (4) = 4, Very Often (5) = 5)

1. I seek out consultation on how to address clients' religious/spiritual issues in treatment.
2. I read about ways to integrate clients' religion/spirituality to guide my practice decisions.
3. I read about research evidence on religion/spirituality and its relationship to health to guide my practice decisions.
4. I involve clients in deciding whether their religious/spiritual beliefs should be integrated into our work together.
5. I use empirically supported interventions that specifically outline how to integrate my clients' religion/spirituality into treatment.
6. I conduct a full biopsychosocial*spiritual* assessment with each of my clients.
7. I link clients with religious/spiritual resources when it may potentially help them (e.g. religious/spiritual reading materials, contact information to local clergy, or a prayer room/place of worship).
8. I help clients consider ways their religious/spiritual support systems may be helpful.
9. I help clients consider ways their religious/spiritual support systems may be harmful.
10. I help clients consider the religious/spiritual meaning and purpose of their current life situations

Table 1. Relationships Between Amount of Prior Training or Education in R/S Integrated Practice, Practitioner Religiosity, and Summated Scores on the Final CFA Model of the RSIPAS and its Subscales

	Overall Scale Score (all subscales) (N)	Self-Efficacy (N)	Attitudes (N)	Feasibility (N)	Behaviors (N)
Any courses taken as a student that focused primarily on integrating R/S in practice? (Yes or No)[a]	.18** (391)	.15** (424)	.14* (435)	.10* (445)	.19** (428)
Any prior continuing education on integrating R/S in practice? (Yes or No)[a]	.39** (391)	.33** (424)	.25** (435)	.24** (445)	.42** (428)
Knowledge of any empirically-supported treatments on integrating clients' R/S in practice? (Yes or No)[a]	.31** (388)	.27** (421)	.24** (432)	.16** (442)	.33* (425)
How often do you attend church of other religious meetings? (ORA)[b]	.21** (446)	.18** (446)	.23** (446)	.09 (p=.07) (446)	.20** (446)
How often do you spend time in private religious activities, such as prayer, meditation or Bible study? (NORA)[b]	.42** (449)	.35** (449)	.39** (449)	.31** (449)	.42** (449)
DUREL Intrinsic Religiosity Subscale[c]	.46** (443)	.40** (443)	.42** (443)	.31** (443)	.43** (443)

* p values are significant at the .05 level; ** p values are significant at the .01 level
[a] Point-biseral coefficient; [b] Spearman's rho correlation; [c] Pearson's r correlation

Table 2. Sample Characteristics and Background Variables for Sample (N=470*)

	M	*SD*
Age (n=464)	56.62	11.00
Years of Practice Experience (n=449)	23.03	11.28
	n	*%*
Gender (n=465)		
Female	371	(79.8)
Male	94	(20.2)
Ethnicity (n=464)		
Caucasian	405	(87.3)
African American	17	(3.7)
Hispanic	19	(4.1)
Asian/Pacific Islander	9	(1.9)
American Indian/Alaskan Native	3	(0.6)
Other	11	(2.4)
Region (n=462)		
Northeast	179	(38.7)
Midwest	84	(18.2)
South	107	(23.2)
West	92	(19.9)
Prior Continuing Education on R/S Integrated Practice (n=451)		
Yes	203	(45.0)
Prior Courses on R/S Integrated Practice (n=451)		
Yes – Course	55	(12.2)
Field Education Only	121	(26.8)
Self-Reported Knowledge on R/S Integrated Practice ESTs (n=448)		
Yes	91	(20.3)

*Note: 12 cases from the original sample were deleted for not having any RSIPAS data

Table 3. Summary of CFA Fit Results

Model	Items	*df*	χ^2	p	χ^2/df	RMSEA [90% CI]	CFI	TLI
Baseline CFA	41	773	3,489.76	0.00	4.51	.086 [.084 .089]	0.90	0.89
Final CFA Model	40	724	2,653.06	0.00	3.66	.075 [.072 .078]	0.93	0.92
Second Order CFA	40	726	2,753.89	0.00	3.79	.077 [.074 .080]	0.92	0.92

Note: RMSEA = root mean square error of approximation; CI = confidence interval; CFI = comparative fit index; TLI = Tucker-Lewis index

Table 4. Coefficient α, Mean Score, and Standard Deviation for Entire Scale and Each Subscale (Based on Final 40-Item CFA)

Scale (Number of Items, N)	Coefficient α	Mean Score	SD
Entire Scale (40, 393)	0.95	153.53	21.05
Self-Efficacy with religious/spiritually integrated practice (13, 439)	0.91	52.92	7.28
Attitudes toward religious/spiritually integrated practice (12, 445)	0.88	48.07	6.65
Feasibility to integrate clients' religion/spirituality in practice (6, 454)	0.84	24.05	3.73
Frequency of engaging in religious/spiritually integrated practice (9, 437)	0.87	28.10	6.67

Figure 1. Baseline Hypothesized First-Order Model (includes standardized loadings)

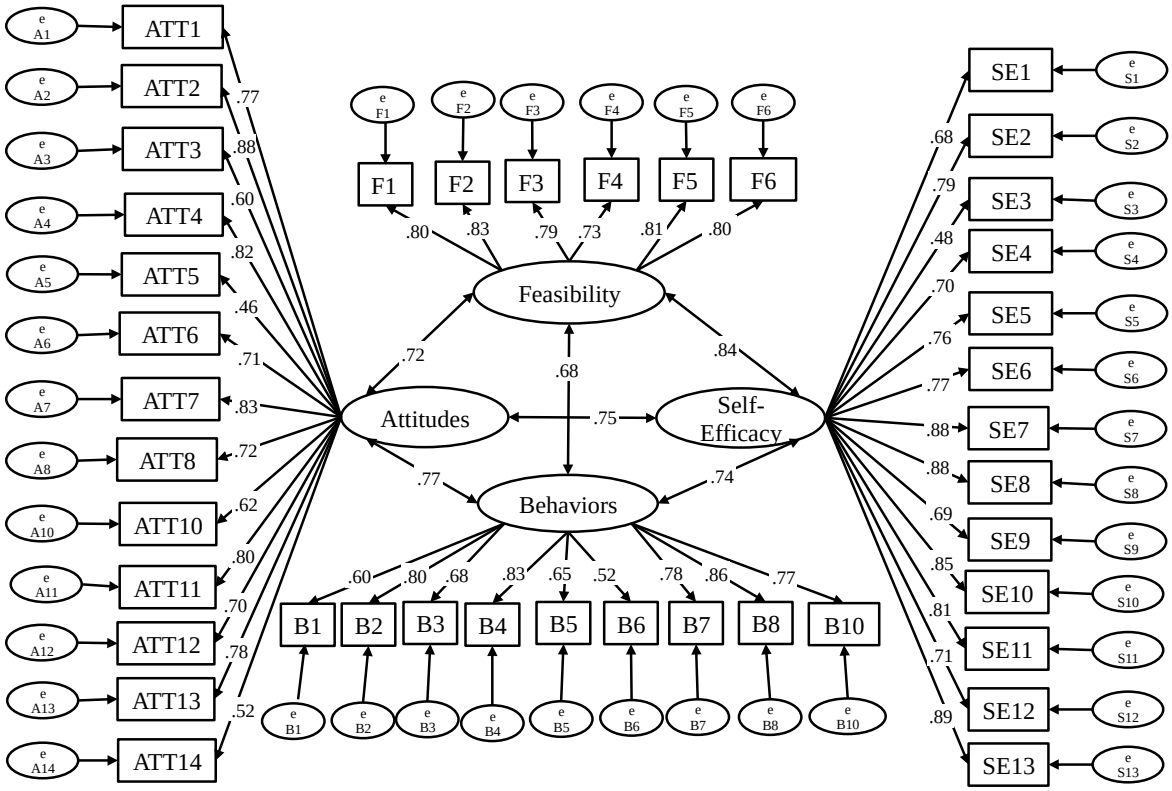


Figure 2. Final First-Order Model (includes standardized loadings)

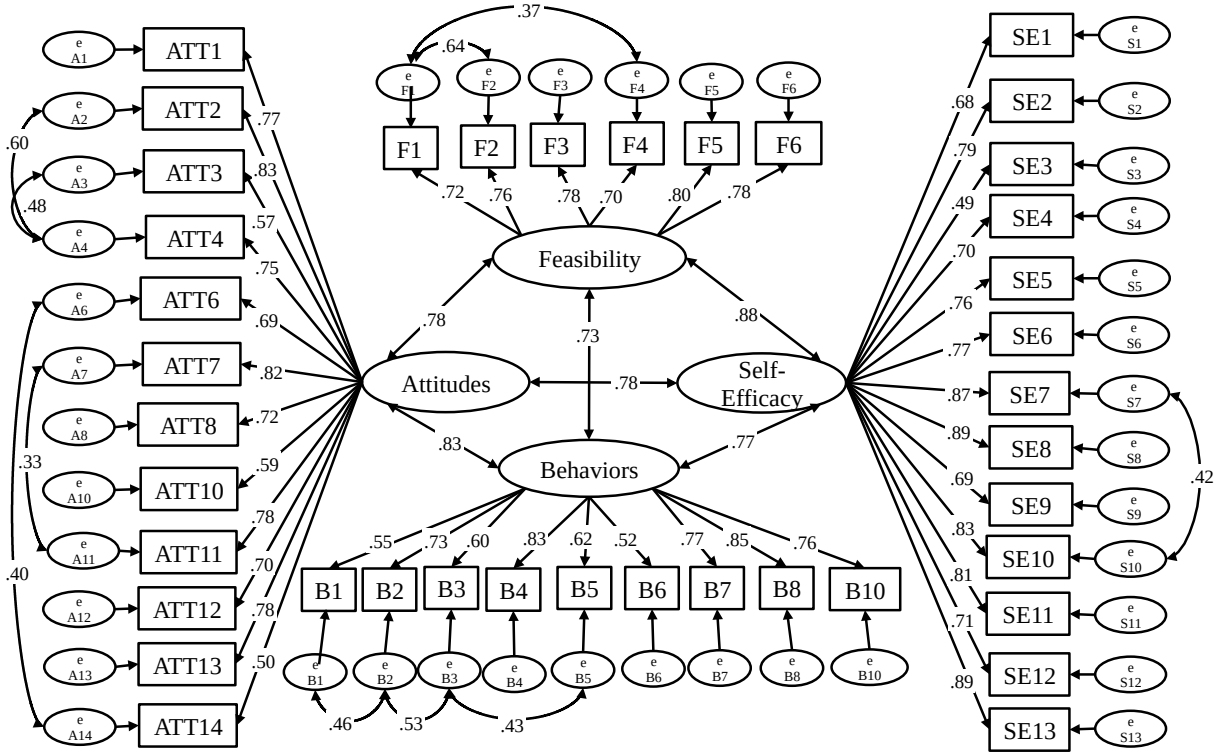
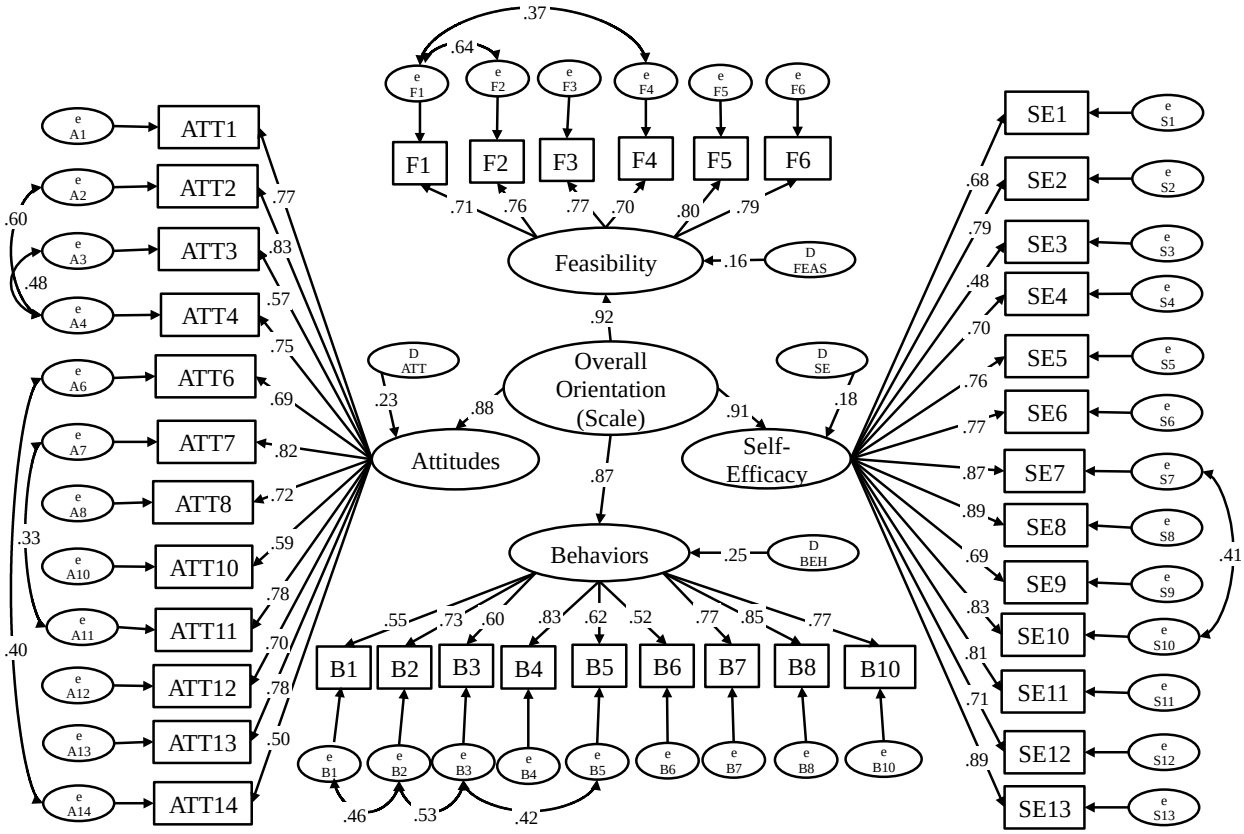


Figure 3. Hypothesized and Final Second-Order Model (includes standardized loadings)



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Chapter Four: Article 3

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Holly Kay Oxhandler, MSW, PhD Candidate, contributed to the conception and design of the project, acquisition of data, and the analysis and interpretation of the data. She drafted the article, worked with the team on revisions, and gave final approval of the version to be published.

Danielle Parrish, PhD, Dissertation Chair, contributed to the conception and design of the project and the analysis and interpretation of the data. She provided critical revisions and gave final approval of the version to be published.

Luis R. Torres, PhD, Dissertation Committee Member, contributed to the conception and design of the project, provided critical revisions, and gave final approval of the version to be published.

W. Andrew Achenbaum, PhD, Dissertation Committee Member, contributed to the conception and design of the project, provided critical revisions, and gave final approval of the version to be published.

Walking the Talk: Do LCSWs Integrate Clients' Religion/Spirituality in Practice?

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Abstract

This article describes the results of a cross-sectional study of Licensed Clinical Social Workers' (LCSWs) views and behaviors related to integrating clients' religion and spirituality in clinical practice. A total of 442 LCSWs from across the United States who advertised their services on the Internet anonymously responded to an online administration of the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS). The results indicate LCSWs have positive attitudes, high levels of self-efficacy, and perceive such integration as feasible, but report low levels of engagement in integrating clients' religious/spiritual beliefs into practice. Moreover, two variables emerged as significant predictors for LCSWs' overall orientation toward integrating clients' religion/spirituality in practice: practitioners' intrinsic religiosity and prior training (prior course or continuing education). Implications and next steps for social work education and continuing training efforts are discussed.

Walking the Talk: Do LCSWs Integrate Clients' Religion/Spirituality in Practice?

A client walks in your office for her first visit after being referred by a concerned friend. Conflicted about leaving her abusive husband, she states she cannot wait a year to have an annulment, and is afraid she will never again be able to marry in her church. After that session, the next client comes in with Major Depression. When asked how he is coping with his negative thoughts, he says he attends synagogue weekly and prays often, but wonders if God has abandoned him. Your last client of the day is an older woman who constantly suffers from anxiety. When asked about how she manages her symptoms, she says lately she has been reading books on Buddhism and has found meditation to be helpful.

Social workers address a variety of issues in clinical practice such as addiction, marital and family, aging, disability, legal issues, trauma, child welfare, LGBTQ, and school social work. However, clients' religion and spirituality (R/S) is typically relegated to a small aspect of client culture, if considered at all. Yet the scenarios described above are common, and research has shown attending to clients' R/S can positively impact outcomes across a variety of health and behavioral health issues (Koenig, McCullough, & Larson, 2001; Koenig, King & Carson, 2012). Moreover, most Americans consider religion as at least somewhat important (PEW Forum on Religion & Public Life, 2012), and *prefer* their R/S beliefs be discussed in treatment (Koenig, 2005; Leitz & Hodge, 2013; Rose, Westefeld, & Ansley, 2001; Stanley, et al., 2011; Tepper, Rogers, Coleman, & Maloney, 2001; Weld & Erickson, 2007). With social workers comprising the largest proportion of mental health workers in the United States (SAMHSA, 2010), it is imperative they be equipped to assess, respect and address clients' R/S issues and concerns.

Unfortunately, few social workers have been trained on the assessment and integration clients' R/S in practice (Canda & Furman, 2010). Much of this is due to the profession's move

toward the medical model from the 1920s to 1970s. Also, with little research on R/S in practice, discussion of R/S in the classroom and clinical practice was removed (Marshall, 1991; Russel, 1998; Canda & Furman, 2010). An added fear of proselytizing in practice exists, with social workers concerned their professional role may influence clients' R/S beliefs (Sherr, Singletary, & Rogers, 2009). In most schools of social work, issues concerning R/S are taught as a small part of cultural diversity, and often not addressed in depth (Hodge & Derezotes, 2008). When addressed, discussions of R/S are often stifled by varied educator perspectives, comfort levels with the topic, and occasionally, religious discrimination (Thyer & Myers, 2009). This likely leaves many social work graduates unprepared to address the challenging cases described above.

The Council on Social Work Education's (CSWE) Educational Policy Accreditation Standards (EPAS, 2008) support R/S content by: 1) encouraging diversity within the learning environment; 2) acknowledging diversity (and self-awareness) within the learning process, 3) understanding spiritual development and the person within the environment, and 4) advising that ethical principles guide practice decisions while managing personal values. Additionally, the National Association of Social Workers' (NASW) Code of Ethics (2008) mandates practitioners to attend to clients' R/S by respecting diversity, avoiding discrimination, and practicing competently, whether they received training on the matter or not.

Despite the lack of widespread or consistent education on this topic, there are some encouraging recent developments. For example, some educators have suggested the need for a course solely focused on R/S in practice (Canda & Furman, 2010; Hodge & Derezotes, 2008) and recently, a CSWE Religion and Spirituality Clearinghouse emerged to disseminate teaching materials on this topic (Sherr, Land, Canda, Husain, & Sheridan, 2011). Additionally, there has been an increase in social work programs offering a course on R/S in practice since 1998 (Canda,

2005; Russel, 1998). While this is encouraging, the quality or effectiveness of these courses is unknown, and few efforts have been made to reach current practitioners in real practice settings.

Another encouraging trend is the emergence of empirically-supported interventions designed to integrate clients' R/S into treatment. For example, Rosmarin and colleagues' (2010) internet-based, spiritually-integrated treatment lowered stress, worry, depression, and intolerance to uncertainty. Other methods of integration include standardized assessments, such as the FICA Spiritual History (Puchalski & Romer, 2000) or CSI-MEMO (Koenig, 2002), or research-supported, spiritually-oriented psychotherapies (Smith, Bartz, & Richard, 2007). However, like other empirically-supported treatments, the degree to which such interventions are adopted with fidelity and competence among social workers when integrating clients' R/S is uncertain.

Prior assessments of social workers' integration of R/S examined attitudes and use of specific R/S practices, such as praying with a client or touching a client for healing purposes (Canda & Furman, 1999, 2010; Sheridan, Bullis, Adcock, Berlin, & Miller, 1992). However, a broader perspective is necessary to understand their views and behaviors, such as perceived feasibility and self-efficacy in addressing these complex client issues (Oxhandler and Pargament, in press). Feasibility is particularly important when assessing the translation of practice skills into real practice settings (Parrish & Rubin, 2011; Rubin & Parrish, 2010). For example, time constraints or agency policies may affect practitioners' perceived feasibility of integrating R/S (Oxhandler & Parrish, under review). Self-efficacy has also been identified as a factor that impacts social workers' practice behaviors (Parrish & Rubin, 2011; Rubin & Parrish, 2010), but has not yet been explored with R/S in practice. Bandura describes self-efficacy's influence on behaviors, noting "people fear and tend to avoid threatening situations they believe exceed their coping skills, whereas they get involved in activities and behave assuredly when they judge

themselves capable of handling situations that would otherwise be intimidating" (1977, p. 194). Considering few social workers have been trained on R/S in practice (Canda & Furman, 1999, 2010; Sheridan, et al., 1992), practitioners' self-efficacy is worth exploring. Finally, though inconsistent across studies, characteristics that predict social workers' use of R/S practices with clients include demographic variables (age, race, mental illness), client characteristics, prior training, theoretical orientation, attitudes, and personal religiosity (participation in R/S services, private R/S practices, or religious affiliation) (Kvarfordt & Sheridan, 2009; Sheridan, 2009).

Prior studies have improved our understanding of social workers' attitudes and use of specific R/S practices with clients. However, research is needed to explore practitioners' self-efficacy and perceived feasibility with assessing and integrating clients' R/S in practice, as well as implementing empirically-supported interventions and culturally sensitive R/S techniques in real practice settings. To address these gaps, we conducted a national survey of Licensed Clinical Social Workers (LCSWs) to answer the following: 1) What are the attitudes, behaviors, self-efficacy, and perceived feasibility concerning the integration of clients' religion/spirituality into practice among Licensed Clinical Social Work practitioners?; and 2) Are there any significant relationships between various practitioner background characteristics and RSIPAS variables?

