Mental Health Clients' Preferences for Spiritually Oriented Treatment

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ABSTRACT

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The purpose of this study was to determine whether outpatient mental health clients prefer a counselor who integrates spirituality into the counseling process. Questions on spirituality and religion were included in the study to help differentiate between the two and to reduce the possibility of placing respondents into a category they may not necessarily be comfortable with.

A total of 67 clients participated in the research. The majority of respondents strongly agreed they wanted a counselor who understood their spirituality. Only two respondents indicated they were not at all spiritual. Pearson r results indicated that of those that indicated they were very religious, having a counselor who understood their religion was very important to them. Respondents who categorized themselves as more spiritual than

religious tended to be more interested in developing their faith than those who were religious.

There were no significant correlations when comparing high spirituality with desire for religious understanding by a counselor or high religiosity and desire for spiritual understanding. This points to the importance of distinguishing between religion and spirituality and providing options for all clients and not just non-spiritual or highly religious.

Recommendations were to include spiritual development and world religion coursework in the curriculum for counseling students. Discussions on ethics, personal beliefs, and the ability to assist others by integrating spiritual and or religious ideals that are not necessarily parallel to the counselors' must take place in the classroom. Counselors can not be assumed competent in this area, as it tends to be a sensitive topic for many people. A spiritual and religious history should be included in the psychosocial interview and assessment.

Clients have clearly indicated they want their counselor to understand their spirituality and religion if it is important to them, and to most of them it is. It is now the duty of the profession to deliver. Delivery must occur on the levels of personal development and discovery, training and education, integrative policies in clinics, hiring and availability of spiritually competent counselors, and coverage by insurance carriers for services including or directly related to spiritual concerns.

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CHAPTER 1
INTRODUCTION

Psychology is always evolving. Although the field has moved into a more eclectic mix of its founders' theories with newer constructs instead of the single recipe approach, it has also moved away from one concept that the entire field of Psychology was built on: spirituality. Most people associate the mind, not spirituality with Psychology. However, the original definition of the word Psychology is "study of the soul" (Morgan, 1994). This makes it difficult to argue with the original purpose of Psychology. One of the most respected founding fathers of Psychology, Carl Jung, incorporated spiritual concepts into his famous theories and writings (1994). However, throughout history the recognition of the spiritual aspect of Psychology has dwindled, even as it has become more common in the mainstream. Increasingly, organizations compartmentalize spirituality by offering traditionally trained counselors or Christian counselors, possibly leaving little room for the vast area in between the two, and leaving a difficult choice for those who do not completely identify with either of those two categories or identify with both.

Despite the decline of spirituality in Psychology, studies consistently indicate that more than 90% of Americans believe in God (Gallup & Castelli, 1989). Kroll and Sheehan (1989) make a case that the belief in God contributes to values and therefore the formation of identity. These are some of the very issues dealt with in counseling. Levin, Larson, & Puchalski (1997) cite recent studies showing 80% of Americans believe the power of prayer can improve their health. At a conference of family physicians in 1996, out of 296 physicians surveyed, 99% think religious beliefs can heal (Sloan, Bagiella, & Powell, 1999).

Although psychological and medical literature both point to society's strong spiritual and/or religious beliefs, and that those beliefs or practices can heal, studies showing the efficacy of such treatments are difficult to administer. Furthermore, results are mixed. A comparative study by Koss (1987) shows mental health patients had more confidence in a spiritual healer than a traditional counselor. They were also more satisfied with their recovery. Koss explained that the study didn't prove the efficacy of the spiritual treatment, because the subjects had higher expectations to begin with. This author would argue that there is a great deal of benefit in having higher expectations for recovery, and that in and of itself may bring the mode of treatment some credibility and demonstrate efficacy. The fact that the actual outcome was better for those with higher expectations solidifies the efficacy of that spiritual treatment.

Another problem in determining efficacy of spiritual treatment is the testing. Many of the studies showing little or no benefit of spiritual treatment were using religious practices as the measurement for spiritual well being. Larson, Sherrill, Lyons, et al. (1992) found the majority of studies between 1978 and 1989 classified religiosity in terms of affiliation. Even with this narrow of a definition, many of the studies showed a positive relationship between mental health and religion. But what would those studies have found if they had a comprehensive measure of spirituality? In other words, the perspective of spirituality was one dimensional – limited to the practice of a religion. 90% of the population believes in God, but only about 42% attend worship services weekly (Marwick, 1995). Some of those people may go to the woods, meditate, serve their community, pray at home, or practice spirituality in other ways.

Spirituality is moving more into mainstream society (Morgan, 1994), which again proves how important it is to people in their lives. The 90's have seen the popularity of angels, massage therapy, meditation, yoga, Ti Chi, Native American totem animals, evangelic television, The

Promise Keepers, psychic networks, and more. People are looking outside traditional realms of medicine and psychiatry for sources of inspiration or healing. Hospitals and mental health clinics are incorporating nontraditional healing "arts" to accommodate demands. In Eau Claire and Baldwin, Wisconsin acupuncture and massage therapy are currently prescribed and performed in a traditional clinic setting by health professionals. Yet the debate goes on as to whether spirituality should be incorporated and few Universities or medical colleges across the country prepare clinicians to deal with spirituality (Sloan, Bagiella, & Powell, 1999).