Method

Sample

The University of Houston's Committee for the Protection of Human Subjects approved this study. The sampling frame included a national sample of LCSWs with public profiles on HelpPRO (www.helppro.com). HelpPRO has partnered with NASW (HelpPRO, n.d.) to develop the National Social Worker Finder, a referral resource for social workers. HelpPRO was selected

for the ability to contact a national sample of LCSWs via mail and email, its NASW affiliation, and because others have obtained high response rates using this site (Pignotti & Thyer, 2009).

One limitation of HelpPRO's search option is the inability to identify social workers without searching by zip code. Based on Pignotti and Thyer's (2009) methods, 2,000 U.S. zip codes were systematically randomly selected to maximize our chances of a representative sample. Each zip code was entered into HelpPRO's National Social Worker Finder with a five-mile radius search. Only individual social work practitioners were included in the sampling frame. Group practices, agencies, and schools were excluded, as well as those without a social work degree, or without an email option and mailing address. Since Pignotti and Thyer's (2009) sampling resulted in a 52% response rate and the need for approximately 400 respondents was anticipated, 1,000 individuals were randomly selected from the remaining 1,381 eligible.

Data Collection

Dillman, Smyth, and Christian's (2009) survey methods were utilized, including a pre-invitation email, an initial invitation email with a SurveyMonkey® link, a mailed letter with the survey link and $1 token incentive, and a follow-up email with the survey link and a link to assess non-response reasons. Each contact described the study, assured anonymity, and provided IRB information. The sampling frame of 1,000 was reduced to 984 as three individuals had both returned letters and bounce-back emails, 11 asked to be removed before the initial invitation, one was repeated on the list, and one passed away. A total of 482 responded to the survey, yielding a 49% response rate. The final sample includes 442 LCSWs who completed all survey items.

The first page of the online survey included purpose, consent procedures, and definitions of religion and spirituality. The online questionnaire included the Religious/Spiritually Integrated Practice Assessment Scale (Oxhandler & Parrish, under review), 26 background items, and two

open-ended items. Background questions included demographics, items utilized in prior studies of practitioners (Parrish & Rubin, 2011), the Duke University Religion Index (DUREL; Koenig & Büssing, 2010), one item assessing burnout (Rohland, Kruse, & Rohrer, 2004), and two R/S items from the General Social Survey (Smith, Hout, & Marsden, 2013). The RSIPAS consists of 40 items and four subscales: 1) Self-Efficacy with Regard to Integrating Clients' R/S in Practice (α=.91), 2) Attitudes Toward Integrating Clients' R/S in Practice (α=.88), 3) Perceived Feasibility to Engage in R/S Integrated Practice (α=.84), and 4) Behaviors Related to Integrating Clients' R/S in Practice (α=.87). The RSIPAS has excellent reliability (α=.95), and established content, criterion, construct, discriminant, and factorial validity (Oxhandler & Parrish, under review).

Data Analysis

The Statistical Package for Social Sciences (SPSS) 20.0 was used to check assumptions and run descriptive analyses and the multiple regression analysis. To provide more meaningful descriptions of the scale items, Likert responses were collapsed into three categories: Strongly Disagree/Disagree; Neutral; Agree/Strongly Agree (for Attitudes, Self-Efficacy, and Feasibility subscales), and Never/Rarely; Some of the time; Often/Very Often (for the Behaviors subscale).

Bivariate and multivariate analyses were conducted to identify background variables associated with LCSWs' integration of R/S in practice, as measured by their RSIPAS scale score. Continuous independent variables included: age, years in clinical practice, and the DUREL intrinsic religiosity scale. Dichotomous independent variables included: gender, region (South, West, Midwest, Northeast), race (coded *White* and *non-White* due to few non-White LCSWs), age of most clients (coded *29 and younger* and *30 and older*, as Americans under 30 are often less religious than older Americans [PEW Forum on Religion & Public Life, 2010]), DUREL

Organized Religious Activities (frequency of attending church or religious meetings, coded *Never/Rarely* and *At least a few times a month*), Non-Organized Religious Activities (frequency of private religious activities, such as prayer, meditation, or Bible study, coded *Never/Rarely* and *At least once a week*) and whether or not the LCSW had prior training on R/S in practice.

Missing Data and Assumptions

Missing data was found to be missing completely at random and not differing across demographic items between those with and without missing data. Since less than a third of data was missing for individuals or subscales utilized when calculating scale scores, missing values were replaced for regression analyses using mean imputation. Univariate normality and linearity assumptions were assessed and met for the RSIPAS overall and subscale scores. A baseline regression was run to inspect the Durbin-Watson statistic for independence of error and multicollinearity through collinearity diagnostics, and neither was problematic. Univariate outliers were explored with the studentized residuals, influential cases were identified using Cook's distance, and multivariate outliers were identified and removed if the probability for Mahalanobis D^2 was significant at .001 (Tabachnick & Fidell, 2007). After listwise deletion of cases with missing background variables, the sample size for the regression analysis was 408.

Results

Sample characteristics and demographics are reported in Table 1. Most respondents were female (79%) and White (89%), with a mean age of 57 years. These demographics closely reflect NASW's licensed social workers in the United States (81% female, 85% White, and 57% between 45-64 years old) (Center for Health Workforce Studies, 2006). Our sample had more practice experience, with 61% having over 20 years compared to 32% of NASW members, likely because NASW includes BSW and MSW-level practitioners before obtaining an LCSW. The

majority of our sample was in solo private practice (76%), addressing mental health issues (84%) with most clients 30-45 years old (54%). Regarding prior training, 13% took a course on R/S in practice, 26% received content only in their field education, and 46% have sought continuing education on the topic. Finally, 35% of LCSWs consider themselves moderately/very religious and 82% moderately/very spiritual. Many also personally use R/S practices, such as meditation (57%), prayer (46%), and yoga or some other form of physical practice (38%) (Table 2).

Table 3 provides the responses to all RSIPAS items. Self-efficacy was generally high, with LCSWs feeling efficacious across R/S practice situations (61% - 96%). Similarly, most reported favorable views across attitudes items (56% - 98% agree or disagree in the appropriate direction), with the exception of item 12 (44%). Perceived feasibility was also high, ranging from 82% to 89%, with the exception of item 6 (53%), which assessed being adequately trained to integrate clients' R/S into therapy. However, fewer respondents reported integrating clients' R/S across various practice behaviors, with the three most frequent behaviors including helping clients identify ways their religious/spiritual support systems may be helpful (64%), involving clients in deciding whether religious/spiritual beliefs should be integrated (59%), and conducting a full biopsychosocialspiritual assessment (57%).

The second research question examined the association between practitioner background characteristics and their overall orientation toward integrating clients' R/S in practice. There were no significant bivariate relationships between the overall RSIPAS score and LCSWs' gender, race, age, region, age of clients served, degree of burnout, or years in practice. The only variables significantly related with the overall RSIPAS score at the bivariate level for inclusion in the regression were religiosity (DUREL) items and prior training (continuing education or a course) on integrating clients' R/S in practice. Of the DUREL subscales, intrinsic religiosity was

selected for the regression model, since it measures how often one's R/S guides and carries over into all areas of their life (such as their social work practice), and it had the highest correlation with the overall RSIPAS score compared with the other DUREL subscales. At the multivariate level, the regression was significant with both independent variables [(F=117.43 (2, 408), p<.001)]. These variables accounted for 37% of the variance (R^2=.367) (Table 4), with intrinsic religiosity having more influence on the model (β=.44) compared to prior training (β=.32).

Discussion

Two important findings emerge from this study. First, LCSWs have positive attitudes about integrating clients' R/S in practice, feel surprisingly efficacious in doing so, and find it feasible. However, their self-reported practice behaviors tell a different story: most are not, in fact, engaging in behaviors related to discussing clients' R/S. While this is discouraging on one hand, it is also encouraging that over half of LCSWs are conducting *biopsychosocialspiritual* assessments, considering ways clients' R/S support systems may be helpful, and involving clients in the degree to which their R/S beliefs are integrated into treatment. However, the quality of these behaviors is unknown, given that half of practitioners feel adequately trained to integrate clients' R/S into therapy, yet most lack training on this topic (with only 13% reportedly taking a course on this topic in graduate school). While 46 percent of the sample sought post-MSW training on R/S practice integration, these trainings likely vary in length and educational quality.

The second important finding is that two variables emerge as predictive of LCSWs' orientation toward integrating clients' R/S: intrinsic religiosity and prior training. These findings have critical implications for social work education and training efforts for two reasons. First, LCSWs with high levels of intrinsic religiosity may not have received appropriate training on maintaining proper boundaries between their personal R/S beliefs, clients' R/S beliefs, and the

treatment process. Second, the positive relationship between prior training and improved orientation toward use of R/S in practice – encompassing self-efficacy, attitudes, perceived feasibility and implementation – suggests that increased graduate and continuing education training can improve these constructs among LCSWs as a whole.

These results suggest some areas for improvement within social work education and practice. For example, despite research suggesting clients prefer the practitioner initiate a discussion concerning the integration of their R/S, these results suggest that many LCSWs are waiting for clients to initiate the discussion. Specifically, consider the discrepancy between the 57 percent who conduct a biopsychosocialspiritual assessment (thereby initiating the conversation) versus the 89 percent who will integrate R/S if the client communicates this preference. This suggests that many clients are not even being asked about the potential impact this important aspect of culture – specifically, their religious or spiritual beliefs or practices – has on their lives and presenting issue. Not all clients may be as direct with their R/S issues as those presented at the beginning of this paper, and bypassing this information can lead to a very incomplete assessment. However, this may be a reflection of LCSWs receiving discouraging messages on the topic in their graduate program (Thyer & Myers, 2009). As such, it is important for social workers to receive high quality education on conducting biopsychosocialspiritual assessments.

While most LCSWs reported favorable views concerning the integration of clients' R/S in practice, and saw such integration as feasible, there were some important discrepancies. For example, 9 of 10 LCSWs felt sensitivity to clients' R/S would improve one's practice, but fewer felt integration would improve client outcomes (69%) or help clients meet their goals (63%). So it seems that while LCSWs find sensitivity to clients' R/S important, some are hesitant about

addressing or building upon these issues in the practice context. Similarly, 8 out of 10 are open to referring clients to religious/pastoral counseling and two-thirds feel efficacious with ensuring clients have access to R/S resources, but less than half link clients with R/S resources when helpful. Linking clients with R/S resources would then be another important area for training..

Though attempts to disseminate information on this practice behavior exist (Sherr, et al., 2011), efforts appear slow to reach educators, students and practitioners. As of May 2014, three years after CSWE's Religion and Spirituality Clearinghouse was launched, only three syllabi and four modules were available. The question arises on how often this resource is utilized, and if rarely, the Clearinghouse could reconsider how it disseminates information. Alternative methods for dissemination include a focused training for deans and educators at the CSWE APM, or providing an online training for field directors or instructors. Such training of field instructors would not only provide information for those involved in the signature pedagogy of social work (CSWE, 2008), but may more quickly and effectively diffuse the information into the profession. For current practitioners, if a need for more training on R/S in practice is identified, steps can be taken to assess for and address areas that require training. For example, schools of social work can survey alumni using the RSIPAS, and train alumni based on responses. Likewise, NASW (or other professional social work organizations) could use the RSIPAS to survey its members, and provide the training online. Given social work's emphasis on evidence-based practice (EBP), it is recommended that future training and education efforts focus on viewing clients' R/S within this five-step EBP process, particularly under step four (with a focus on considering client values, characteristics, and preferences) (Sackett, Strauss, Richardson, Rosenberg, & Haynes, 2000). Such education efforts are especially supported by research on R/S and health (Koenig, et al., 2001; Koenig, et al., 2012), consideration of clients' positive and negative coping strategies

(Pargament, 1997, 2007), and emerging R/S interventions with support for various client demographics (Rosmarin, et al. [2010] or Armento, et al. [unpublished]). Finally, considering the difference between LCSWs' R/S beliefs and the general population (Table 2), it is recommended that education efforts ensure attention to how religious affiliation or beliefs impact clients' coping mechanisms (Pargament, 1997, 2007) or healthcare decisions (Ehman, Ott, Short, Ciampa, & Hansen-Flaschen, 1999; Silvestri, Knitting, Zoller, & Nietert, 2003).

Consistent with prior studies, few respondents in our sample received training on R/S in practice, and more held positive attitudes on R/S in practice than those who engage in related behaviors (Canda & Furman, 2010; Sheridan, 2009). Additionally, both predictive variables have been identified in prior studies; however, this study is the first to examine practitioners' intrinsic religiosity and its predictive power (instead of religious service attendance or affiliation), and the second to identify prior training as a predictor (Murdock, 2005). Unlike prior efforts to assess social workers' use of R/S practices, this study focused on LCSWs' use of the EBP process, a widely recognized decision making process (Sackett, et al., 2000). LCSWs were asked if they read about research on R/S and health or ways to integrate clients' R/S, involve clients in the decision to integrate R/S, or use empirically-supported interventions that integrate clients' R/S.

Though our study has a number of strengths, it is not without limitations. Our sample was obtained through HelpPRO's website, so LCSWs not advertising their services on HelpPRO were not included. Most respondents were in solo private practice, treating mental health issues, so findings cannot generalize to LCSWs in other practice settings. As mentioned above, this sample's demographics are fairly comparable with NASW's licensed social workers, with the exception of more years of practice experience; however, few males or non-Whites were included in our study so findings cannot be generalized to these groups. Though the response rate

was high for an online survey, there is a potential for response bias. Though possible that those interested in the topic would be more likely to respond, our follow-up survey concerning response bias suggested this is less likely. Social desirability bias may also have impacted responses, though these concerns are mostly offset by the anonymous nature of the study.

Despite these limitations, this is the first national survey of LCSWs concerning their concurrent self-efficacy, attitudes, perceived feasibility, behaviors and overall orientation related to integrating clients' R/S in practice. It is also the first study to examine and identify intrinsic religiosity as a predictor for integrating R/S in practice, and the second to identify prior training as a predictor. Therefore, despite its limitations, this study is an important contribution to the literature, providing useful information for future training on integrating clients' R/S in practice.

Conclusion

Practitioners' overall positive responses to the Self-Efficacy, Attitudes, and Perceived Feasibility subscales of the RSIPAS indicate openness to integrating R/S in practice. However, their responses to the Behaviors subscale underscore the need to bolster educational efforts for social workers, and possibly develop additional, standardized continuing education training for this practice area. Future studies should examine educators' responses to the RSIPAS, field instructors' responses, and students' responses, assessing change over time. It may also be worth comparing social workers' responses with similar helping professions (e.g., psychology, marriage and family therapy). Finally, qualitative research may assist in understanding the identified gap between behaviors and attitudes, self-efficacy, and perceived feasibility.

Table 1. Background Characteristics of Licensed Clinical Social Workers

	M	*SD*
Age (N = 437)	56.57	11.00
Years of Practice Experience (N = 424)	22.99	11.19
Years in Current Practice Setting (N = 423)	14.84	10.45
	n	*%*
Gender (N = 438)		
Female	347	(79.2)
Male	92	(20.8)
Ethnicity (N = 437)		
Caucasian	379	(86.7)
African American	17	(3.9)
Hispanic	19	(4.3)
Asian/Pacific Islander	9	(2.1)
American Indian/Alaskan/Native	3	(0.6)
Other	10	(2.3)
Region (N = 435)		
Northeast	169	(38.9)
Midwest	71	(16.3)
South	104	(23.9)
West	91	(20.9)
Prior Continuing Education on R/S Integrated Practice (N = 426): Yes	194	(45.5)
Prior Courses on R/S Integrated Practice (N =426)		
Yes – Course	54	(12.7)
No course, but received some info in Field/Clinical training	112	(26.3)
Knowledge of empirically-supported R/S integrated interventions (N = 423): Yes	87	(20.6)

Table 2. Licensed Clinical Social Workers' Religious/Spiritual Characteristics

	LCSWs		GSS*	
	N	(%)	N	(%)
Religious Preference	(N = 420)		(N = 4,509)	
Protestant	84	(20.0)	2087	(46.3)
Catholic	54	(12.9)	1084	(24.0)
Jewish	91	(21.7)	82	(1.8)
Muslim	1	(0.2)	33	(0.7)
Buddhism	27	(6.4)	32	(0.7)
Hinduism	1	(0.2)	17	(0.4)
None	84	(20.0)	843	(18.7)
Other	78	(18.6)	331	(7.3)
To what extent do you consider yourself a religious person?	(N = 421)		(N = 1,952)	
Not religious	162	(38.5)	382	(19.6)
Slightly religious	111	(26.4)	426	(21.8)
Moderately religious	111	(26.4)	784	(40.2)
Very religious	37	(8.8)	360	(18.4)
To what extent do you consider yourself a spiritual person?	(N = 424)		(N = 1,929)	
Not spiritual	26	(6.1)	203	(10.5)
Slightly spiritual	51	(12.0)	412	(21.4)
Moderately spiritual	161	(38.0)	731	(37.9)
Very spiritual	186	(43.9)	583	(30.2)

Personal Spiritual Practices	LCSWs (N = 426)
Regularly attending religious service	135 (31.7)
Attending small social gatherings on a religious/spiritual matter (e.g. Bible studies)	81 (19.0)
Listening to religious/spiritual music or radio	86 (20.2)
Watching religious/spiritual TV or videos	37 (8.7)
Prayer	195 (45.8)
Meditation	242 (56.8)
Reading religious texts	107 (25.1)
Worship (outside of a religious service)	35 (8.2)
Yoga or some other form of physical practice	161 (37.8)
None of the above	55 (12.9)
Other	69 (16.2)

*Based on 2012 General Social Survey data, which is the most recent data available
Note: LCSW = Licensed Clinical Social Workers. GSS = General Social Survey Participants

Table 3. Frequencies of Responses to RSIPAS Items*

Self-Efficacy with Regard to Integrating Clients' R/S in Practice	Strongly Disagree/ Disagree *N* *%*	Neutral *N* *%*	Strongly Agree/ Agree *N* *%*
1. I know how to skillfully gather a history from my clients about their religious/spiritual beliefs and practices. (n=440)	27 (6.1)	55 (12.5)	358 (81.4)
2. I am able to recognize when my clients are experiencing religious/spiritual struggles. (e.g. tension or conflict with his/her Higher Power, religious/spiritual community, spiritual beliefs, etc.) (n=439)	12 (2.7)	40 (9.1)	387 (88.2)
3. I know what to do if my client brings up thoughts of being possessed by Satan or the Devil. (n=438)	75 (17.1)	94 (21.5)	269 (61.4)
4. I consider the unique needs of diverse clients with different religious/spiritual backgrounds in my practice. (n=440)	7 (1.6)	21 (4.8)	412 (93.6.)
5. I am able to recognize when my clients utilize positive religious/spiritual coping strategies. (e.g. trying to find a spiritual lesson in the presenting issue, etc.) (n=441)	4 (0.9)	15 (3.4)	422 (95.7)
6. I am able to ensure my clients have access to religious/spiritual resources if they see this as an important aspect to their healing process. (e.g. religious/spiritual reading materials, pastoral counseling, contact information to local clergy, or a prayer room/place of worship). (n=439)	60 (13.7)	95 (21.6)	284 (64.7)
7. I feel as though I have the skills to discuss my clients' religious/spiritual strengths. (n=440)	25 (5.7)	39 (8.9)	376 (85.5)
8. I feel confident in my ability to integrate my clients' religious/spiritual beliefs into their treatment. (n=438)	32 (7.3)	45 (10.3)	361 (82.4)
9. I know when it is beneficial to refer my client to pastoral or religious counseling. (n=438)	22 (5.0)	75 (17.1)	341 (77.9)
10. I feel as though I have the skills to discuss my clients' religious/spiritual struggles. (n=439)	32 (7.3)	58 (13.2)	349 (79.5)
11. I am able to recognize when my clients utilize negative religious/spiritual coping strategies. (e.g. viewing the presenting issue as punishment from his/her Higher Power, etc.) (n=441)	8 (1.8)	29 (6.6)	404 (91.6)
12. I know what to do when my client has religious/spiritual beliefs that I am unfamiliar with. (n=440)	26 (5.9)	39 (8.9)	375 (85.2)
13. I am comfortable discussing my clients' religious/spiritual struggles in therapy. (n=439)	15 (3.4)	30 (6.8)	394 (89.7)

Attitudes Toward Integrating Clients' R/S in Practice	Strongly Disagree/ Disagree *N* *%*	Neutral *N* *%*	Strongly Agree/ Agree *N* *%*
1. It is essential to assess clients' religious/spiritual beliefs in practice. (n=437)	51 (11.7)	117 (26.8)	269 (61.6)
2. Integrating clients' religious/spiritual needs during treatment helps improve client outcomes. (n=435)	12 (2.8)	121 (27.8)	302 (69.4)
3. Practitioners who take time to understand their clients' religious/spiritual beliefs show greater concern for client well-being than practitioners who do not take time to understand their clients' religious/spiritual beliefs. (n=436)	82 (18.8)	112 (25.7)	242 (55.5)
4. Integrating clients' religious/spiritual beliefs in treatment helps clients meet their goals. (n=437)	20 (4.6)	144 (33.0)	273 (62.5)

5. Referring my clients to religious or pastoral counseling is harmful. (n=434) **Removed from RSIPAS*	329 (75.8)	99 (22.8)	6 (1.4)
6. I am open to learning about my clients' religious/spiritual beliefs that may differ from mine. (n=435)	3 (0.7)	10 (2.3)	422 (97.0)
7. Attending to clients' religious/spiritual needs is consistent with the principles of meeting the client where he/she is at. (n=436)	13 (3.0)	27 (6.2)	396 (90.8)
8. Sensitivity to clients' religious/spiritual beliefs will improve one's practice. (n=435)	5 (1.1)	24 (5.5)	406 (93.3)
9. Clients' religious/spiritual beliefs are not an important part of their culture. (n=435) **Removed from RSIPAS*	377 (86.7)	9 (2.1)	49 (11.3)
10. I am open to referring my clients to religious or pastoral counseling. (n=434)	18 (4.1)	73 (16.8)	343 (79.0)
11. Attending to clients' religious/spiritual beliefs is consistent with my profession's code of ethics. (n=436)	11 (2.5)	52 (11.9)	373 (85.6)
12. Empirically-supported religious/spiritually integrated therapies are relevant to my practice. (n=437)	81 (18.5)	164 (37.5)	192 (43.9)
13. There is a religious/spiritual dimension to the work I do. (n=434)	60 (13.8)	96 (22.1)	278 (64.1)
14. I refuse to work within my clients' religious/spiritual belief system if it differs from my own. (n=435)	425 (97.7)	7 (1.6)	3 (0.7)

Perceived Feasibility to Engage in R/S Integrated Practice	Strongly Disagree/ Disagree *N* *%*	Neutral *N* *%*	Strongly Agree/ Agree *N* *%*
1. I have enough time to assess my clients' religious/spiritual background. (n=436)	17 (3.9)	60 (13.8)	359 (82.3)
2. I have enough time to identify potential strengths or struggles related to my clients' religion/spirituality. (n=435)	12 (2.8)	46 (10.6)	377 (86.7)
3. My primary practice setting does not support the integration of religion/spirituality into practice. (n=434)	354 (81.6)	59 (13.6)	21 (4.8)
4. I don't have enough time to think about incorporating a religious/spiritually integrated approach to practice. (n=434)	365 (84.1)	53 (12.2)	16 (3.7)
5. Given the many issues that must be addressed in treatment, I still find time to integrate my clients' religion/spirituality if they communicate a preference for this. (n=435)	14 (3.2)	32 (7.4)	389 (89.4)
6. I have been adequately trained to integrate my clients' religion/spirituality into therapy. (n=434)	82 (18.9)	123 (28.3)	229 (52.8)

Behaviors Related to Integrating Clients' R/S in Practice	Never/ Rarely *N* *%*	Some of the time *N* *%*	Often/ Very Often *N* *%*
1. I seek out consultation on how to address clients' religious/spiritual issues in treatment. (n=432)	205 (47.5)	179 (41.4)	48 (11.1)
2. I read about ways to integrate clients' religion/spirituality to guide my practice decisions. (n=434)	157 (36.2)	167 (38.5)	110 (25.3)
3. I read about research evidence on religion/spirituality and its relationship to health to guide my practice decisions. (n=433)	189 (43.6)	160 (37.0)	84 (19.4)
4. I involve clients in deciding whether their religious/spiritual beliefs should be integrated into our work together. (n=431)	64 (14.8)	115 (26.7)	252 (58.5)

5. I use empirically supported interventions that specifically outline how to integrate my clients' religion/spirituality into treatment. (n=433)	254 (58.7)	116 (26.8)	63 (14.5)
6. I conduct a full biopsychosocial*spiritual* assessment with each of my clients. (n=430)	99 (23.0)	84 (19.5)	247 (57.4)
7. I link clients with religious/spiritual resources when it may potentially help them (e.g. religious/spiritual reading materials, contact information to local clergy, or a prayer room/place of worship). (n=429)	119 (27.7)	125 (29.1)	185 (43.1)
8. I help clients consider ways their religious/spiritual support systems may be helpful. (n=430)	25 (5.8)	131 (30.5)	274 (63.7)
9. I help clients consider ways their religious/spiritual support systems may be harmful. (n=433) **Removed from RSIPAS score*	191 (44.1)	170 (39.3)	72 (16.6)
10. I help clients consider the religious/spiritual meaning and purpose of their current life situations. (n=431)	81 (18.8)	159 (36.9)	191 (44.3)

*Note: The items reported in these tables based on the original data collection, but are not included in the subscale scores or overall RSIPAS scores and should be removed in subsequent administrations (Oxhandler & Parrish, under review): Attitudes 5, 9 and Behaviors 9.

Table 4. Variables with Statistically Significant Relationships to the RSIPAS & Summary of Multiple Regression

Variable				*r*
Organizing Religious Activity (Never/Rarely or At least a few times a month)				.197**
Non-Organized Religious Activity (Never/Rarely or At least once a week)				.384**
Intrinsic Religiosity Score (Continuous)				.463**
Any Prior Training: No or Yes (Continuing Education or Course)				.415**
Predictors	B	SE	β	*t*-value
Intrinsic Religiosity	2.38	0.22	0.44	10.76**
Prior Training (Course or Continuing Education)	12.93	1.65	0.32	7.83**

**p<.001. R^2 = .367

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Chapter Five: Conclusion

Conclusion

The purpose of this dissertation was to examine the status of social workers' integration of mental and behavioral health clients' religion and spirituality into clinical practice. Research has shown clients' would prefer their religious or spiritual beliefs be assessed for and discussed in clinical practice (Koenig, 2005; Leitz & Hodge, 2013; Rose, Westefeld, & Ansley, 2001; Stanley, et al., 2011; Tepper, Rogers, Coleman, & Maloney, 2001; Weld & Erickson, 2007), and that such integration has the potential of improving health and mental health outcomes (Koenig, McCullough, & Larson, 2001; Koenig, King & Carson, 2012). However, despite social workers constituting the largest group of clinically trained mental health professionals (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010), few have received training on how to ethically and effectively discuss or assess this area of clients' lives (Canda & Furman, 2010). Much of this gap in training is due to the secularization of the profession from the 1920s – 1970s (Marshall, 1991; Russel, 1998; Canda & Furman, 2010), but considering a large majority (80 percent) of Americans consider religion to be at least somewhat important in their lives (PEW Forum on Religion & Public Life, 2012), it is important that social workers consider the cultural role of R/S within their clients' lives in clinical practice.

In order to better understand social work practitioners' orientation toward integrating clients' religion and spirituality into clinical practice, this dissertation involved three articles. The purpose of the first article was to identify whether any instruments exist to measure social workers' views and behaviors with integrating clients' R/S in practice, and how social workers' attitudes and behaviors compare with other, related helping professions' attitudes and behaviors. The findings suggested no instrument existed with all levels of validity, and that the three instruments identified focused on assessing social workers' use of specific R/S practices with

clients, rather than integrating clients' R/S in practice. Thurs, the second article was based on the development and validation of the Religious/Spiritually Integrated Practice Scale (RSIPAS), which addressed this gap in the literature by measuring social workers' attitudes, behaviors, perceived feasibility, and self-efficacy, as well as their overall orientation, with integrating clients' R/S in practice. Additionally, the RSIPAS demonstrates high internal consistency and has strong evidence of validity, especially compared with the other instruments identified in the first article. Finally, the third article described Licensed Clinical Social Workers' responses to the first administration of the RSIPAS, and reported a clear gap between social workers' self-efficacy, perceived feasibility, and attitudes with their self-reported behaviors around integrating clients' R/S in clinical practice.

Each article within this dissertation is described in greater detail below.

Article One

Oxhandler, H.K. & Pargament, K.I. (in press). Social work practitioners' integration of clients' religion and spirituality in practice: A literature review. *Social Work.*

The first aim of this dissertation was to conduct a comprehensive literature review of religion and spirituality in social work education and practice, and compare social work with other helping professions. Specifically, the two research questions that guided this portion of the dissertation included:

1) What (if any) instruments exist to assess social workers' attitudes, beliefs and behaviors regarding the integration of clients' religion and spirituality into practice?; and

2) Based on the literature, how do social workers' attitudes, beliefs, and behaviors regarding the integration of clients' religion and spirituality into practice differ from other helping professions?

The findings indicate that prior efforts to assess social workers' integration of clients' religion and spirituality in practice have used one of three instruments: the *Spiritually Derived Intervention Checklist (SDIC)* (Canda & Furman, 1999; 2010) the *Role of Religion and Spirituality in Practice Scale (RRSP)* (Sheridan, Bullis, Adcock, Berlin, & Miller 1992) or the *Religion and Prayer in Practice Scale (RPPS)* (Mattison, Jayaratne, & Croxton, 2000), with the SDIC and RRSP being the two most commonly used instruments. All three instruments were similar, in that they each measured the frequency by which the practitioner utilizes a specific religious or spiritual practice with their client (e.g., praying with a client, meditating with a client). In addition to asking practitioners about the frequency of using the R/S practice, these instruments also examined practitioners' attitudes toward the use of the specific R/S practice, asking whether the activity was considered an appropriate helping activity, regardless if the behavior had research to support its use in practice.

Though the instruments had high internal consistency, none of the instruments had established factorial validity. Additionally, the RRSP and SDIC had established content validity and criterion validity, the RRSP had convergent and divergent validity, and the SDIC describes divergent validity based on how atheists and agnostics responses compare with Christians' responses.

What is clear in prior studies using these instruments is that while most social workers have not received training on integrating clients' R/S in practice, they generally have positive attitudes toward integrating clients' R/S in practice. In 2010, Canda and Furman reported that 65 percent of social workers had not received education on R/S in practice. Considering that few social workers have received training on this subject, two constructs were identified in this

article as being important for consideration in future studies: self-efficacy and perceived feasibility.

The second research question for this article involved comparing social workers' attitudes, beliefs, and behaviors regarding integrating clients' R/S in practice. In the National Association of Social Work's Code of Ethics (2008), religion is mentioned in the purpose statement and under five standards (1.05, 2.01, 4.02, 6.04, and 1.06). The focus within these standards involves avoiding discrimination, respecting diversity, and avoiding conflicts of interest (such as not practicing to further religious interests). In similar helping professions, religion was included under the topic of discrimination in the American Psychological Association (APA) (2002), the American Association for Marriage and Family Therapy (AAMFT) (2012), and the American Counseling Association (ACA) (2005). The ACA and American Nurses Association's (ANA) Code of Ethics also considers religion during assessment (ACA, 2005), and treatment planning (ANA, 2001).

With regard to practitioners' integration, most psychologists are open to discussing clients' R/S, even though they are far less religious than the population they serve. Additionally, though only a quarter believe it is relevant to practice, 82% believe a positive relationship exists between religion and mental health (Delaney, Miller, & Bisonó, 2007; Shafranske & Cummings, 2013). Both psychologists and marriage and family therapists (MFTs) feel awareness of their own R/S beliefs is important to consider in practice, and MFTs have openly expressed interest in incorporating R/S in therapy (Prest, Russel, & D'Sousa, 1999; Carlson, Kirkpatrick, Hecker, & Kilmer, 2002). In nursing, the Code of Ethics (ANA, 2001) actually includes R/S in treatment planning, and many nurses have described spirituality as a source of strength and a coping mechanism for handling stress in their practice (Cavendish, et al., 2004; Ekedahl & Wengstrom,

2010; Pesut, 2013). In one cross sectional study, MFTs were the most religious, compared to psychologists, social workers, and psychiatrists (Bergin & Jensen, 1990). Finally, across professions, there is a clear desire for more training on R/S in practice (Crook-Lyon, et al., 2012; Prest, et al., 1999; Canda & Furman, 2010).

This manuscript's primary conclusion was though there is a great deal of complexity surrounding integrating clients' R/S in practice, a need exists to support practitioners in ethically and effectively integrating clients' R/S in practice. Additionally, the evidence-based practice (EBP) process (Sackett, et al., 2000) was identified as a potential method for identifying current, empirically-supported methods for integrating clients' R/S in practice, especially for those who had not received training on R/S in their graduate program, and as studies on R/S and health continue to emerge. Therefore, beyond identifying self-efficacy and perceived feasibility as two constructs to consider in future studies of practitioners' integration of clients' R/S in practice, it was also recommended that future studies include assessing practitioners' use of the EBP process for integrating clients' R/S in practice.

This article, written by Holly K. Oxhandler and Kenneth I. Pargament, was submitted to the journal, *Social Work*, on August 1, 2013 and underwent 2 revision phases. The article was accepted for publication on March 17, 2014.

Article Two

Oxhandler, H.K. & Parrish, D.E. (under review). The development and validation of the Religious/Spiritually Integrated Practice Assessment Scale. *Submitted to Research on Social Work Practice.*

Following the literature review provided in article one, the next aim of this dissertation was to develop an instrument to measure social work practitioners' integration of clients' R/S in practice. Specifically, three research questions guided this portion of the dissertation:

1) Does the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS) have face, content and criterion validity?;

2) Can responses to the RSIPAS be explained by four factors (self-efficacy, attitudes, behaviors, and perceived feasibility)?; and

3) Can responses to the RSIPAS be explained by four first-order factors (self-efficacy, attitudes, behaviors, and perceived feasibility) and one second-order factor (orientation toward integrating clients' religion/spirituality into practice)?

In order to achieve this aim, the first version of the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS) was developed in 2012, based on a training at Duke University on R/S and health, an extensive literature review on R/S in social work practice, and the author's experience with writing a manualized cognitive behavioral intervention for older adults with anxiety and depression that integrates clients' R/S into treatment (Armento, Zeno, Barber, Phillips, Oxhandler, Barrera, & Stanley, unpublished). The RSIPAS was modeled off the Evidence-Based Practice Process Assessment Scale – Short Version (EBPPAS-SV), which has strong reliability and validity and measures another practice behavior, the evidence-based practice process (Parrish & Rubin, 2011).

Upon developing the initial version, the RSIPAS underwent four phases of review to establish face and content validity and for piloting the instrument with current social work practitioners, thereby answering the first research question. During the spring of 2013, HelpPRO (www.HelpPRO.com), a therapist finder website with a social worker finder feature (HelpPRO,

n.d.), was identified to obtain a national sampling frame of clinical social workers. Others having a high response rate with this site (Pignotti & Thyer, 2009) also helped support our decision to utilize this website. Two thousand zip codes were entered with a five-mile radius, and 1,381 individuals were identified as eligible, from which, 1,000 were randomly selected. An adapted version of the Dillman method (Dillman, Smyth & Christian, 2009) was used for data collection, which resulted in a 49% response rate.

These results were then used to answer research questions two and three, which involved identifying if the four hypothesized factors (self-efficacy, attitudes, perceived feasibility, and behaviors) were validated, as well as a second-order factor (overall orientation toward R/S in practice). A confirmatory factor analysis was conducted using Mplus, and after deleting two items for having low loadings (<.45; Comrey & Lee, 1992), the 41-item model was very close to adequate fit: χ^2 (773, N=470) = 3489.76, p<.001, χ^2/df = 4.51, CFI = .90, TLI = .89, RMSEA = .086 (low90 = .084, high90 = .089). Following this baseline model, modification indices were explored resulting in one additional item being dropped, and 11 error terms were correlated. The 40-item model fit was thus, improved, and met adequate fit indices: χ^2 (724, N=470) = 2653.06, p<.001, χ^2/df = 3.66, CFI = .93, TLI = .92, RMSEA = .075 (low90 = .072, high90 = .078). A second-order factor was then tested, and had adequate fit as well: χ^2 (726, N=470) = 2753.89, p<.001, χ^2/df = 3.79, CFI = .92, TLI = .92, RMSEA = .075 (low90 = .074, high90 = .080).

These findings answer both questions two and three. In addition to the adequate fit indices, internal consistency was very good to excellent, ranging from .84 to .91 for the subscales, and .95 for the overall scale (Kline, 2005). Convergent validity and discriminant validity were also established.

The conclusion from this article was that the 40-item RSIPAS is a reliable and valid instrument for assessing social work practitioners' attitudes, behaviors, perceived feasibility and self-efficacy, as well as their overall orientation, toward integrating clients' R/S in practice. Additionally, a number of suggestions for the use of this instrument are included, such as educators evaluating students' orientation, alumni's orientation, or their field instructors' orientation toward this practice behavior. It was also recommended that agencies may wish to examine their practitioners' views and integration of clients' R/S in treatment, or the profession may want to conduct a similar, national survey of social work practitioners in about 10 to 15 years to see to what degree education efforts (such as the CSWE Clearinghouse) are reaching the profession.

Article two, written by Holly K. Oxhandler and Danielle E. Parrish, was submitted to the journal, *Research on Social Work Practice*, on April 10, 2014.

Article Three

Oxhandler, H.K., Parrish, D.E., Torres, L.R., & Achenbaum, W.A. (under review). Walking the talk: Do LCSWs integrate clients' religion/spirituality in practice? *Submitted to Social Work.*

After establishing that the Religious/Spiritually Integrated Practice Assessment Scale was reliable and valid (Oxhandler & Parrish, under review), a descriptive analysis and regression was conducted to answer the research questions for article three. These questions included:

1) What are the attitudes, behaviors, self-efficacy, and perceived feasibility concerning the integration of clients' religion/spirituality into practice among MSW-level, licensed, clinical social work practitioners?; and

2) Are there any significant relationships between various practitioner background characteristics and RSIPAS variables (e.g., degree of religiosity, prior courses/continuing education units, or age)?

To answer question one, descriptive analyses were run using data from the Licensed Clinical Social Workers (LCSWs) within our sample. A total of 442 individuals of the 482 that responded had both an LCSW and complete RSIPAS data. Each of the items were collapsed into three categories for responses: Strongly Disagree/Disagree, Neutral, Strongly Agree/Agree (for Self-Efficacy, Attitudes, and Feasibility subscales) and Never/Rarely, Some of the time, Often/Very Often (for Behaviors subscale). All items from the original RSIPAS were included in this description; however, a note was included in the frequency table indicating the three items that were removed from the factor analysis in article two.

The findings from the first research question indicated a majority of LCSWs have positive attitudes regarding integrating clients' R/S in practice (44% - 98%), feel as though such integration is feasible (53% - 89%), and have high self-efficacy with this practice behavior (61% - 96%). However, there is a very different story with behaviors, with far fewer practitioners actually engaging in practice behaviors related to integrating clients' R/S in treatment (11% - 64%). Though only 13% took a course on this topic, almost half have sought additional training since graduating, indicating an openness and potential desire to learn more about discussing this area of clients' lives in practice. Therefore, it seems as though a clear openness to this topic in practice exists, but practitioners are lacking clear guidance on how to address this area of clients' lives in practice. Or, it may be that practitioners are wishing clients would initiate the discussion, as 89% would be willing to discuss it if a client brings it up, but only half conduct a full biopsychosocialspiritual assessment. This finding regarding social work practitioners'

predilections clearly opposes what clients have reported regarding their preferences to have the practitioner initiate the discussion (Koenig, 2005; Leitz & Hodge, 2013; Rose, et al., 2001; Stanley, et al., 2011; Tepper, et al., 2001; Weld & Erickson, 2007).

Regarding the second research question, four variables were significantly correlated with the overall RSIPAS score, including frequency of religious service attendance, frequency of personal R/S practices, intrinsic religiosity, and prior training (including a course or continuing education). There were no significant relationships between the overall RSIPAS score and the respondents' gender, race, age, region of the country in which the respondent lived, age of the clients served, and the number of years in clinical practice. As described in the article, intrinsic religiosity was selected over the two other religiosity items (frequency of religious service attendance and personal R/S practices) due to intrinsic religiosity conceptually making more sense for predicting the RSIPAS score, and due to it having the highest correlation with the RSIPAS. A multiple regression analysis was run using the enter method with the two variables (intrinsic religiosity and prior training). Thirty seven percent of the variance was explained, with both items as predictors, and intrinsic religiosity contributing more to the variance.

The implication of the regression analysis is important for consideration in social work education. Not only does training predict practitioners' orientation toward integrating clients' R/S in practice, reinforcing the need for this discussion in the classroom, but their intrinsic religiosity is important to consider as well. With intrinsic religiosity being the strongest predictor variable, social work programs may want to strongly consider having open discussions about how their religious beliefs relate to practice, rather than allowing situations of discrimination or negative messages about R/S in practice, as described in Thyer and Myers (2009).

Our sample was also highly comparable to NASW membership demographics (Center for Health Workforce Studies, 2006), though our sample had more practice experience due to our sample being all LCSWs (NASW also includes BSW-level practitioners and LMSWs before applying for their clinical license). However, compared to the general population, our sample of LCSWs was far less religious, but slightly more spiritual, than the population they serve.

The conclusion from this article is that most LCSWs have positive attitudes, high perceived feasibility, and favorable self-efficacy with regards to integrating clients' R/S in practice, but are not often engaging in such practice behaviors. Additionally, the two variables that emerged as the greatest predictors were intrinsic religiosity and prior training. A number of suggestions were included in this article, such as developing a standardized training on this practice behavior, including attention to students' intrinsic religiosity (in the same way students' culture or political ideology are explored in social work programs)

Article three, written by Holly K. Oxhandler, Danielle E. Parrish, Luis R. Torres, & W. Andrew Achenbaum, was submitted to the journal, *Social Work*, on April 27, 2014.

Limitations

Though this dissertation has a number of strengths, it is not without limitations. With regard to the literature review, though no instrument with factorial validity was identified that measures social workers' attitudes, behaviors, perceived feasibility, and self-efficacy with this practice behavior, there is always the chance that an instrument may exist that was not located in the literature review. There may also be additional articles comparing varied helping professions with regard to this practice behavior that fell outside the scope of our literature search. Regarding the development of the RSIPAS, though the results of the confirmatory factor analysis on the scale indicated an adequate fit, future studies may examine if the instrument's fit could be

improved with additional modifications through exploratory structural equation modeling procedures.

Considering that our sample was obtained through the therapist finder website, HelpPRO, LCSWs who do not advertise their services on this website were not included in our sampling frame, nor were those whose zip codes fell outside of the systematically randomly selected zip codes and five-mile radius. Of those who responded, few males or non-Whites were included in our sample; therefore, the instrument's validity or findings in the third article cannot generalize to these groups. Though our sample of LCSWs' demographics are comparable to licensed social workers in NASW, our sample had more practice experience compared with NASW's list. However, as described in the third article, this may be a reflection of NASW's list also including BSW and MSW-level practitioners prior to obtaining their LCSW. Finally, since the majority of the respondents were treating mental health issues in solo private practice, the findings cannot generalize to social workers who primarily address issues unrelated to mental health concerns in other practice settings.

Though the response rate was fairly high for an online survey and extremely close to Pignotti and Thyer's (2009) response rate on assessing LCSWs' views of empirically supported therapies, there is the chance that those who responded to the survey hold a personal bias or interest in the topic of R/S in practice. However, an assessment of reasons for non-response suggested that it is more likely that lack of time or perceived irrelevance to practice was the issue rather than personal bias against the survey topic. There is also the chance that social desirability bias played a role in the responses due to the kind of questions asked or the fact that participants received a $1 token incentive and were offered the opportunity to be entered into a drawing for a

$50 gift card. These limitations were reduced by the anonymous nature of the study, and the fact that everyone was offered the $1 token incentive.

Integrative Summary and Conclusions

This dissertation, including the findings presented in each of the three articles, together forms a cohesive body of work from which the social work profession may advance. The first article, a comprehensive literature review on existing instruments and R/S and social work education and practice, served as a basis for the development of the second two articles. This review suggested there was a need for a validated instrument to measure practitioners' overall orientation to R/S in practice, and that no instrument to date had examined self-efficacy, perceived feasibility and the integration of empirically supported R/S approaches and interventions. In addition, research identified for this review suggested that education of social work students and practitioners in this area is limited. The second article built upon the first by addressing an identified need in the literature, the development and validation of a multidimensional scale – the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS) – to measure practitioners' overall orientation to the integration of R/S in practice by measuring four disparate, but related constructs: self-efficacy, attitudes, perceived feasibility and R/S behaviors related to rely upon and using empirically supported R/S strategies and treatments. The internal consistency reliability, content validity, criterion validity and factorial validity were supported, resulting in a scale that can now be disseminated for use in surveys of practitioners and the evaluation of educational efforts to train social work students and practitioners.

Given the need to obtain a large enough sample to conduct the aforementioned scale validation study, a second aim of this dissertation was to obtain a random sample of Licensed Clinical Social Workers' (LCSWs) and describe their responses to the RSIPAS items and scales.

A 49 percent response rate was obtained, which is higher than average for online surveys. A follow up survey of reasons for non-response suggested that the topic of the survey was an unlikely reason for non-response. Interestingly, LCSWs reported positive views regarding the integration of clients' R/S in practice, but are not frequently engaging in such practice behaviors. The favorable views of social workers towards the integration of R/S and practice are consistent with prior findings, which were discussed in article one. This study, however, provides new information concerning the self-efficacy, perceived feasibility and views of a novel perspective on integrating client's R/S, as it focuses less on traditionally religious practices (e.g., prayer) and more on strategies and interventions that are empirically-supported. There was also an inconsistency between the degree of openness to the topic of integrating R/S in practice, and the amount of related training or education that has been offered or provided. In addition, the predictive power that intrinsic religiosity and prior training had on overall orientation towards the integration of R/S and practice provides interesting implications for future social work education, training and research. As, such, these three articles, as a unified dissertation, provide an important contribution to the social work literature by publishing a comprehensive literature review on the topic of the integration of clients' R/S in practice, an instrument to measure this construct, and the description of responses of LCSWs to a national cross-sectional survey concerning their orientation towards its integration in practice. The implications of this work for social work practice, policy and research are discussed below.

Future Directions

This important contribution to the social work literature opens a wide road for future training and research efforts. The RSIPAS examines integrating clients' R/S in practice beyond simply utilizing R/S practice behaviors (e.g., praying with a client), by assessing whether

practitioners are reading about research on the relationship between religion and health to guide practice decisions, or seeking consultation on R/S issues, or involving clients in whether or not their R/S beliefs will be discussed. Following this assessment, the social work profession would benefit from having a standardized training developed to address the topics assessed for in the RSIPAS.

Utilizing the Diffusion of Innovations Theory (Rogers, 2003), the RSIPAS will be disseminated through the CSWE Religion and Spirituality Clearinghouse and through the articles that have been submitted for publication. This innovation (the RSIPAS and the methods of integrating clients' R/S that it measures) will be passed through channels of communication (such as the CSWE Clearinghouse, members of the Religion and Spirituality working group, professional presentations scheduled this fall and winter, and the journals *Research on Social Work Practice* and *Social Work*), will move into the element of time (which will depend on whether and how the profession adopts this instrument and innovation, and the rate of adoption), and then finally, focus on the social system, including opinion leaders (such as CSWE policy makers, social work deans and educators, field instructors, social work practitioners), as well as change agents (such as those who engage in future research and evaluation efforts and use opinion leaders to influence this social system). In addition to disseminating this instrument through the social work profession, attempts will be made to disseminate this scale to those in the Duke Center for Spirituality, Theology, and Health Community Group, which include an international group of researchers studying the topic of religion, spirituality, and health. Finally, this instrument will also be sent to the Institute for Spirituality and Health in the Texas Medical Center, for those who may be interested in evaluating social work practitioners' use of R/S in clinical practice in Houston, TX.

A number of future research efforts are possible from this study. First, though the confirmatory factor analysis resulted in a model with adequate fit, exploratory structural equation modeling procedures may identify a model with better fit for future administrations of this instrument. For example, the profession might be interested in examining how field instructors compare with non-field instructors; especially considering field education is the signature pedagogy of social work education (CSWE, 2008). Additionally, longitudinal evaluation of the integration of R/S in social work practice might be of interest, in order to determine the rate of adoption of this innovation or identify specific areas of training need. As mentioned before, a standardized training program might be considered for development, and the RSIPAS could be used to measure the outcomes of the training effort. Finally, especially after the findings identified in the first article, it might be interesting to conduct a cross sectional study that compares multiple helping professionals' responses to the RSIPAS, such as psychology, marriage and family therapy, nursing, or counseling.

In addition to future studies being done with the RSIPAS, during this dissertation, an overwhelming amount of qualitative data was collected better understand what helps or prevents practitioners from integrating clients' R/S in practice. This data exceeded the original research questions for this dissertation, but is available for analysis in the future. Thus, another future study would be to analyze the qualitative responses to the two open-ended questions, and comparing that with the story within the quantitative data.

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APPENDIX A – Cover letter 1 (Contact 1, Email #1)

Standard Subject line: Request for information (via HelpPRO.com)

Dear (NAME),

I am writing to ask for your help with my dissertation study that is currently being conducted at the University of Houston to understand social work practitioners' views and use of clients' religion or spirituality in practice. In the next few days you will be one of 1,000 social workers who will receive a request to participate in this important project by answering questions about your thoughts and experiences concerning the integration of clients' religion or spirituality in practice.

I am writing in advance because many people like to know ahead of time that they will be asked to fill out a questionnaire. This dissertation research can only be successful with the generous help of social workers like you, and my goal is to make this survey easy and enjoyable while also benefiting the mental health profession.

To say thanks, you will receive a small token of appreciation by mail about a week after being invited to participate, using the address you have publicly made available on your HelpPRO profile. If you'd prefer I use a different address, please email me within the next few days at hkoxhandler@uh.edu with your preferred mailing address. Additionally, I will be giving away five $50 gift cards after the study is complete that you can enter to win!

Your participation is voluntary, all responses are anonymous, and your choice to enter into the gift card drawing will be kept confidential. Neither we nor anyone else will be able to identify from whom any completed questionnaire came. Should you have any further questions, concerns, or comments, please do not hesitate to contact me at hkoxhandler@uh.edu. If you have any questions about your rights as a research participant, please contact the University of Houston Committee for the Protection of Human Subjects at (713) 743-9204. Your current or future relationship with University of Houston will not be affected by your decision to participate in this research.

I hope you will take 15 minutes of your time to help me with my dissertation research. Most of all, I hope that you enjoy the opportunity to voice your thoughts and opinions about integrating clients' religion or spirituality into practice. If you are interested in the results of this study, I would be happy to send them to you at the conclusion of the study if you email me, indicating you would like the results.

Kindly,
Holly K. Oxhandler, MSW
PhD Candidate
University of Houston
Graduate College of Social Work
Email: hkoxhandler@uh.edu

APPENDIX B – Cover letter 2 (Contact 2, Email #2)

Standard Subject line: Request for information (via HelpPRO.com)

Dear (NAME),
I am writing to ask for your participation in a survey that we are conducting at the University of Houston as a part of my dissertation research. We are asking social work practitioners, like you, to reflect on your views and use of clients' religion and spirituality in practice.

Your responses to this survey are very important, as they will help us better understand social workers' views and use of clients' religion and spirituality in practice. This is a short survey and should only take about 15 minutes. Please click on the link below to go to the survey website (or copy and paste the link into your internet browser). Upon completion of the survey, you will have the option of entering to win one of five $50 Target gift cards!

Survey Link: http://www.surveymonkey.com/s/RSIPAS

You are one of 1,000 social workers asked to participate in this survey. Your participation is voluntary, all responses are anonymous, and your choice to enter into the gift card drawing will be kept confidential. Neither we nor anyone else will be able to identify from whom any completed questionnaire came. Should you have any further questions, concerns, or comments, please do not hesitate to contact me at hkoxhandler@uh.edu. If you have any questions about your rights as a research participant, please contact the University of Houston Committee for the Protection of Human Subjects at (713) 743-9204. Your current or future relationship with University of Houston will not be affected by your decision to participate in this research.

I will be sending a small token of appreciation in the mail to your address on HelpPRO as a way of thanking you for participation. Your responses are important for helping to identify perspectives that can inform future social work practice and educational efforts, as well as help me complete my dissertation research! Thank you, again, for your participation and time! I hope you enjoy the opportunity to share your thoughts and opinions on this area of practice.

Kindly,

Holly K. Oxhandler, MSW
PhD Candidate
University of Houston
Graduate College of Social Work
Email: hkoxhandler@uh.edu

Danielle E. Parrish, PhD.
Assistant Professor
Chair of Ms. Oxhandler's Dissertation Committee
University of Houston
Graduate College of Social Work
Email: dparrish@uh.edu

APPENDIX C – Cover Letter 3 (Contact 3, Physical letter)

August 2013

Dear (NAME),

I recently sent you an email through HelpPRO's contact form, asking you to respond to a brief survey about your views and use of clients' religion and spirituality in practice. Your response to this survey is important and will help in better understanding social workers' integration of clients' religion and spirituality in practice. If you did not receive this email, please feel free to contact me at hkoxhandler@uh.edu and I will send it to you.

I wanted to personally thank you for your time and attention to this survey (my dissertation research), by sending you this letter and a small token of my appreciation. Your participation is very important for better understanding this area of practice and its implications for our profession, as well as the success of my dissertation. If you have already completed the survey, thank you for your time.

If you have not yet had a chance to complete this survey, you may do so by entering the link below into your Internet browser. This is a short survey and should only take about 15 minutes to complete. Upon completion of the survey, you will have the option of entering to win one of five $50 Target gift cards! Please know how grateful I am for your time, attention, and important contribution to this study.

Survey Link: **http://www.surveymonkey.com/s/RSIPAS**

As mentioned in the initial email, you are among 1,000 social workers being asked to participate in this survey. Your participation is voluntary, all responses are anonymous, and your choice to enter into the gift card drawing will be kept confidential. Neither we nor anyone else will be able to identify from whom any completed questionnaire came. Should you have any further questions, concerns, or comments, please do not hesitate to contact me at hkoxhandler@uh.edu. If you have any questions about your rights as a research participant, please contact the University of Houston Committee for the Protection of Human Subjects at (713) 743-9204. Your current or future relationship with University of Houston will not be affected by your decision to participate in this research.

Thank you again for your help with this important study! It is only through the help of people like you that we can gather important information to guide our social work profession and practice efforts.

Kindly,

Holly K. Oxhandler, MSW
PhD Candidate
University of Houston
Graduate College of Social Work
Email: hkoxhandler@uh.edu

Danielle E. Parrish, PhD.
Assistant Professor
Chair of Ms. Oxhandler's Dissertation Committee
University of Houston
Graduate College of Social Work
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APPENDIX D – Cover Letter 4 (Contact 4, Email #3)

Standard Subject line: Request for information (via HelpPRO.com)

Dear (NAME),

Early fall can be a busy time for many, and we understand how valuable your time is. Recently, we sent you an email and letter asking you to respond to a brief, 15-minute questionnaire about your views and use of clients' religion and spirituality in practice.

If you have already completed the survey, thank you for your participation! If you have not yet participated, we urge you to do so by clicking the link below (or copy and paste the link into your internet browser). Upon completion of the survey, you will have the option of entering to win one of five $50 Target gift cards!

Survey Link: http://www.surveymonkey.com/s/RSIPAS

If you have chosen not to participate, we are interested in better understanding these reasons to eliminate response bias to the survey. Please use this link to indicate reasons for non-participation: http://www.surveymonkey.com/s/RSIPAS_NR

As mentioned in prior contacts, you are among 1,000 social workers being asked to participate in this survey. Your participation is voluntary, all responses are anonymous, and your choice to enter into the gift card drawing will be kept confidential. Neither we nor anyone else will be able to identify from whom any completed questionnaire came. Should you have any further questions, concerns, or comments, please do not hesitate to contact me at hkoxhandler@uh.edu. If you have any questions about your rights as a research participant, please contact the University of Houston Committee for the Protection of Human Subjects at (713) 743-9204. Your current or future relationship with University of Houston will not be affected by your decision to participate in this research.

Thank you for your help and participation, as this survey will provide valuable information to guide social work practice and educational efforts. We sincerely appreciate your time and contribution to this important effort!

Kindly,

Holly K. Oxhandler, MSW
PhD Candidate
University of Houston
Graduate College of Social Work
Email: hkoxhandler@uh.edu

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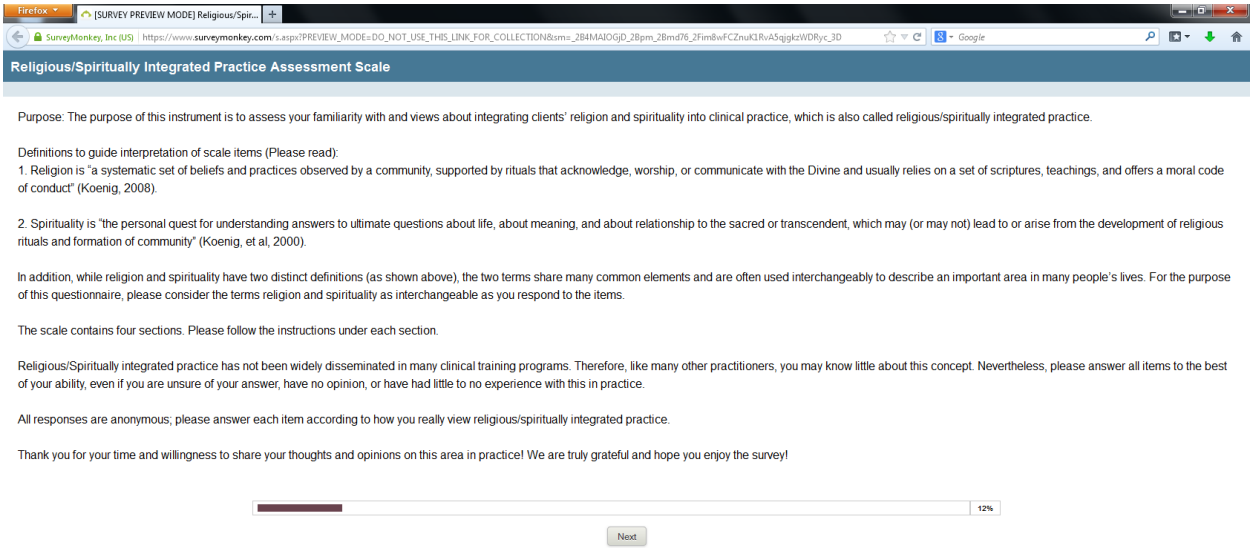
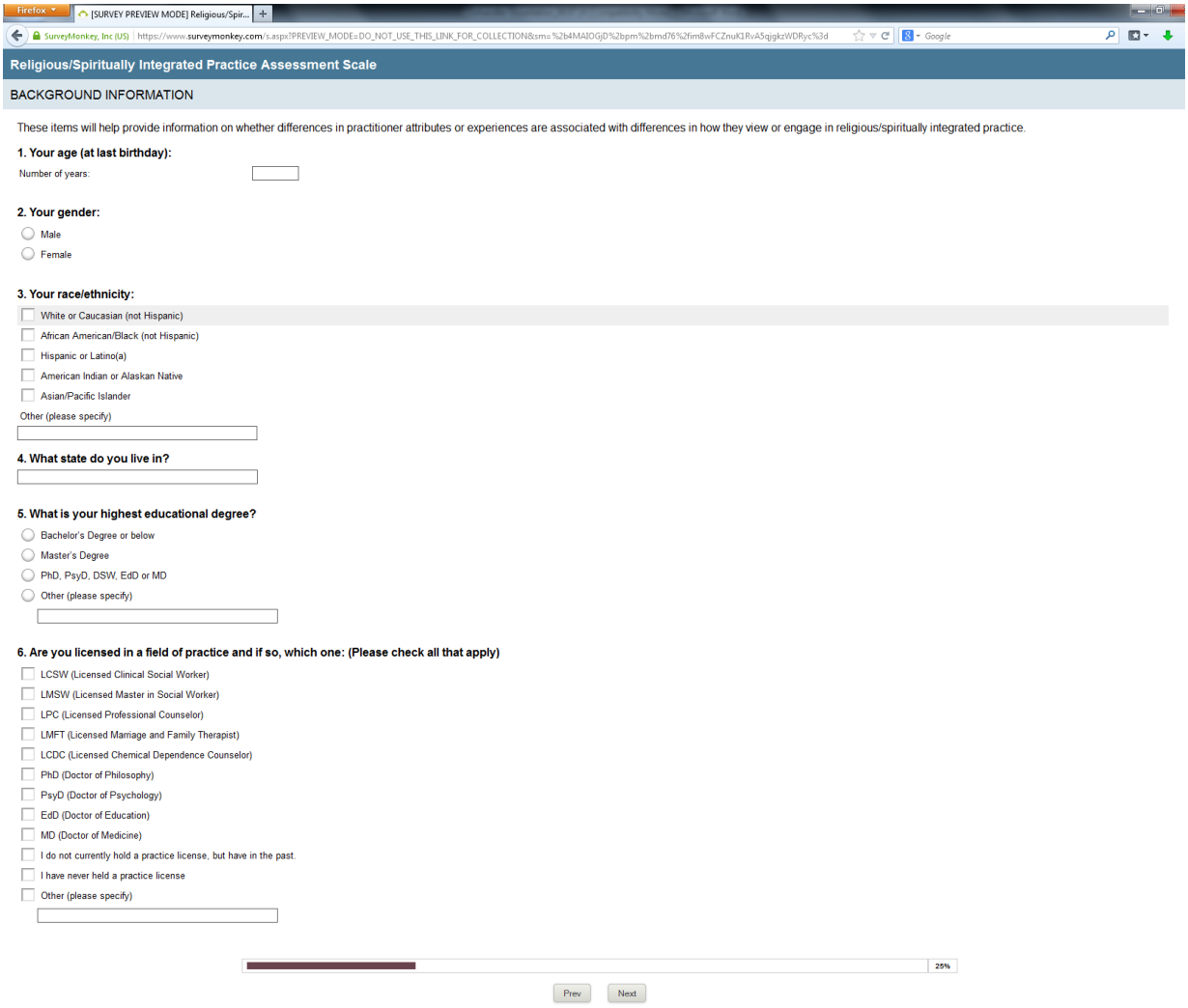
APPENDIX E – Screen Shots of the SurveyMonkey® link for the Religious/Spiritually Integrated Practice Assessment Scale and Background Items

Survey Page 1. Purpose, Definitions, and Information on Study Beyond Emails



Survey Page 2. Background Items to Ease Participants into Survey



Religious/Spiritually Integrated Practice Assessment Scale

BACKGROUND INFORMATION

These items will help provide information on whether differences in practitioner attributes or experiences are associated with differences in how they view or engage in religious/spiritually integrated practice.

1. Your age (at last birthday):

Number of years:

2. Your gender:

- Male
- Female

3. Your race/ethnicity:

- White or Caucasian (not Hispanic)
- African American/Black (not Hispanic)
- Hispanic or Latino(a)
- American Indian or Alaskan Native
- Asian/Pacific Islander

Other (please specify)

4. What state do you live in?

5. What is your highest educational degree?

- Bachelor's Degree or below
- Master's Degree
- PhD, PsyD, DSW, EdD or MD
- Other (please specify)

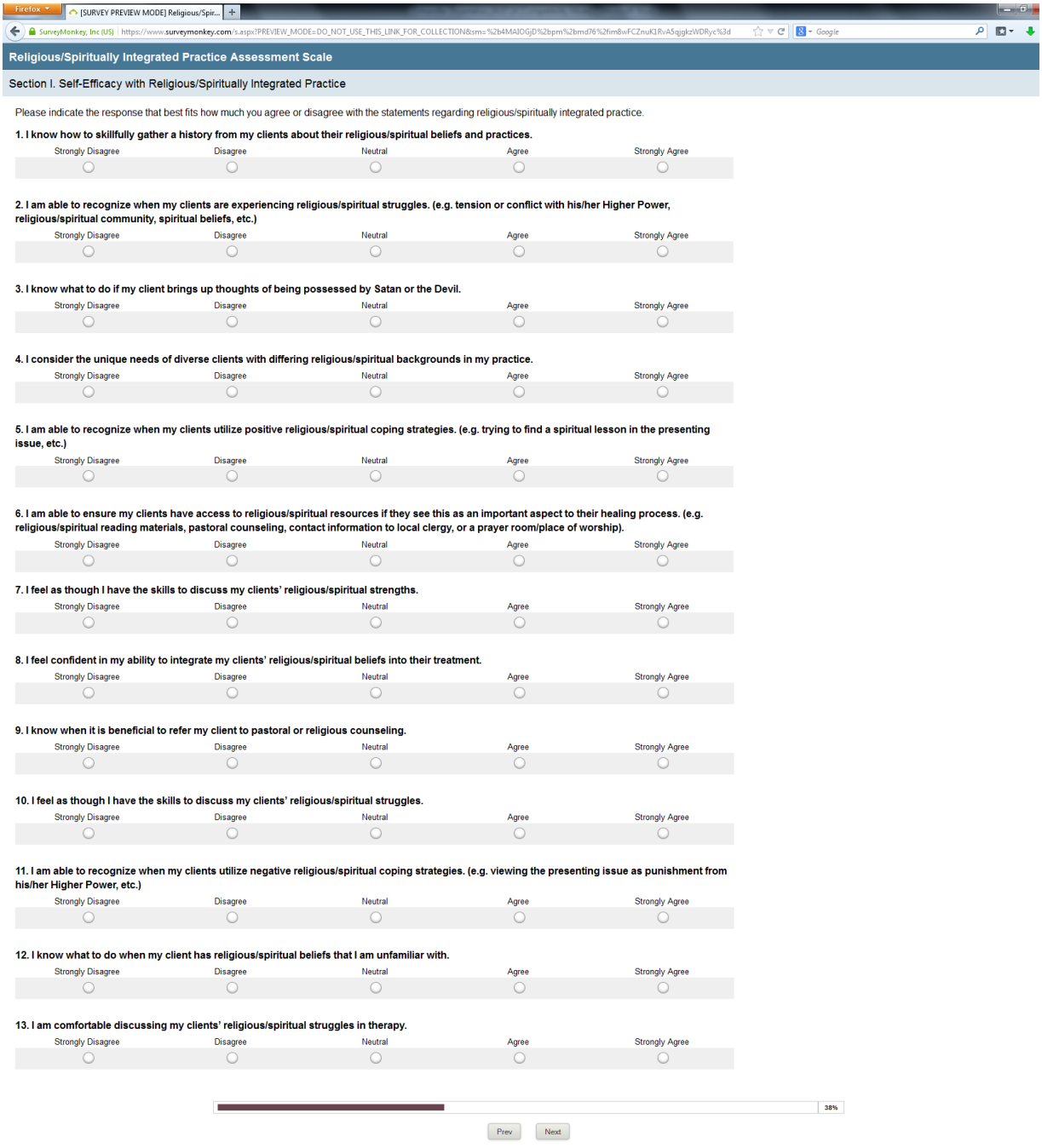
6. Are you licensed in a field of practice and if so, which one: (Please check all that apply)

- LCSW (Licensed Clinical Social Worker)
- LMSW (Licensed Master in Social Worker)
- LPC (Licensed Professional Counselor)
- LMFT (Licensed Marriage and Family Therapist)
- LCDC (Licensed Chemical Dependence Counselor)
- PhD (Doctor of Philosophy)
- PsyD (Doctor of Psychology)
- EdD (Doctor of Education)
- MD (Doctor of Medicine)
- I do not currently hold a practice license, but have in the past.
- I have never held a practice license
- Other (please specify)

25%

Prev Next

Survey Page 3. Self-Efficacy Subscale



Firefox [SURVEY PREVIEW MODE] Religious/Spir...

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Google

Religious/Spiritually Integrated Practice Assessment Scale

Section I. Self-Efficacy with Religious/Spiritually Integrated Practice

Please indicate the response that best fits how much you agree or disagree with the statements regarding religious/spiritually integrated practice.

1. I know how to skillfully gather a history from my clients about their religious/spiritual beliefs and practices.

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

2. I am able to recognize when my clients are experiencing religious/spiritual struggles. (e.g. tension or conflict with his/her Higher Power, religious/spiritual community, spiritual beliefs, etc.)

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

3. I know what to do if my client brings up thoughts of being possessed by Satan or the Devil.

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

4. I consider the unique needs of diverse clients with differing religious/spiritual backgrounds in my practice.

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

5. I am able to recognize when my clients utilize positive religious/spiritual coping strategies. (e.g. trying to find a spiritual lesson in the presenting issue, etc.)

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

6. I am able to ensure my clients have access to religious/spiritual resources if they see this as an important aspect to their healing process. (e.g. religious/spiritual reading materials, pastoral counseling, contact information to local clergy, or a prayer room/place of worship).

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

7. I feel as though I have the skills to discuss my clients' religious/spiritual strengths.

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

8. I feel confident in my ability to integrate my clients' religious/spiritual beliefs into their treatment.

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

9. I know when it is beneficial to refer my client to pastoral or religious counseling.

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

10. I feel as though I have the skills to discuss my clients' religious/spiritual struggles.

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

11. I am able to recognize when my clients utilize negative religious/spiritual coping strategies. (e.g. viewing the presenting issue as punishment from his/her Higher Power, etc.)

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

12. I know what to do when my client has religious/spiritual beliefs that I am unfamiliar with.

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

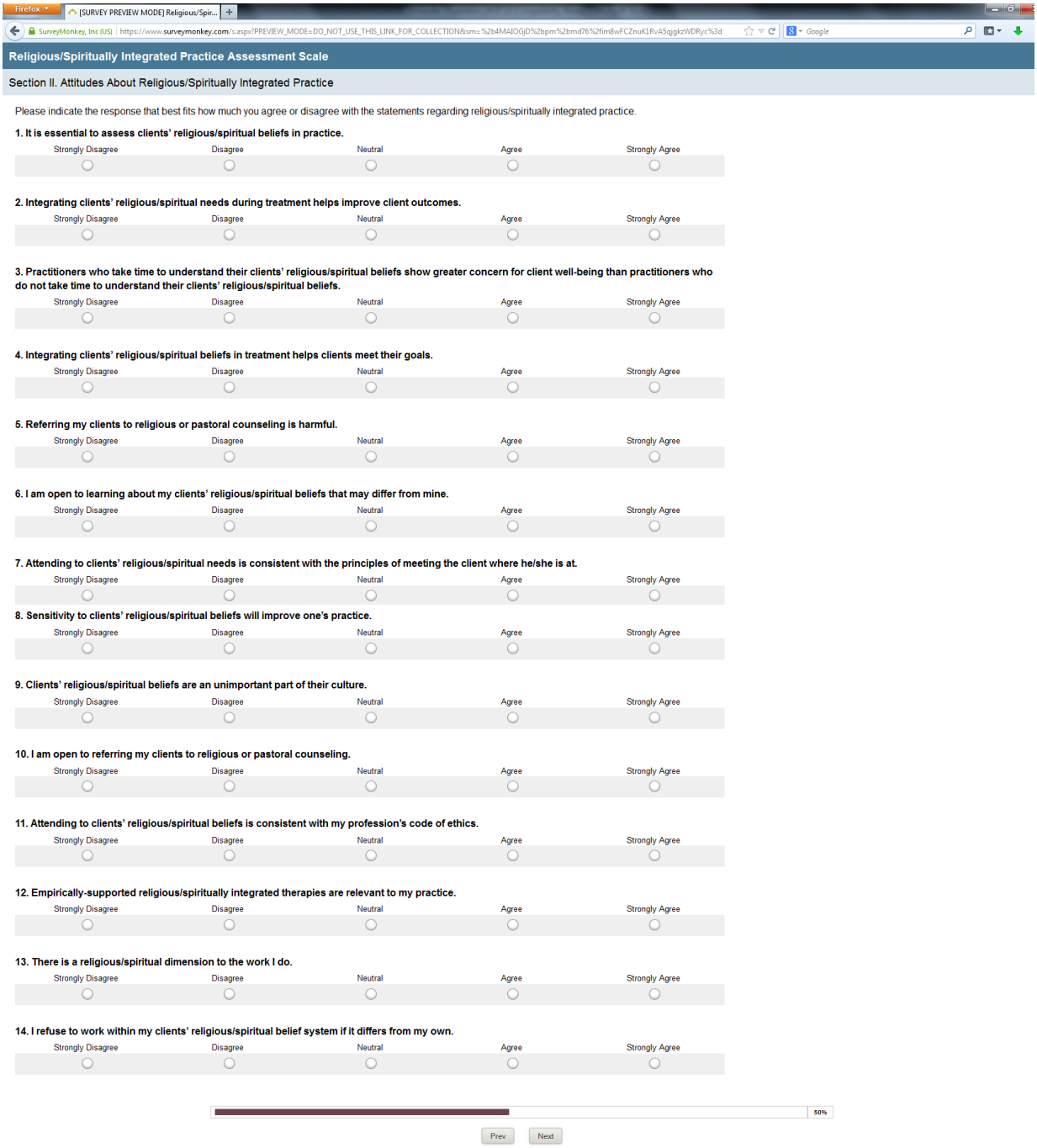
13. I am comfortable discussing my clients' religious/spiritual struggles in therapy.

Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree

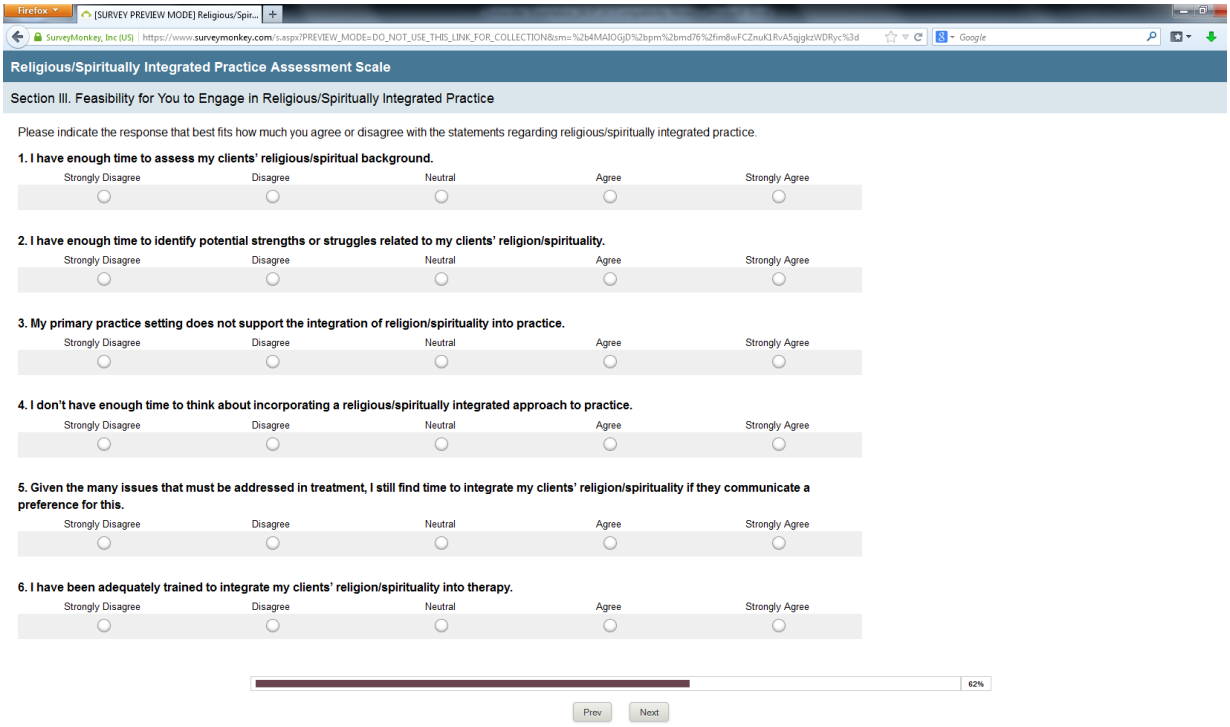
38%

Prev Next

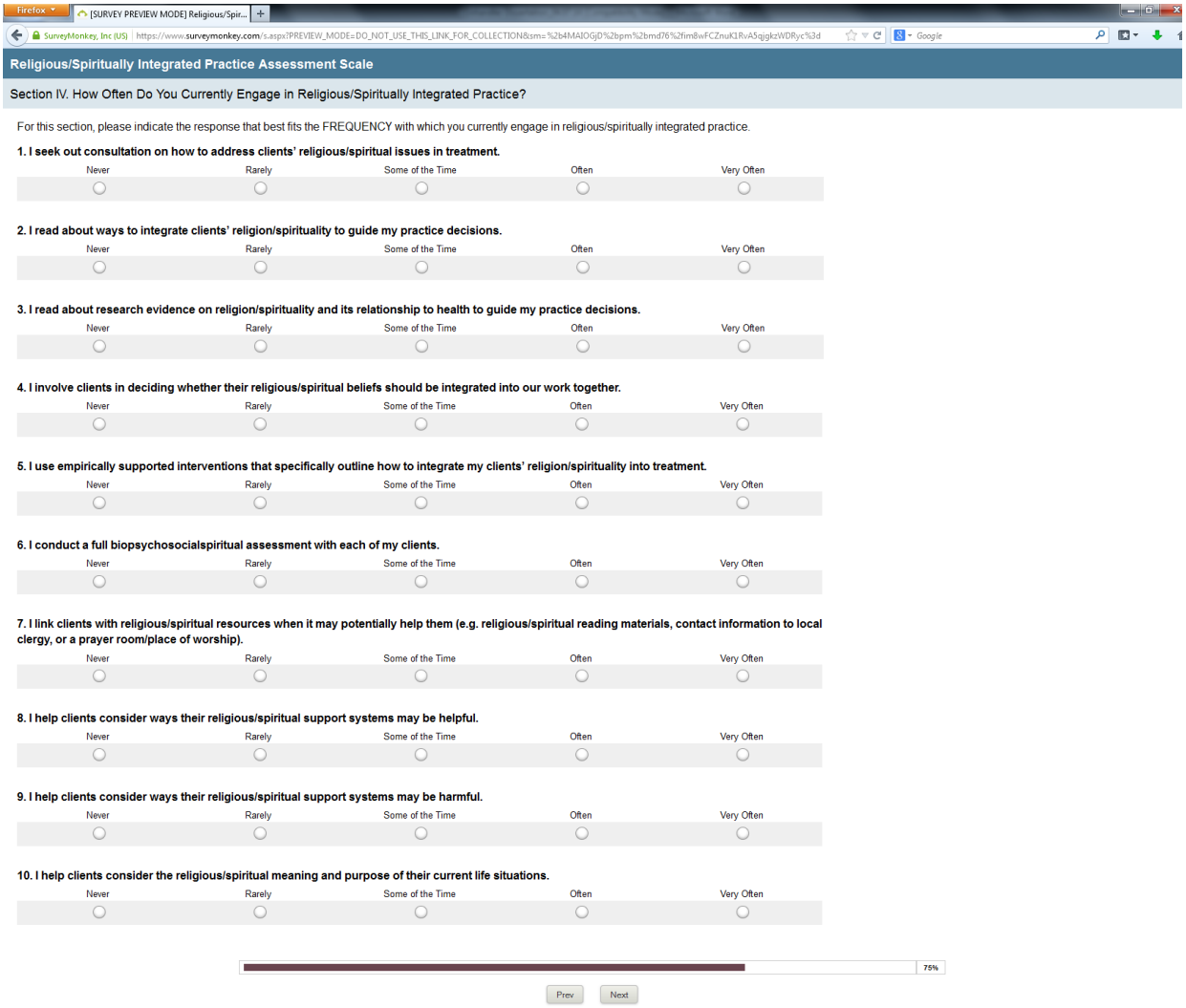
Survey Page 4. Attitudes Subscale



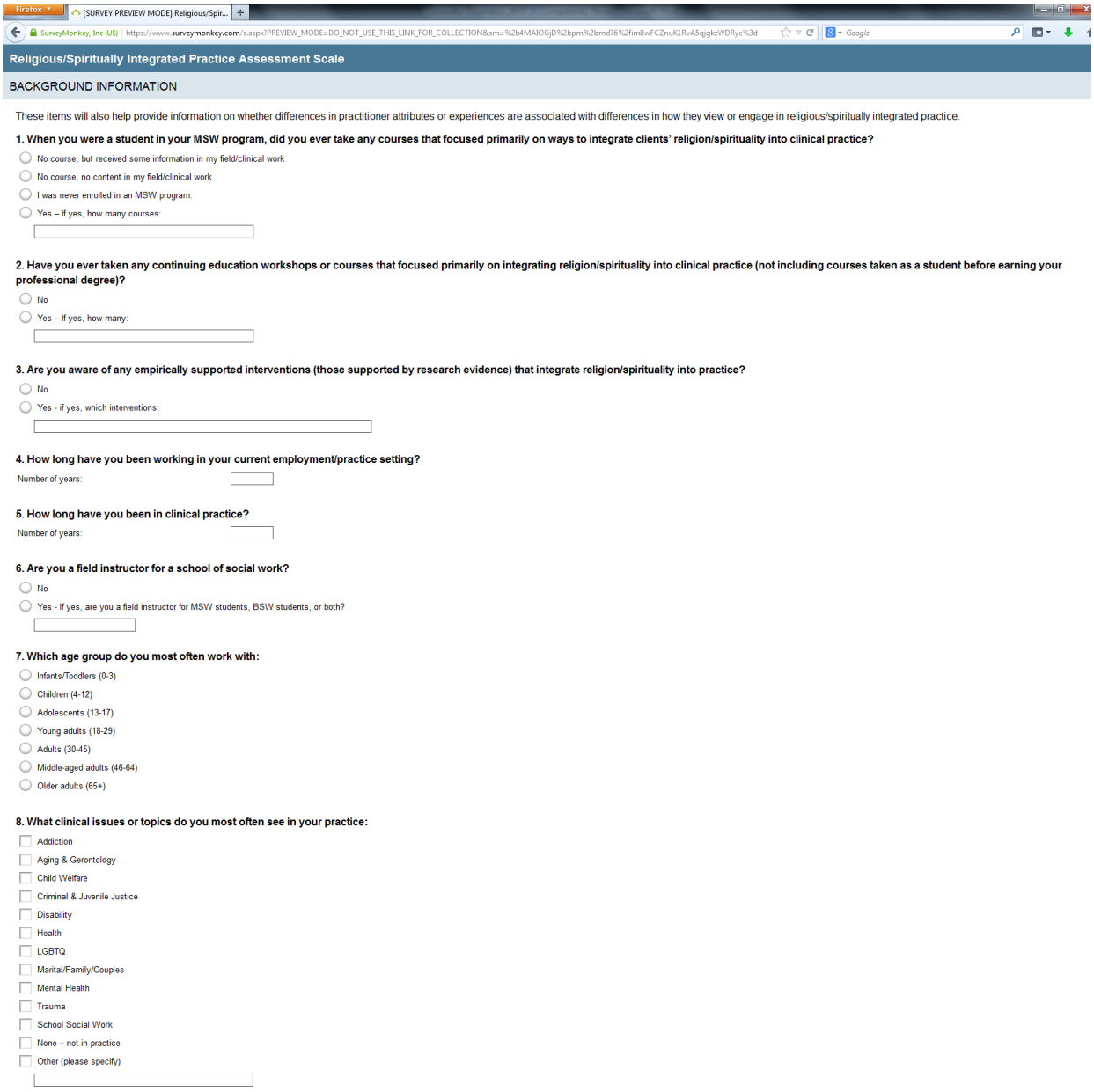
Survey Page 5. Perceived Feasibility Subscale



Survey Page 6. Behaviors Subscale



Survey Page 7. Continued Background Information



Firefox [SURVEY PREVIEW MODE] Religious/Spir...

SurveyMonkey, Inc (US) https://www.surveymonkey.com/s.aspx?PREVIEW_MODE=DO_NOT_USE_THIS_LINK_FOR_COLLECTION&sm=%2b4MAlOGjD%2bpm%2bmd76%2fim8wFCZnuk1RvA5qjgkzWDRyc%3d

Google

Religious/Spiritually Integrated Practice Assessment Scale

BACKGROUND INFORMATION

These items will also help provide information on whether differences in practitioner attributes or experiences are associated with differences in how they view or engage in religious/spiritually integrated practice.

1. When you were a student in your MSW program, did you ever take any courses that focused primarily on ways to integrate clients' religion/spirituality into clinical practice?

- No course, but received some information in my field/clinical work
- No course, no content in my field/clinical work
- I was never enrolled in an MSW program.
- Yes – If yes, how many courses:

2. Have you ever taken any continuing education workshops or courses that focused primarily on integrating religion/spirituality into clinical practice (not including courses taken as a student before earning your professional degree)?

- No
- Yes – If yes, how many:

3. Are you aware of any empirically supported interventions (those supported by research evidence) that integrate religion/spirituality into practice?

- No
- Yes - if yes, which interventions:

4. How long have you been working in your current employment/practice setting?

Number of years:

5. How long have you been in clinical practice?

Number of years:

6. Are you a field instructor for a school of social work?

- No
- Yes - If yes, are you a field instructor for MSW students, BSW students, or both?

7. Which age group do you most often work with:

- Infants/Toddlers (0-3)
- Children (4-12)
- Adolescents (13-17)
- Young adults (18-29)
- Adults (30-45)
- Middle-aged adults (46-64)
- Older adults (65+)

8. What clinical issues or topics do you most often see in your practice:

- Addiction
- Aging & Gerontology
- Child Welfare
- Criminal & Juvenile Justice
- Disability
- Health
- LGBTQ
- Marital/Family/Couples
- Mental Health
- Trauma
- School Social Work
- None – not in practice
- Other (please specify)

9. How would you describe your current employment/practice setting? (Please check all that apply)

- [ ] Non-profit agency
- [ ] For-profit agency
- [ ] Public/private teaching hospital
- [ ] Public/private non-teaching hospital
- [ ] Child protective services
- [ ] Public welfare
- [ ] Solo private practice
- [ ] Group private practice
- [ ] Governmental agency
- [ ] Mental health services
- [ ] Managed care
- [ ] School (K-12)
- [ ] School (college/university)
- [ ] Judicial system
- [ ] Currently unemployed
- [ ] Currently enrolled in school
- [ ] Retired
- [ ] Other (please specify)

10. Please classify how you feel with regard to your level of burnout, using the statements below:

- ○ I enjoy my work. I have no symptoms of burnout.
- ○ Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out.
- ○ I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion.
- ○ The symptoms of burnout that I'm experiencing won't go away. I think about frustration at work a lot.
- ○ I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.

11. What theoretical orientation (e.g., Psychodynamic, Psychoanalytic, Cognitive-Behavioral, etc.) do you most closely identify with (other than Eclectic):

12. What is your religious preference?

- ○ Protestant
- ○ Catholic
- ○ Jewish
- ○ Muslim
- ○ Buddhism
- ○ Hinduism
- ○ None
- ○ Other (please specify)

13. To what extent do you consider yourself a religious person?

- ○ Not Religious
- ○ Slightly Religious
- ○ Moderately Religious
- ○ Very Religious

14. To what extent do you consider yourself a spiritual person?

- ○ Not Spiritual
- ○ Slightly Spiritual
- ○ Moderately Spiritual
- ○ Very Spiritual

15. Below are some common methods of practicing religious/spiritual beliefs. Which of the following do you most frequently practice for religious/spiritual reasons? (Please check all that apply)

- [ ] Regularly attending religious service
- [ ] Attending small social gatherings on a religious/spiritual matter (e.g. Bible studies)
- [ ] Listening to religious/spiritual music or radio
- [ ] Prayer
- [ ] Meditation
- [ ] Reading religious texts
- [ ] Watching religious/spiritual TV or videos
- [ ] Worship (outside of a religious service)
- [ ] Yoga or some other form of physical practice
- [ ] None of the above
- [ ] Other (please specify)

16. How often do you attend religious services?

- Never
- Once a year or less
- A few times a year
- A few times a month
- Once a week
- More than once a week

17. How often do you spend time in private religious activities, such as prayer, meditation or Bible study (or other religious text)?

- Rarely or never
- A few times a month
- Once a week
- Two or more times a week
- Daily
- More than once a day

The following section contains 3 statements about religious belief or experience. Please mark the extent to which each statement is true or not true for you.

18. In my life, I experience the presence of the Divine (ie, God).

- Definitely not true
- Tends not to be true
- Unsure
- Tends to be true
- Definitely true of me

19. My religious beliefs are what really lie behind my whole approach to life.

- Definitely not true
- Tends not to be true
- Unsure
- Tends to be true
- Definitely true of me

20. I try hard to carry my religion over into all other dealings in life.

- Definitely not true
- Tends not to be true
- Unsure
- Tends to be true
- Definitely true of me

21. We are interested in hearing more about your personal experience with religious/spiritually integrated practice.

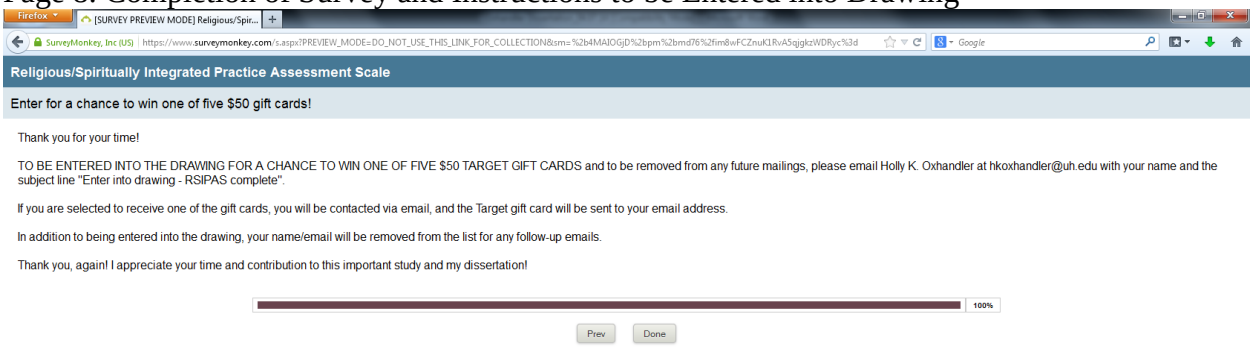
What (if anything) has helped or supported you to assess and/or integrate your clients' religious/spiritual beliefs in your clinical practice?

22. What (if anything) has hindered or prevented you from assessing and/or integrating your clients' religious/spiritual beliefs in your clinical practice?

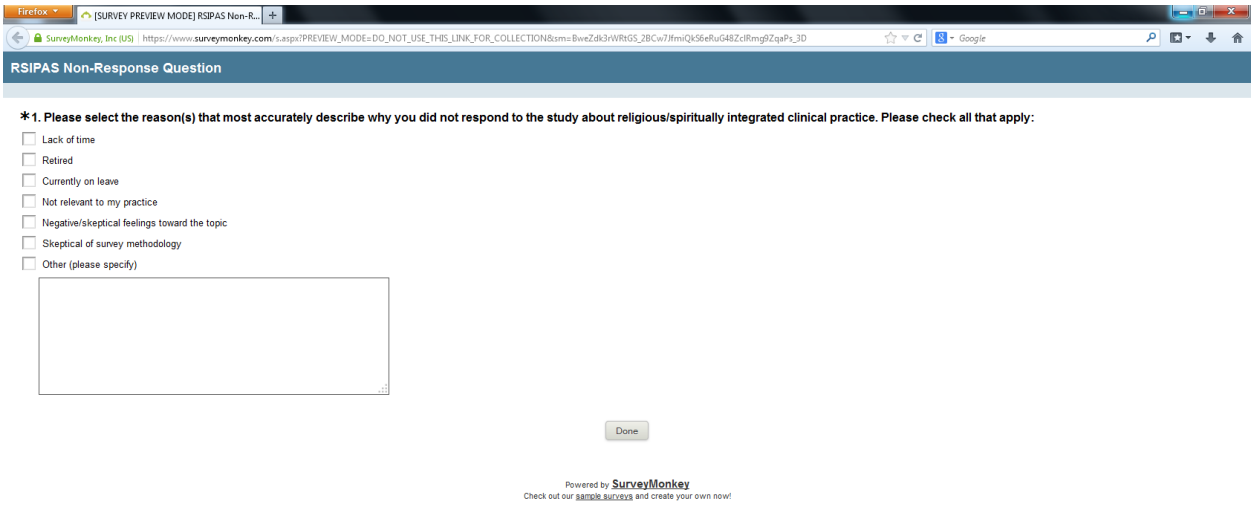
88%

Prev Next

Page 8. Completion of Survey and Instructions to be Entered into Drawing



APPENDIX F – Screen Shot of the SurveyMonkey® link for Reasons for Non-Response



APPENDIX G – Request for Waiver of Documentation of Consent

Informed consent shall be documented by the use of a written consent form approved by the IRB and signed by the subject or the subject's legally authorized representative. (45 CFR 46.117)

A waiver of documentation of consent may be waived if either of the following conditions are true of the proposed research activity. An explanation must be provided.

___X__ The only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject must be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; OR

_____ The research presents no more than minimal risk of harm to subjects AND involves no procedures for which written consent is normally required outside of the research context.

Explanation: This is an anonymous survey of members of the National Association of Social Work regarding their orientation to integrating their clients' religion and spirituality into practice. Maintaining anonymity increases the chance that participants will respond honestly to this survey. If written informed consent were required, it would require linking the responses to this survey to the individuals who respond. In the absence of written informed consent, participants will be provided with the attached cover letter or information in the body of a cover letter, which will provide details of the study, contact information for the principal investigator, and the voluntary and anonymous nature of the research. Participants will also receive a postcard in which they can record their name and indicate whether or not they've completed the survey, and will return the postcard separately from the survey. This will allow the respondent to maintain anonymity yet provide the investigator with information on who has and has not completed the survey.

APPENDIX H – University of Houston Institutional Review Board Application

UNIVERSITY OF HOUSTON
Learning. Leading.

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Division of Research
Institutional Review Board Application

Generated at: 4/8/2014 11:16:59 AM

Institutional Review Board Application ID : 13225-01 - (3541)

Title : Advancing the Integration of Religion and Spirituality in Mental Health Care: Measurement and Current Implementation

Approval details for the Application Id: 3541

	Decision	Approver Name	Date	Comment
PI signature	Approved	Oxhandler, Holly Ms.	07/29/2013	
DOR signature	Approved	Admin, IRB	07/30/2013	

Application Data for Application ID: 3541

Title	Advancing the Integration of Religion and Spirituality in Mental Health Care: Measurement and Current Implementation
Application Type	Revision
Review Type	Expedited
Expedite Code	7: Research on individual or group characteristics or
Exemption Code	Not Applicable
Research Reason	Unfunded Research,Candidacy/Professional Paper,Doctoral Dissertation

Investigator Data for Application ID: 3541

PI Name	Is Pricipal?	Is Co-Investigator?	Is External?	Other Personnel Type?	Is Student?	Faculty Sponsor Name
Oxhandler, Holly Ms.	Yes		No		Yes	Parrish, Danielle Dr.
Achenbaum, W. Andrew Dr.			No	Thesis Committe Member	No	Not Applicable

Revision application data for application Id: 3541

Question	Answer
1) Revision Description (check all that are appropriate)	Revision to currently approved protocol
2) Risk Involve:(Check One)	This revision does not increase risks to participants enrolled in this study. (For students, signature of faculty sponsor is required.)
3) Describe the proposed revision. If applicable, include a scientific justification for the revision (for example, changes in the study population).	The proposed revision is mainly in the source of which the participants are contacted through. In the previously approved protocol, I was going to send the emails for recruitment/cover letter content through a marketing company (InFocus Marketing). After more recent discussions with the individual I had been in contact with at InFocus Marketing, I learned it would not be the best avenue for my research (extremely low response rates in prior student studies (2%), lack of clarity on number of individuals they would email, inability to track certain emails or replace bounce-back emails with other addresses, and extremely expensive). After reading a study by Pignotti & Thyer (2009) where the methodology I'm proposing was used, it seemed to be a much more scientifically-grounded approach (with a much higher response rate) to collecting this data. HelpPRO.com is an NASW-supported therapist finder website which appears to have more updated email addresses tied to the website (with many profile pages being updated within the past year), as social workers use this site for potential clients to contact them. Additionally, instead of sending out just emails as I was planning to do with InFocus Marketing, HelpPRO's publicly available mailing addresses allows me to contact the potential participants in other methods. Based on the Dillman method for surveying to increase response rate, I would like to first send an email through HelpPRO's contact form, informing participants they will be invited to participate in the next few days (Contact 1). They will then be invited to participate through HelpPRO's contact form a few days later

	(Contact 2). Contact 3 is a mail-based invitation to participate, with a $1 token incentive included, which will come about 2 weeks after Contact 2. Contact 4 will be sent about 2-3 weeks after Contact 3. It is the final invitation to participate, including a link to assess for reasons of non-response, and is again through HelpPRO's contact form. Each Contact (1-4) is uploaded, and contains all necessary information that would be in a cover letter. The content has not changed much from the original emails that were approved before, and all pieces of information that UH IRB requires is still included. Finally, instead of sampling 7,500 which was proposed with InFocus Marketing, my primary sample will be 1,000. This was based on prior studies with similar methods' response rates, knowing I will need at least 400 participants to respond. However, if I am unable to obtain 400 participants after the first 1,000 are sampled, I will sample up to an additional 500 individuals (though this is not anticipated to be necessary). Therefore, my sample is up to 1,500. Besides these changes, the proposal remains the same. The main changes are just the source of obtaining the sample (HelpPRO instead of InFocus Marketing), the slightly adjusted emails/contacts with participants, and the sample size change.

Project Review Summary Data for Application ID: 3541

Question	Answer
4) State the specific research hypotheses or questions to be addressed in this study	1) Does the Religion/Spiritually Integrated Practice Assessment Scale (RSIPAS) have face, content and criterion validity? 2) Can responses to the Religion/Spiritually Integrated Practice Assessment Scale (RSIPAS) be explained by four factors (self-efficacy, attitudes, behaviors, and perceived feasibility)? In addition, can responses to the RSIPAS be explained by four first-order factors (self-efficacy, attitudes, behaviors, and perceived feasibility) and one second-order factor (orientation toward integrating clients¿ religion/spirituality into practice)? 3) What are the attitudes, behaviors, self-efficacy, and perceived feasibility concerning the integration of clients¿ religion/spirituality into practice among licensed clinical social work practitioners? 4) Are there any significant relationships between various practitioner background characteristics and RSIPAS variables (e.g., degree of religiosity, prior courses/continuing education units, age, or theoretical orientation)?
	Currently, social work is the largest clinically trained profession in the United States, accounting for roughly 45 percent of clinically trained mental health personnel (SAMHSA, 2010). While the profession of social work offers a unique contribution to mental health services with its strengths-based approach to problems, empowerment model, respect for self-determination, sensitivity to disparate cultures and backgrounds, and holistic perspective when working with clients (Saleeby, 2009), there is a lack of training with regard to integrating clients¿ religious/spiritual beliefs into practice. Today, over 80 percent of Americans identify with some faith tradition (U.S. Census Bureau, 2010), with 82 percent of adults having reported religion being at least somewhat important to them (PEW Forum on Religion & Public Life, 2008). Consequently, many who seek mental health services may utilize religious coping skills (Pargament, 1997, 2007), causing many clients¿ religious/spiritual beliefs and coping strategies to become a topic that clients

5) What is the importance/significance of the knowledge that may result?	may want to talk about with their mental health practitioner. However, many clients are unsure of whether or not this topic is acceptable to discuss in a therapeutic setting (Kahle & Robbins, 2004). In addition, the emerging research suggests that integrating clients¿ religious/spiritual beliefs into practice may actually improve treatment outcomes (Koenig, et al., 2012; Koenig, et al., 2001). A critical issue arises, however, when clients report a preference for their mental health practitioner to initiate the discussion or integrate religion/spirituality in treatment (Stanley, et al., 2011), but the majority (65 percent) of social workers have not received any content addressing religion/spirituality within the practice context during their social work program (Canda & Furman, 2010). While some research has described practitioner views and implementation of specific religious or spiritual techniques (e.g., prayer, meditation) (Canda & Furman, 1999, 2010; Sheridan, 2004; Sheridan, et. al, 1992), there remains a dearth of research concerning social work practitioners¿ self-efficacy and their perceived feasibility regarding the integration of religion/spirituality in practice. Similarly, practitioners¿ more global views of integrating spirituality/religion beyond specific techniques, or whether they are currently utilizing extant evidence-based interventions that focus on such integration, has not yet been studied. There is not currently a validated instrument to measure constructs that assess the multiple factors that might bear on social workers¿ acceptance or orientation toward the integration of spirituality/religion and practice. A second part of this dissertation will describe the prevalence of factors that are expected to play an important role in practitioners' decisions to integrate religion/spirituality as a part of their practice (e.g. feasibility, self-efficacy). Prior studies have shown that these are important variables (that have not yet been addressed in the literature) when assessing new or controversial practice components, such as evidence-based practice (Parrish & Rubin, 2011a, 2011b). This information can then be used to inform the development and evaluation of religion/spirituality in practice BSW and MSW curriculum, as well as continuing education efforts. If research continues to emerge demonstrating positive health and mental health outcomes for clients whose religion/spirituality is integrated into treatment (Koenig, et al., 2012; Koenig, et al., 2001) it is critical to provide this training to social workers, the largest profession of clinically trained mental health care providers (SAMHSA, 2010), so that clients may have the best possible outcomes.
6) Type of Subject Population (check all that are appropriate)	Adults,Elderly (65yrs and above)
6.01) Expected maximum number of participants	1,500
6.02) Age of proposed subject(s) (check all that apply)	Adults (18yrs-64yrs),Elderly Adults (65yrs and above)
6.03) Inclusion Criteria:	Social Workers from the US who advertise their services through NASW-supported HelpPRO.com with a working email address linked to their HelpPRO.com webpage and a mailing address on their HelpPRO webpage (or if no address is listed on HelpPRO, a mailing address on an advertised website on their HelpPRO webpage) will be included in the sampling frame.
6.04) Exclusion Criteria:	Participants who do not have an email address linked to their HelpPRO.com webpage will be excluded. Additionally, a physical mailing address will be required to send the physical letter with the token incentive. Thus, if a physical mailing address is not indicated on his/her HelpPRO.com webpage

	and the PI cannot find a public address for the individual (e.g., on the individual's company webpage advertised in HelpPRO), that individual will be excluded as well.
6.05) Justification:	In order to execute each step of this research protocol, a linked email address to their HelpPRO.com contact form is needed (or a public email address that may be found on their agency website or other public location), as well as a physical address to mail the token incentive.
6.06) Determination:	Only those identified on HelpPRO's website with a linked email adderss and mailing address on HelpPRO's website, or found on a business website advertised on HelpPRO, will be included in the sample.
7) If this study proposes to include children, this inclusion must meet one of the following criterion for risk/benefits assessment according to the federal regulations (45 CFR 46, subpart D). Check the appropriate box:	
8) If the research involves any of the following, check all that are appropriate:	Survey/Questionnaire
9) Location(s) of Research Activities:	UH campus,Other (Explain) :Data collection will take place through an online survey.
10) Informed Consent of Subjects: Your study protocol must clearly address one of the following areas:	Cover Letter. You may request a waiver of documented informed consent with Appendix A - Request for Waiver of Documentation of Consent. ATTACH COPY OF PROPOSED COVER LETTER AND APPENDIX A.

Research Protocol Data for Application ID: 3541

Question	Answer
11) Describe the research study design. (Describe the research methods to be employed and the variables to be studied. Include a description of the data collection techniques and/or the statistical methods to be employed.)	The proposed cross-sectional study will utilize an online survey to validate the proposed Religion/Spiritually Integrated Practice Assessment Scale (RSIPAS) and describe a national sample of social workers' orientation (e.g. attitudes, behaviors, perceived feasibility and self-efficacy) to integrating clients' religion/spirituality into practice. A copy of the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS), along with a demographics section and one open-ended question, will be administered via a Survey Monkey link that will be emailed through HelpPRO.com (a public, National Association of Social Workers-supported therapist finder website) to up to 1,500 individuals. Individuals will be identified by randomly selecting 2000 zip codes, then searching the zip codes and entering appropriate contact/personal information (e.g. name, HelpPRO.com link, phone number, address, licensure, and whether the individual advertises that he/she addresses religious/spiritual concerns that clients may have). From the names that emerge after searching the zip codes, up to 1,500 will be randomly selected and invited to participate through HelpPRO.com's contact form, as the email addresses are not provided directly. Based on the Dillman (2011) method, which has shown to greatly increase response rate, the first email will briefly describe the project and inform the individual that he/she will be receiving an invitation to participate in a survey within the next few days. The second email will be the initial invitation to participate in the survey, and will include a link to participate in the online survey through a Survey Monkey

	link as well as the chance to win a gift card upon participation. Their response to the survey implies their consent to participate in this anonymous study. About 2 weeks after sending the initial invitation to participate, a physical letter will be sent to the participants (using the mailing address available on HelpPRO or a preferred address provided by the participant after the first contact) with a $1 token incentive, encouraging participation with the RSIPAS SurveyMonkey link included in the letter, and thanking those who have already participated. About 2-3 weeks after that, a final follow-up email will be sent through HelpPRO's contact form with the survey link included, as well as the "Non-Response survey" link, to assess for non-response bias.
12) Describe each task subjects will be asked to perform.	Participants will be asked to complete the online version of the Religion/Spiritually Integrated Practice Assessment Scale, along with the included background questions that ask about age, gender, ethnicity, prior training and exposure to integrating clients¿ religion/spirituality into practice, types of degree/licensure, education, number of years in practice, the current setting that he/she works in, religious orientation, spiritual/religious practices, and religiosity. The questionnaire will also include the Duke University Religion Index (DUREL), a five-item measure of that assesses three major dimensions of religiosity: religious activity, non-religious activity, and intrinsic (or subjective) religiosity (Koenig & Büssing, 2010). One open-ended question will also be included at the end of the RSIPAS to capture social workers¿ views and experiences with integrating clients¿ religion/spirituality into practice.
13) Describe how potential subjects will be identified and recruited? (Attach a script or outline of all information that will be provided to potential subjects. Include a copy of all written solicitation, recruitment ad, and/or outline for oral presentation.)	HelpPRO.com is supported by the National Association of Social Workers and is a therapist finder website for clients across the United States. Therapists are found by entering the desired zip code, and indicating the number of miles one would like to search around the entered zip code. Based on Pignotti & Thyer's 2009 study, using this website to recruit participants, 2000 zip codes will be randomly selected and entered with a 5 mile radius specification to search for social workers. Public information listed on this website will be entered for contacting and general sample description. Of those identified from this search, up to 1,500 will be randomly selected and invited to participate. In an effort to increase response rate, participants will be informed that five $50 gift cards will be drawn randomly at the end of the study, as an incentive to participate. In order to enter, the participant must email the principal investigator their email address separately, after completing the survey. Their contact information will be in no way tied to their data, as the data will be entered into SurveyMonkey, and the email will be sent separately to the principal investigator to keep a list of those who would like to be entered into the drawing. The email messages that will be sent through HelpPRO's contact form, and the physical letter to thank them for participating are attached.
14) Describe the process for obtaining informed consent and/or assent. How will investigators	Each subject's choice to participate will be completely voluntary, all responses are anonymous, and their choice to enter into the gift card drawing will be kept confidential. . After the email containing the link to the survey is sent through HelpPRO.com's contact form, the participant has the option of completing it or not. No identifying information will be collected within the survey, limiting any possibility of connecting the data to a particular individual. A request for waiver of documentation of consent will be submitted, since

ensure that each subjects participation will be voluntary (i.e., free of direct or implied coercion)?	there is a minimal risk of harm to subjects and there is no procedure for which written consent is obtained. Each participant has the option of also sending the principal investigator their email address to be entered into the drawing to be randomly selected to win one of five $50 gift card and to be removed from future emails. However, the email the participant will send to be entered into the drawing and removed from future emails will be optional and completely separate from the SurveyMonkey data.
15) Briefly describe each measurement instrument to be used in this study (e.g., questionnaires, surveys, tests, interview questions, observational procedures, or other instruments) AND attach to the application a copy of each (appropriately labeled and collated). If any are omitted, please explain.	The newly developed instrument, the Religion/Spiritually-Integrated Practice Assessment Scale (RSIPAS), will be used to examine social work practitioners¿ attitudes, self-efficacy, perceived feasibility, and behaviors, (together considered ¿overall orientation¿) to integrating clients¿ religion/spirituality into practice. This scale is modeled after Parrish & Rubin¿s Evidence-Based Practice Process Assessment Scale ¿ Short Version, which assesses practitioner views toward using evidence-based practice, and has good reliability and validity (Parrish & Rubin, 2011). In addition to the RSIPAS (http://www.surveymonkey.com/s/RSIPAS), the questionnaire will include a background/demographics section that asks about age, gender, ethnicity, prior training and exposure to integrating clients¿ religion/spirituality into practice, types of degree/licensure, education, number of years in practice, the current setting that he/she works in, religious orientation, spiritual/religious practices, and religiosity. The questionnaire will also include the Duke University Religion Index (DUREL), a five-item measure of that assesses three major dimensions or religiosity: religious activity, non-religious activity, and intrinsic (or subjective) religiosity (Koenig & Büssing, 2010). This brief measure of religiosity will also be added for future, secondary analyses (King, 2011). One open-ended question will also be included at the end of the RSIPAS to capture social workers¿ views and experiences with integrating clients¿ religion/spirituality into practice. In addition, to assess for non-response bias, a link to a one-item "Non-response survey" will be sent in the 3rd email. This question and link (http://www.surveymonkey.com/s/RSIPAS_NR) is attached.
16) Describe the setting and mode for administering any materials listed in question 15 (e.g., telephone, one-on-one, group). Include the duration, intervals of administration, and amount of time required for each survey/procedure. Also describe how you plan to maintain privacy and confidentiality during the administration.	Participants will complete the survey online, at their convenience. It is expected that the RSIPAS and demographics section should take about 15 minutes to complete, total, based on piloting. The non-response question should take about one minute to assess for non-response bias. As mentioned before, the survey will be completely anonymous ¿ no identifying information will be tied to the participants¿ responses.
17) Approximately how much time will be required of each subject? Provide both a total time commitment as well as a time commitment for each visit/session.	It is anticipated that each participant will have a total time commitment of about 15 minutes, depending on how long it takes the individual to complete the online survey.
18) Will Subjects experience any possible risks involved with participation in this project?	
18.01) Risk of Physical Discomfort or Harm	No:
18.02) Risk of Psychological Harm (including stress/discomfort)	Yes: :While highly unlikely, it is possible that a participant may have had a bad experience with the subject of integrating clients' religion/spirituality into practice, and may react negatively toward the survey. To address this unlikely occurrence, the lead researcher will indicate within the email that there are no foreseeable risks, but if the participant has any concerns, to

	contact the principal investigator. Given the anonymous nature of the data, no other risks are anticipated.
18.03) Risk of Legal Actions (such as criminal prosecution or civil sanctions)	No:
18.04) Risk of Harm to Social Status (such as loss of friendship)	No:
18.05) Risk of Harm to Employment Status	No:
18.06) Other Risks	No:
19) Does the research involve any of these possible risks or harms to subjects? Check all that apply.	
20) What benefits, if any, can the subject expect from their participation?	The potential benefits could be an increased self-awareness of ways in which the participant does or does not integrate his/her clients¿ religion/spirituality into clinical practice. In addition, it may allow the participant to identify areas in which he/she may want to become further educated on certain ways to discussing clients¿ religion/spirituality into practice. In addition, the participant may experience a form of satisfaction, knowing that his/her responses are contributing to further understanding and potentially advancing areas within social work education efforts.
21) What inducements or rewards (e.g., financial compensation, extra credit, and other incentives), if any, will be offered to potential subjects for their participation?	Participants who would like to be entered in the drawing to be one of five individuals to receive a $50 gift card, will email the principal investigator separately after completing the survey. The email address will not be connected to the data in any possible way, maintaining anonymity. A total of 5 gift cards will be randomly selected after data has been completed, and the winners will be notified via email and asked for their best contact to send the gift card. Additionally, a small token incentive will be used, based on Dillman's (2009) methods, where $1 will be included in the physical letter mailed, to help increase response rates.

Research Data for Application ID: 3541

Question	Answer
22) Will you record any direct identifiers, names, social security numbers, addresses, telephone numbers, patient or student ID numbers, etc.?	Yes: :The only direct identifiers collected will be the available public info collected from HelpPRO.com (e.g. name, address, HelpPRO website, advertised business website) and the email address from those who wish to be entered in the incentive drawing/removed from future emails. Absolutely NO data will be tied to names, contact information, or email addresses.
23) Will you retain a link between study code numbers and direct identifiers after the data collection is complete?	No: :There will no way of linking the data with the public info collected from HelpPRO.com or email addresses of those who would like to be entered into the gift card drawing
24) Will anyone outside the research team have access to the links or identifiers?	No: :No one outside the research team will have access to any participant information. Additionally, there are no links between data and participants.
25) Where, how long, and in what format (such as paper, digital or electronic media, video, audio or photographic) will data be kept? In addition, describe what security provisions will be taken to protect these data (password protection,	

encryption, etc.). [Note: University of Houston policy on data retention requires that research data be maintained for a minimum of 3 years after completion of the project. All research data collected during this project is subject to the University of Houston data retention policy found at http://www.research.uh.edu/Home/Division-of-Research/Research-Services/Research-Policies/Access-to-and-Retention-of-Research-Data.aspx]	All data collected will be anonymous in nature, and will be downloaded from the Survey Monkey website, and then kept on the Faculty Advisor's (Dr. Danielle Parrish) computer in room 312 of the social work building for a minimum period of three (3) years after the completion of the project.

Appendix A Data for Application ID: 3541

Question	Answer
26) Documentation of consent may be waived if either of the following conditions are true of the proposed research activity. An explanation must be provided.	The research presents no more than minimal risk of harm to subjects AND involves no procedures for which written consent is normally required outside of the research context. :Data collection will be completely anonymous, and no identifiers will be tied to respondents' data. The recruitment email that will be sent through HelpPRO.com's contact form will contain information about the project, allowing the individual to make an informed decision whether he/she would like to participate. In addition, there is no coercion involved and all procedures will occur at the respondent's convenience.

Contact 1 - Email through HelpPRO

Dear INSERT NAME

I am writing to ask for your help with my dissertation study that is currently being conducted at the University of Houston to understand social work practitioners' views and use of clients' religion or spirituality in practice. In the next few days you will be one of 1,000 social workers who will receive a request to participate in this important project by answering questions about your thoughts and experiences concerning the integration of clients' religion or spirituality in practice.

I am writing in advance because many people like to know ahead of time that they will be asked to fill out a questionnaire. This dissertation research can only be successful with the generous help of social workers like you, and my goal is to make this survey easy and enjoyable while also benefiting the mental health profession.

To say thanks, you will receive a small token of appreciation by mail about a week after being invited to participate, using the address you have publicly made available on your HelpPRO profile. If you'd prefer I use a different address, please email me within the next few days at hkoxhandler@uh.edu with your preferred mailing address. Additionally, I will be giving away five $50 gift cards after the study is complete that you can enter to win!

Your participation is voluntary and anonymous. Neither we nor anyone else will be able to identify from whom any completed questionnaire came. Should you have any further questions, concerns, or comments, please do not hesitate to contact me at hkoxhandler@uh.edu. If you have any questions about your rights as a research participant, please contact the University of Houston Committee for the Protection of Human Subjects at (713) 743-9204. Your current or future relationship with University of Houston will not be affected by your decision to participate in this research.

I hope you will take 15 minutes of your time to help me with my dissertation research. Most of all, I hope that you enjoy the opportunity to voice your thoughts and opinions about integrating clients' religion or spirituality into practice. If you are interested in the results of this study, I would be happy to send them to you at the conclusion of the study if you email me, indicating you would like the results.

Kindly,

Holly K. Oxhandler, MSW
PhD Candidate
University of Houston
Graduate College of Social Work
Email: hkoxhandler@uh.edu

Contact 2 - Email through HelpPRO

Dear INSERT NAME,

I am writing to ask for your participation in a survey that we are conducting at the University of Houston as a part of my dissertation research. We are asking social work practitioners, like you, to reflect on your views and use of clients' religion and spirituality in practice.

Your responses to this survey are very important, as they will help us better understand social workers' views and use of clients' religion and spirituality in practice. This is a short survey and should only take about 15 minutes. Please click on the link below to go to the survey website (or copy and paste the link into your internet browser). Upon completion of the survey, you will have the option of entering to win one of five $50 Target gift cards!

Survey Link: **http://www.surveymonkey.com/s/RSIPAS**

You are one of 1,000 social workers asked to participate in this survey. Your participation is voluntary and anonymous. Neither we nor anyone else will be able to identify from whom any completed questionnaire came. Should you have any further questions, concerns, or comments, please do not hesitate to contact me at hkoxhandler@uh.edu. If you have any questions about your rights as a research participant, please contact the University of Houston Committee for the Protection of Human Subjects at (713) 743-9204. Your current or future relationship with University of Houston will not be affected by your decision to participate in this research.

I will be sending a small token of appreciation in the mail to your address on HelpPRO as a way of thanking you for participation. Your responses are important for helping to identify perspectives that can inform future social work practice and educational efforts, as well as help me complete my dissertation research! Thank you, again, for your participation and time! I hope you enjoy the opportunity to share your thoughts and opinions on this area of practice.

Kindly,

Holly K. Oxhandler, MSW
PhD Candidate
University of Houston
Graduate College of Social Work
Email: hkoxhandler@uh.edu

University of Houston

Division of Research

Danielle E. Parrish, PhD
Assistant Professor
Chair of Ms. Oxhandler's Dissertation Committee
University of Houston
Graduate College of Social Work
Email: dparrish@uh.edu

Contact 3 - Mailed letter with token incentive

Dear INSERT NAME,

I recently sent you an email through HelpPRO's contact form, asking you to respond to a brief survey about your views and use of clients' religion and spirituality in practice. Your response to this survey is important and will help in better understanding social workers' integration of clients' religion and spirituality in practice. If you did not receive this email, please feel free to contact me at hkoxhandler@uh.edu and I will send it to you .

I wanted to personally thank you for your time and attention to this survey (my dissertation research), by sending you this letter and a small token of my appreciation. Your participation is very important for better understanding this area of practice and its implications for our profession, as well as the success of my dissertation. If you have already completed the survey, thank you for your time. .

If you have not yet had a chance to complete this survey, you may do so by entering clicking on the link below or copying and pasting it into your Internet browser. This is a short survey and should only take about 15 minutes to complete. Upon completion of the survey, you will have the option of entering to win one of five $50 Target gift cards! Please know how grateful I am for your time, attention, and important contribution to this study.

Survey Link: **http://www.surveymonkey.com/s/RSIPAS**

As mentioned in the initial email, you are among 1,000 social workers being asked to participate in this survey. Your participation is voluntary and all responses are anonymous. Neither we nor anyone else will be able to identify from whom any completed questionnaire came. Should you have any further questions, concerns, or comments, please do not hesitate to contact me at hkoxhandler@uh.edu. If you have any questions about your rights as a research participant, please contact the University of Houston Committee for the Protection of Human Subjects at (713) 743-9204. Your current or future relationship with University of Houston will not be affected by your decision to participate in this research.

Thank you again for your help with this important study! It is only through the help of people like you that we can gather important information to guide our social work profession and practice efforts.

Kindly,

Holly K. Oxhandler, MSW
PhD Candidate
University of Houston
Graduate College of Social Work
Email: hkoxhandler@uh.edu

Danielle E. Parrish, PhD.
Assistant Professor
Chair of Ms. Oxhandler's Dissertation Committee
University of Houston
Graduate College of Social Work
Email: dparrish@uh.edu

Contact 4 - Email through HelpPRO

Dear INSERT NAME

Summer can be a busy time for many, and we understand how valuable your time is. Recently, we sent you an email and letter asking you to respond to a brief, 15-minute Internet questionnaire about your views and use of clients' religion and spirituality in practice.

If you have already completed the survey, thank you for your participation! If you have not yet participated, we urge you to do so by clicking the link below (or copy and paste the link into your internet browser). Upon completion of the survey, you will have the option of entering to win one of five $50 Target gift cards!

Survey Link: **http://www.surveymonkey.com/s/RSIPAS**

If you have chosen not to participate, we are interested in better understanding these reasons to eliminate response bias to the survey. Please use this link to indicate reasons for non-participation: http://www.surveymonkey.com/s/RSIPAS_NR

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Thank you for your help and participation, as this survey will provide valuable information to guide social work practice and educational efforts. We sincerely appreciate your time and contribution to this important effort.

Kindly,

Holly K. Oxhandler, MSW
PhD Candidate
University of Houston
Graduate College of Social Work
Email: hkoxhandler@uh.edu

Danielle E. Parrish, PhD
Assistant Professor
Chair of Ms. Oxhandler's Dissertation Committee
University of Houston
Graduate College of Social Work
Email: dparrish@uh.edu

Contact 1 - Email through HelpPRO 7.29.13

Dear INSERT NAME

I am writing to ask for your help with my dissertation study that is currently being conducted at the University of Houston to understand social work practitioners' views and use of clients' religion or spirituality in practice. In the next few days you will be one of 1,000 social workers who will receive a request to participate in this important project by answering questions about your thoughts and experiences concerning the integration of clients' religion or spirituality in practice.

I am writing in advance because many people like to know ahead of time that they will be asked to fill out a questionnaire. This dissertation research can only be successful with the generous help of social workers like you, and my goal is to make this survey easy and enjoyable while also benefiting the mental health profession.

To say thanks, you will receive a small token of appreciation by mail about a week after being invited to participate, using the address you have publicly made available on your HelpPRO profile. If you'd prefer I use a different address, please email me within the next few days at hkoxhandler@uh.edu with your preferred mailing address. Additionally, I will be giving away five $50 gift cards after the study is complete that you can enter to win!

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I hope you will take 15 minutes of your time to help me with my dissertation research. Most of all, I hope that you enjoy the opportunity to voice your thoughts and opinions about integrating clients' religion or spirituality into practice. If you are interested in the results of this study, I would be happy to send them to you at the conclusion of the study if you email me, indicating you would like the results.

Kindly,

Holly K. Oxhandler, MSW
PhD Candidate
University of Houston
Graduate College of Social Work
Email: hkoxhandler@uh.edu

Contact 2 - Email through HelpPRO 7.29.13

Dear INSERT NAME,

I am writing to ask for your participation in a survey that we are conducting at the University of Houston as a part of my dissertation research. We are asking social work practitioners, like you, to reflect on your views and use of clients' religion and spirituality in practice.

Your responses to this survey are very important, as they will help us better understand social workers' views and use of clients' religion and spirituality in practice. This is a short survey and should only take about 15 minutes. Please click on the link below to go to the survey website (or copy and paste the link into your internet browser). Upon completion of the survey, you will have the option of entering to win one of five $50 Target gift cards!

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Danielle E. Parrish, PhD
Assistant Professor
Chair of Ms. Oxhandler's Dissertation Committee
University of Houston
Graduate College of Social Work

Email: dparrish@uh.edu

Contact 3 - Mailed letter with token incentive 7.29.13

http://www.surveymonkey.com/s/RSIPAS

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Thank you again for your help with this important study! It is only through the help of people like you that we can gather important information to guide our social work profession and practice efforts.

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Danielle E. Parrish, PhD.
Assistant Professor
Chair of Ms. Oxhandler's Dissertation Committee
University of Houston
Graduate College of Social Work
Email: dparrish@uh.edu

Contact 4 - Email through HelpPRO 7.29.13

Dear INSERT NAME

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If you have already completed the survey, thank you for your participation! If you have not yet participated, we urge you to do so by clicking the link below (or copy and paste the link into your internet browser). Upon completion of the survey, you will have the option of entering to win one of five $50 Target gift cards!

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Thank you for your help and participation, as this survey will provide valuable information to guide social work practice and educational efforts. We sincerely appreciate your time and contribution to this important effort.

Kindly,

Holly K. Oxhandler, MSW
PhD Candidate
University of Houston
Graduate College of Social Work
Email: hkoxhandler@uh.edu

Danielle E. Parrish, PhD
Assistant Professor
Chair of Ms. Oxhandler's Dissertation Committee
University of Houston
Graduate College of Social Work
Email: dparrish@uh.edu

Approved with Stipulation

UNIVERSITY of HOUSTON

DIVISION OF RESEARCH

July 25, 2013

Ms. Holly Oxhandler
c/o Dr. Danielle Parrish
Dean, Social Work

Dear Ms. Holly Oxhandler,

The University of Houston Committee for the Protection of Human Subjects (1) reviewed your research proposal entitled "Advancing the Integration of Religion and Spirituality in Mental Health Care: Measurement and Current Implementation" on July 19, 2013, according to institutional guidelines.

The Committee has given your project approval pending clarification of the stipulations listed below:

1. Please provide a direct link to the online survey/cover letter (the link included does not provide a copy of the cover letter).

2. The "voluntary and anonymous" language in the application (question 14), contact letters and cover letter must be revised to indicate that subjects' participation is confidential (as contact information will be collected for gift card drawing, so you may know who participated) but the associated responses are anonymous.

3. The response to question 3 indicates that 1000 individuals will be approached to recruit 400 subjects, and "if I am unable to obtain 400 participants after the first 1000 are sampled, I will sample up to an additional 500". The answer to question 6.01 indicates 7500 subjects as the max number. Please reconcile these numbers; the number of participants must be consistently stated within the application and all other documents.

You must submit evidence of compliance with the above stipulations online via the Research Administration Management Portal (RAMP), by August 19, 2013. The material you submit to meet these contingencies must be certified by the Committee for the Protection of Human Subjects as acceptable before you may begin data collection. If you fail to respond by this date, your approval may be revoked. This would necessitate your reapplying to the Committee prior to initiation of your research project. Research without the Committee's sanction could result in an administrative block to the receipt of your degree.

In order to expedite review, please prepare a cover letter that explains the response to each item. Once you met these requirements, this project must be reviewed annually, or prior to any change approved procedures.

If you have any questions, please contact Alicia Vargas at (713) 743-9215.

Sincerely yours,

for

Dr. Norma Olvera, Vice -Chair
Committee for the Protection of Human Subjects (1)

Protocol Number: 13225-01 Full Review: ____ Expedited Review: X

316 E. Cullen Building Houston, TX 77204-2015 (713) 743-9204 Fax: (713) 743-9577

COMMITTEES FOR THE PROTECTION OF HUMAN SUBJECTS

IRB Approval Response letter 7.29.13

July 29, 2013

Dear UH CPHS (c/o Dr. Norma Olvera),

Thank you for reviewing my IRB protocol on 7/19/13. I have received the approval letter with stipulations and have addressed the three stipulations below:

1. The link to participate in the survey is: http://www.surveymonkey.com/s/RSIPAS . The link to share reasons for non-response (prompted in the final email) is: http://www.surveymonkey.com/s/RSIPAS_NR . Both surveys should be accessible without a problem now. With regards to the cover letter, the email content contains all required information that a cover letter would typically contain, but is written in a style that's a bit more email-friendly. The email serves as the cover letter. This was discussed with Alicia Vargas earlier this year, as I had to make some other changes to the protocol at that time, and it was approved. There were just some slight wording changes for this revision, compared to the last protocol update, based on the Dillman method for surveying. None of the necessary information was removed.
2. The "voluntary and anonymous" language in question 14 and in all 4 methods of contact has been updated. They now read, "Your participation is voluntary, all responses are anonymous, and your choice to enter into the gift card drawing will be kept confidential." I have uploaded the updated documents for all 4 methods of contact to this revision.
3. The maximum number of individuals approached will be 1500. This has been updated in 3 (request for revision), 6.01, 11, and 13.

Thank you for your time and support of this research! I truly appreciate it. Please feel free to contact me if you have any further questions.

Kindly,

Holly K. Oxhandler, MSW
PhD Candidate
University of Houston
Graduate College of Social Work
P: 713-805-9535

Final Approval

UNIVERSITY of HOUSTON

DIVISION OF RESEARCH

July 30, 2013

Ms. Holly Oxhandler
c/o Dr. Danielle Parrish
Dean, Social Work

Dear Ms. Holly Oxhandler,

The University of Houston Committee for the Protection of Human Subjects (1) reviewed your research proposal entitled "Advancing the Integration of Religion and Spirituality in Mental Health Care: Measurement and Current Implementation" on July 19, 2013, according to institutional guidelines.

At that time, your project was granted approval contingent upon your agreement to modify your protocol as stipulated by the Committee. The changes you have made adequately fulfill the requested contingencies, and your project is now **APPROVED**.

- **Approval Date: July 30, 2013**
- **Expiration Date: February 1, 2014**

As required by federal regulations governing research in human subjects, research procedures (including recruitment, informed consent, intervention, data collection or data analysis) may not be conducted after the expiration date.

To ensure that no lapse in approval or ongoing research occurs, please ensure that your protocol is resubmitted in RAMP for renewal by the **deadline for the January 2014** CPHS meeting. Deadlines for submission are located on the CPHS website.

During the course of the research, the following must also be submitted to the CPHS:

- Any proposed changes to the approved protocol, prior to initiation; AND
- Any unanticipated events (including adverse events, injuries, or outcomes) involving possible risk to subjects or others, within 10 working days.

If you have any questions, please contact Alicia Vargas at (713) 743-9215.

Sincerely yours,

for

Dr. Norma Olvera, Vice -Chair
Committee for the Protection of Human Subjects (1)

PLEASE NOTE: All subjects must receive a copy of the informed consent document, if one is approved for use. All research data, including signed consent documents, must be retained according to the University of Houston Data Retention Policy (found on the CPHS website) as well as requirements of the FDA and external sponsor(s), if applicable. Faculty sponsors are responsible for retaining data for student projects on the UH campus for the required period of record retention.

Protocol Number: 13225-01 Full Review: ____ Expedited Review: X

316 E. Cullen Building Houston, TX 77204-2015 (713) 743-9204 Fax: (713) 743-9577
COMMITTEES FOR THE PROTECTION OF HUMAN SUBJECTS

CURRICULUM VITAE

Holly Kay Oxhandler, MSW
hkoxhandler@uh.edu

EDUCATION

2010-2014	**Doctor of Philosophy**, Graduate College of Social Work, University of Houston, Houston, TX, May 2014 Dissertation: *Advancing the Integration of Religion and Spirituality in Mental Health Care: Measurement and Current Implementation* Chair: Dr. Danielle E. Parrish. Committee: Drs. W. Andrew Achenbaum, Kenneth I. Pargament, & Luis R. Torres.
2009-2011	**Master of Social Work**, Graduate College of Social Work, University of Houston, Houston, TX, Clinical Track
2007	**Bachelor of Science in Psychology**, University of Houston, Houston, TX Minor in Studio Arts
2004-2006	Lone Star College, The Woodlands, TX
2004	Rio Salado Online, Tempe, AZ
2003	St. Bonaventure University, St. Bonaventure, NY

FUNDING & FELLOWSHIPS

Fellowships

2013-2014 & 2011-2012	Dr. Fernando J. Zuniga y Rivero Doctoral Fellowship in Gerontological Social Work
2012-2014	Gulen Institute Doctoral Fellowship
2010-2014	Doctoral Research Assistant Fellowship, University of Houston GCSW Supervisor: Danielle Parrish, Ph.D.
2009-2010	Masters Research Assistant Fellowship, University of Houston GCSW Supervisor: Danielle Parrish, Ph.D.

Scholarships

2011	John Templeton Foundation Scholarship for Duke University Center for Spirituality, Theology, and Health Summer Research Workshop
2010-2011	Mark Magaziner Research Scholarship Recipient

2010 International Education Scholarship Recipient

ADVANCED TRAINING

05/2012 Structural Equation Modeling, Austin, TX, Four-day workshop
Presented by Tiffany Whittaker, PhD

05/2012 Advanced Regression, Austin, TX, Four-day workshop
Presented by Carlos M. Cavalho, PhD

02/2012 NVivo 9, Houston, TX, Two-day workshop
Presented by Cynthia Jacobs, PhD

08/2011 Duke University Center for Spirituality, Theology, and Health Summer Research Workshop, Durham, NC, Five-day workshop
Presented by Harold Koenig, MD, MHSc

12/2010 "Write Winning Grants" (Grant Writers' Seminars and Workshops, LLC), Houston, TX, One-day workshop
Presented by Stephen Russell, DVM, PhD.

RESEARCH EXPERIENCE

2013 – present North American Association for Christians in Social Work (NACSW), *Consultant*
Invited by Drs. Rick Chamiec-Case and Terry Wolfer to assist with developing an instrument to measure social workers' integration of faith in practice.

2012 – 2014 University of Houston, Graduate College of Social Work, *Principal Investigator*
Faculty Supervisor: Danielle Parrish, PhD
Project: Advancing the Integration of Religion and Spirituality in Mental Health Care: Measurement and Current Implementation

2012 University of Houston, Graduate College of Social Work, *Principal Investigator*
Faculty Supervisor: Danielle Parrish, PhD
Project: PhD Moms: Understanding Faculty and PhD Students' Experiences of Being Pregnant While in Their Doctoral Program (A Qualitative Study)

2011 University of Houston, Graduate College of Social Work, *Principal Investigator*

Faculty Supervisor: Danielle Parrish, PhD
Project: Pay it Forward: A Student-Led MSW Mentoring Program

2009-present — See *Fellowships* for research experience with Danielle Parrish, PhD

2008-2009 — Baylor College of Medicine, Michael E. DeBakey Veterans Administration Medical Center Hospital, Houston Center for Quality of Care & Utilization Studies, *Research Coordinator I*
Supervisor: Melinda Stanley, Ph.D.

- Research Assistant for NIMH-funded R01 Randomized Clinical Trial (Peaceful Living Project)
- Research Assistant for pilot study investigating older adults' opinions on incorporating religion and spirituality into therapy for anxiety/depression, and developing CBT intervention

2007 — University of Houston, Department of Psychology, *Research Assistant*
Supervisor: Amber Bush Amspoker, Ph.D.
Project: Cognitive Representations of Illness

2007 — University of Houston, Department of Psychology, *Research Assistant*
Supervisor: C. Raymond Knee, Ph.D.
Project: Beliefs and Perceptions of Romantic Relationships

2006-2008 — University of Houston, Department of Psychology, *Research Assistant*
Supervisor: Jeremy Pettit, Ph.D.
Project: Suicidal Adolescent Inpatient Study

TEACHING EXPERIENCE

Adjunct Faculty

Fall 2013 — University of Houston, Graduate College of Social Work
Course: Evaluation of Practice (28 students)

Teaching Assistantships

Spring 2014 — University of Houston, Graduate College of Social Work
Instructor: Danielle Parrish, Ph.D.
Course: Evaluation of Practice (Hybrid Course)

Summer 2013 — University of Houston, Graduate College of Social Work
Instructor: Brene Brown, PhD
Course: Shame, Empathy, & Resilience

Spring 2011,
Fall 2011 – 2013 University of Houston, Graduate College of Social Work
Instructor: Danielle Parrish, Ph.D.
Course: Evaluation of Practice

Spring 2012 University of Houston, Graduate College of Social Work
Instructor: Danielle Parrish, Ph.D.
Course: Diagnostic and Statistical Manual of Mental Disorders IV-TR

Guest Lectures

2014 University of Houston, Graduate College of Social Work
Instructor: Patrick Leung, PhD
Course: Advanced Multivariate Statistics (04/2014)
Lecture topic: "A Crash Course in Running a Confirmatory Factor Analysis Using Mplus"

2011 – 2014 University of Houston, Graduate College of Social Work
Instructor: Danielle Parrish, PhD
Course: Evaluation of Practice (10/2011, 10/2012, 11/2013, 04/2014)
Lecture topic: "Conducting and Interpreting Data Analysis Procedures (using Excel)"

Fall 2013 University of Houston, Graduate College of Social Work
Instructor: Sarah Narendorf, PhD
Course: Social Work Research Methods
Lecture topic: "Advancing the Integration of Religion and Spirituality in Mental Health Care: Research Methodology"

Spring 2011 – 2013 University of Houston, Graduate College of Social Work
Instructor: Sandra Lopez, DCSW, LCSW, ACSW
Course: Professional Self-Care (04/2011, 04/2012, & 03/2013)
Lecture topic: "Spirituality and Professional Self-Care"

Spring 2012 University of Houston, Graduate College of Social Work
Instructor: W. Andrew Achenbaum, PhD
Course: Spirituality and Social Work (February 2012)
Lecture topic: "Sacred Moments in Psychotherapy"

CLINICAL EXPERIENCE

2011 Counseling Associates of South Texas, The Woodlands, TX,
Graduate Intern

2009-2010 Arrow Child & Family Ministries, Spring, TX, *Graduate Intern*
Evaluated agency's assessment and integration of clients' religion/ spirituality in treatment; Developed manualized training on integrating children's religion/spirituality into foster care; Assisted in quality assurance reviews; Developed manualized training on professional self-care for foster care workers

2008 – 2009 Baylor College of Medicine and Michael E. DeBakey Veterans Affairs Medical Center, Houston, TX *Counselor*
Supervisor: Melinda Stanley, PhD., full time (40 hours/week)
Trained on manualized cognitive behavior therapy (CBT) for older adults in primary care and patients at the VA; Attended weekly supervision; Administered CBT to patients in person or over the phone; Trained in motivational interviewing and crisis intervention

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PUBLICATIONS

Peer Reviewed

Oxhandler, H.K. & Pargament, K.I. (In press). Social work practitioners' integration of clients' religion and spirituality in practice: A literature review. *Social Work.*

Parrish, D.E. & **Oxhandler, H.K.** (In press). Social work field instructors' views and implementation of evidence-based practice. *Journal on Social Work Education.*

Oxhandler, H.K. & Parrish, D.E. (Under review). The Development and Validation of the Religious/Spiritually Integrated Practice Assessment Scale.

Oxhandler, H.K., Parrish, D.E., Torres, L.R., & Achenbaum, W.A. (Under review). Walking the Talk: Do LCSWs integrate clients' religion/spirituality in practice?

Parrish, D.E., **Oxhandler, H.K.,** Duron, J., & Bordnick, P. (Under review). Utilization of Virtual Reality Technology for Treating Social Anxiety Disorder in Adolescents: A Feasibility Study.

Invited/Not Peer Reviewed

Oxhandler, H.K. (2014, April). Prayer corner: Infusion. *Catalyst, 57*(2), 4.

Oxhandler, H. K. (2012 May 15). Faith and Social Work Practice: A Dual Relationship [Web log post]. Retrieved from http://nacsw.org/blog/2012/faith-and-social-work-practice-a-dual-relationship/#idc-container

Armento, M.E.A., Zeno, D., Barber, C., Phillips, L., **Oxhandler, H.K.**, Barrera, T. & Stanley, M. (Unpublished). *Calmer Life Program – Counselor Manual*

Armento, M.E.A., Zeno, D., Barber, C., Phillips, L., **Oxhandler, H.K.**, Barrera, T. & Stanley, M. (Unpublished). *Calmer Life Program – Participant Workbook*

PEER-REVIEWED PRESENTATIONS

Oxhandler, H.K. & Parrish, D.E. (Under review). The development and validation of the Religious/Spiritually Integrated Practice Assessment Scale. Paper to be presented at the annual meeting of the Society for Social Work and Research, New Orleans, LA.

Oxhandler, H.K. (Accepted). *Integration of clients' spirituality among Christians in social work.* Sixty-minute workshop to be presented at the annual meeting of the North American Association of Christians in Social Work, Annapolis, MD.

Oxhandler, H.K. (Accepted). *Social workers' integration of clients' religion/spirituality in practice: A national survey.* Poster to be presented at the annual program meeting of the Council on Social Work Education, Tampa, FL.

Giardina, T.D., **Oxhandler, H.K.**, & Duron, J.F. (Accepted). *The next generation of social work educators: Reflections from doctoral students.* Panel discussion to be presented at the annual program meeting of the Council on Social Work Education, Tampa, FL.

Oxhandler, H.K. (December 2013). *Social Workers' Integration of Clients' Religion/Spirituality In Practice: Preliminary Findings from the Religious/Spiritually Integrated Practice Assessment Scale.* Presented at the University of Houston Social Work and Research Conference, Houston, TX.

Duron, J.F., **Oxhandler, H.K.**, & Parrish, D.E. (November 2013) *Feasibility of Virtual Reality Exposure Therapy for Adolescent Social Anxiety.* Poster presented at the annual program meeting of the Council on Social Work Education, Dallas, TX.

Oxhandler, H.K. & Militello, P. (October 2013). *The virtue of gratitude: Research, barriers, and practices in social work.* Sixty-minute workshop presented at the annual meeting of the North American Association of Christians in Social Work, Atlanta, GA.

Oxhandler, H.K. (April 2013). *Examining the dissemination of empirically-supported, spiritually-sensitive mental health interventions using the Diffusion of Innovations Theory*. Poster presented at the Bridging the Research and Practice Gap: A National Symposium on Critical Considerations, Successes and Emerging Ideas, Houston, TX.

Oxhandler, H.K. (December 2012). *Measuring the integration of clients' religion/spirituality in clinical practice: Introducing the Religious/Spiritually Integrated Practice Assessment Scale.* Presented at the University of Houston Social Work and Research Conference, Houston, TX.

Oxhandler, H.K., Alquicira, L.M., & Parrish, D.E. (November 2012). *Pay it forward: Implementation and evaluation of a MSW peer mentoring program.* Paper presented at the annual program meeting of the Council on Social Work Education, Washington, DC.

Oxhandler, H.K. (December 2011). *Religion, spirituality, and health: Further disseminating the research.* Presented at the University of Houston Social Work and Research Conference, Houston, TX.

Parrish, D.P., & **Casciani, H.K.** (October 2011). *Social work field instructors' orientation to the evidence-based practice process.* Paper presented at the annual program meeting of the Council on Social Work Education, Atlanta, GA.

Oxhandler, H.K. (October 2011). *Spirituality and professional self-care.* Sixty-minute workshop presented at the annual meeting of the North American Association of Christians in Social Work, Pittsburgh, PA.

Parrish, D.P., Rubin, A. & **Casciani, H.K.** (January 2011). *Social work practitioners' views of and current engagement in the EBP process.* Poster session presented at the annual meeting of the Society for Social Work and Research, Tampa, FL.

Parrish, D.P. & **Casciani, H.K.** (October 2010). *Tools for implementing evidence-based interventions and programs.* Ninety-minute session presented at the annual meeting of the National Association for Social Workers – Texas Chapter, Houston, TX.

Camp, M.E., Cully, J., Barber, C., Phillips, L., Bush, A.L., Zeno, D., **Casciani, H.,** Lomax, J. & Stanley, M. (November 2009). *Religion and spirituality in therapy: Patient preferences and related characteristics.* Poster session presented at the annual meeting of the Gerontological Society of America, Atlanta, GA.

Grover, K.E., Garza, M.J., Mathew, A.R., **Casciani, H.K.**, & Pettit, J.W. (November 2009). *Negative cognitive bias amongst suicidal adolescent inpatients.* Poster session presented at the annual meeting of the Association for Behavioral and Cognitive Therapies conference, New York, NY.

Casciani, H. K., Bush, A.L., & Naus, M.J. (February 2009). *You're not a good support provider, but I still like you: Satisfaction with social support and happiness with close others in patients with chronic illness.* Poster session presented at the annual meeting of the Society for Personality and Social Psychology, Tampa, FL.

Grover, K.E., Garza, M. J., **Casciani, H.K.,** & Pettit, J.W. (November 2008). *Impulsivity and stressful life events in suicidal adolescent inpatients.* Poster session presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, Orlando, FL.

PRESENTATIONS BY INVITATION

Flores, D.V. & **Oxhandler, H.K.** *Spiritual and cultural competency in geriatric and palliative medicine.* Boomer Care Blue Book Lecture Series: The Division of Geriatric and Palliative Medicine, University of Texas Medical School, Houston Texas, February 2014.

Oxhandler, H.K. *Communicating across generations.* Invited workshop to be presented at the Interfaith Ministries of Houston annual Ways of Women Retreat, Houston, TX, February 2014. [Received honorarium for presentation.]

Oxhandler, H.K. *Religion/Spirituality Integrated Practice Assessment Scale*. Invited presentation at the Institute for Spirituality and Health in the Texas Medical Center, Houston, TX, March 2012.

Duron, J.F., Giardina, T.D., McIngvale, E.R., & **Casciani, H.K.** *Using evidence-based practice for effective social work.* Invited panel presentation at University of Houston's Graduate College of Social Work PhD Symposium, Houston, TX, March 2011.

Casciani, H.K. *Integrating spirituality into clinical social work: A student's perspective.* Session presented to students and faculty at University of Houston's Graduate College of Social Work, Houston, TX, August 2010.

CONFERENCE PLANNING EXPERIENCE

2011-2013	Bridging the Gap National Symposium (April 5 & 6, 2013) • Planning Committee Member & Event Coordinator • Student Volunteer Organizer (26 UH GCSW students)
2011	UH GCSW PhD Symposium, *Planning Committee Member*

JOURNAL EDITORIAL BOARDS & EXTERNAL SERVICE TO THE PROFESSION

2014	CSWE 2014 APM Proposal Reviewer for the Evidence-Based Practice Track, Invited by Danielle Parrish, PhD
2013-2014	NACSW Track Co-Chair Coordinator (with Dr. David Sherwood) for the Professional Relationships, Values, and Ethics Track, Invited
2011-2014	Reviewer: *Perspectives in Social Work Journal*
2011-2012	Spirituality Research Team Member at the Institute for Spirituality and Health within the Texas Medical Center

2011 Content reviewer: Semi-Structured interview for *Religiosity and Spirituality among Adolescents with Sickle Cell Disease*, Dora Clayton-Jones, PhD Candidate, Marquette University College of Nursing

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FORMAL MENTORING EXPERIENCE (MSW and PhD students formally mentored)

2013 – 2014 Carol Ann Ross (UH GCSW Student Association Research Committee Chair)
2012 – 2014 Fredreka Levingston (PhD Student, UH GCSW Student Association PhD Representative)
2012 – 2014 Anny Ma (PhD Student)
2012 – 2013 Christina Veillon (UH GCSW Student Association Co-President; Social Workers in Faith-Filled Training Student Group Creator & Chair)
2010 – 2011 Luz Macias (UH GCSW Student Association Clinical Representative; Clinical Leadership Society; Hispanic Student Association)
2010 – 2011 Ivy Crank (UH GCSW Student Association NASW Representative)

SERVICE TO THE UNIVERSITY & COMMITTEE WORK

University of Houston

2010 University of Houston GCSW Student Representative for student meeting with University President, Renu Khator (Selected by GCSW)

University of Houston Graduate College of Social Work

Committees/Groups/Events/Service

2009 – 2014 GCSW Student Ambassador
2013 "I just received an offer for a tenure-track faculty position… Now what?!": A Career Planning Event for PhD Students, *Event Organizer*
2013 GCSW PhD Student Handbook Editor (Invited)
2013 Turning your PhD into a J-O-B: A Career Planning Event for PhD Students, *Event Organizer*
2013 Breakout Session Recorder & Presenter, Bridging the Research and Practice Gap Symposium
2011 – 2013 Student Association PhD Representative (Invited)
2011 – 2013 Doctoral Students Writing Group
2011 – 2012 PhD Curriculum Committee, PhD Student Representative (Elected)
2011 – 2012 GCSW Career Services Student Steering Committee Member (Invited)
2012 Grievance Committee member (Appointed by the Dean)
2012 Student Delegate for the 2012 GCSW Gala – April 26, 2012 (Invited)
2010 –2011 Student Association Clinical Track Representative (Elected)
- Research Committee Founder & Co-Chair
- Mentor Committee Founder & Co-Chair

2009 –2011 Clinical Leadership Society

Presentations

Oxhandler, H.K., Williams, S. *PhD applicant information session*. University of Houston Graduate College of Social Work, Information Session, Houston, TX, December 2011.

Epstein, M., **Oxhandler, H.K.**, Trahan, M., & Eckhart, G. *MSW/PhD dual degree information session*. University of Houston Graduate College of Social Work, Information Session, Houston, TX, November 2011.

Casciani, H.K., Bohn, A., & Argueta, V. *MSW information session.* University of Houston Graduate College of Social Work, Information Session, Houston, TX, February 2011.

Epstein, M., & **Casciani, H.K.** *PhD applicant information session.* University of Houston Graduate College of Social Work, Information Session, Houston, TX, January 2011.

Epstein, M., **Casciani, H.K.** & LaChappelle, A. *MSW/PhD dual degree information session*. University of Houston Graduate College of Social Work, Information Session, Houston, TX, November 2010.

Casciani, H.K., Evanoff, L. & Leung, P. *Independent studies: Opportunities for research and study abroad*. University of Houston Graduate College of Social Work, Student Association, Office for International Social Work Education, and Students for the Advancement of International Social Work event, Houston, TX, October 2010.

Casciani, H.K., Evanoff, L., Garrison, B., Latson, F., Dobbs, C. & Torres, A. *The mentoring committee's second-year field panel*. University of Houston Graduate College of Social Work, Student Association event, Houston, TX, September 2010.

Luby, C. & **Casciani, H.K.** *Life after loss: A client's perspective.* University of Houston Graduate College of Social Work, Clinical Leadership Society event, Houston, TX, September 2010.

White, S., **Casciani, H.K.,** Bohn, A., & Evanoff, L. *Clinical and macro track question & answer session.* University of Houston Graduate College of Social Work, Clinical Leadership/MACRO event, Houston, TX, September 2010.

Mollhagen, A., & **Casciani, H.K.** *Advanced standing student advising meeting*. University of Houston Graduate College of Social Work, Information Session, Houston, TX, September 2010.

Mollhagen, A., & **Casciani, H.K.** *MSW student advising meeting*. University of Houston Graduate College of Social Work, Information Session, Houston, TX, July 2010.

Mollhagen, A., & **Casciani, H.K.** *MSW student advising meeting*. University of Houston Graduate College of Social Work, Information Session, Houston, TX, June 2010.

Mollhagen, A., & **Casciani, H.K.** *MSW information session*. University of Houston Graduate College of Social Work, Information Session, Houston, TX, February 2010.

HONORS & AWARDS

Honors & Awards

2011-present	Phi Alpha Honor Society Member
2010	Nominated for the Jane Addams Unity Award, University of Houston
2010	Nominated for the Mahatma Gandhi Peace Award, University of Houston
2007–present	Golden Key International Honor Society Member
2007	University of Houston Dean's List
2006–2008	The National Scholars Honor Society Member (invitation only)
2006–2008	Phi Kappa Delta Honor Society Member (invitation only)
2005	National Dean's List

PROFESSIONAL ASSOCIATIONS/MEMBERSHIPS

Council on Social Work Education (CSWE)
Society for Social Work and Research (SSWR)
Society for Spirituality and Social Work (SSSW)
National Association of Social Workers (NASW)
North American Association of Christians in Social Workers (NACSW)