If clients are paying out of pocket for spiritual counseling because their insurance will not cover it, clinicians and educators are missing out on an opportunity. They are creating a hole in the market. Furthermore, they are denying their clients exposure to what research indicates is important to them: spirituality. The fact that there are counselors now, touting their titles of "Spiritual Counselor" or "Christian Counselor" shows that there is a demand for this type of therapy. However there are few studies that actually determine whether clients want spiritual counseling from a traditional therapist. Kroll and Sheehan (1989) recommended the inquiry into this issue. Most people apparently believe in God, but do they want help strengthening that relationship and finding spiritual connection and meaning in life?

Statement of the Problem

The objective of this study was to determine whether mental health clients in Eau Claire Wisconsin would prefer a spiritually inclusive therapist or traditionally trained therapist. Health service users are increasingly going outside traditional clinic settings to receive services from practitioners who incorporate spirituality. If it were clearly shown that clients demand spiritually inclusive counseling, educators could expand their programs to address this area more adequately. Furthermore, therapists who were trained in this area would have a more holistic approach, an

advantage over those who were not, and client satisfaction outcomes could increase. The demand for therapists may greatly increase if clients who generally must seek services through their church or alternative practitioners can access those services through a professional counselor. The age of the HMO is upon us, and many of those HMOs and other insurance providers are including chiropractic care, massage therapy and acupuncture/pressure into benefit packages. We are coming into more holistic medical care. Mental health services must also heed the research and remain current in theory and practice. This study was an important first step in clearly identifying what one diverse sample of mental health clients desire of their counselors pertaining to spirituality.

CHAPTER 2
LITERATURE REVIEW

DEFINITIONS AND DISTINCTIONS OF SPIRITUALITY AND RELIGION

The terms spirituality and religion are often used interchangeably in research and literature. Whether this is due to confusion over definition, differences of opinion of definitions, carelessness, or disinterest in such detail, it has paved a rougher road for the scientific study of these concepts. However there can be vast differences between the two, both in definition and perception. In conducting scientific studies as to the benefits of spirituality and/or religion in healthcare, distinctions must be made if accurate and applicable results are to be acquired.

Religion

Religion as defined in *Random House's College Dictionary* (1979) is "a specific and institutionalized set of beliefs and practices generally agreed upon by a number of persons or sects." The dominant religion in the United States is Christian-based. Worldwide, Islam is the dominant religion. There are differences between religions, and differences in opinions and

extremes within religions. Some people live for their religion and others hardly identify with it at all. Then there are those who do not have a religion.

This author sees religion as the container in which spiritual beliefs most closely fit into. However, it is not always the case. Religion is often a matter of family tradition, and one's spiritual beliefs do not necessarily parallel the chosen religion. Others are adopted into a religion through marriage, regardless, at times, of personal spiritual ideals.

Spirituality

So what then is spirituality? How different is it from religion? These are slippery questions with elusive answers. In this author's opinion there are as many answers as there are people. Random House College Dictionary (1979) defines spiritual as "of or pertaining to spirit or its concerns as distinguished from bodily or worldly existence or its concerns". Another more simple definition (1979) is "of or pertaining to sacred things or sacred matters."

The latter definition is helpful in defining spirituality as each individual holds different things and matters sacred. A walk in the woods could be a spiritual experience for one, where a visit to a favorite painting in an art gallery would be sacred to another. Cooking, eating, playing sports, making love, being in nature, spending time with certain people, hearing certain music, or unlimited activities and concepts can be sacred – therefore spiritual.

Chandler, Miner-Holden, and Kolander (1992) bring transcendence into the conception of spirituality. Spirituality, they say, is the innate capacity and tendency to seek to transcend one's current locus of centricity, which involves increased knowledge and love.

Anandarajah (1999) stresses that spirituality is common to all human beings regardless of their religious affiliation or lack thereof. He also stresses the difficulty in measuring something like spirituality due to different interpretations and the essence of spirituality itself. Religion and spirituality must be differentiated in order to make appropriate conclusions from research in this area.

May (1982) described spirituality as a healthy attitude of willingness to surrender to a reality greater than oneself rather than the willfulness that suggests that the mastery and manipulation of existence are possible.

Carl Jung asserted that spiritual well-being is strongly in line with psychological well-being in that the two greatly depend upon an open relationship between the conscious and unconscious forces. He believed that the spiritual core exists underneath the ego. True spirituality is felt when the ego is released from the illusion that it is the center of personality, making room for the genuine self (Mack, 1994).

Operational Definitions

For the purpose of this study, this author proposes the following definitions: Spirituality is a harmonious connectedness to inner strengths and to any source which enhances one's sense of purpose or transcendence. Religion is the institutionalized and organized practice of a particular set of beliefs. Those beliefs may be spiritual or moral, or something other than either of those. Spirituality is a natural creation and is constantly being re-created. It tends to be more individualized than religion. Religion is built and organized by people and has prescribed moral codes. Its practices may seem more uniform than spiritual practices. Spirituality is generally felt,

and is the "coming out" of inner truths. Religion and spirituality can, but do not necessarily coexist.

Religious and spiritual counseling will be differentiated in this study as follows: religious counseling is practiced by clergy or counselors of the same faith or religion. Issues addressed pertain to values. The framework of those values is the particular faith's doctrine or belief system, along with the client's. Spiritual counseling is practiced by a trained counselor who is inclusive of religion and spirituality. An investigation is made into the client's personal source of power, purpose, connectedness, and truth. Those relationships or strengths are then built upon to tackle problems or increase the client's connection to whatever he or she finds sacred.

The discrepancy between spiritual beliefs and attendance or participation in religious rituals demonstrates that there is an important distinction to be made between the two. A 1986 survey of mental health professionals found that although 68% sought a spiritual understanding of the universe, only 40% regularly attended church (Morgan, 1994).

IMPORTANCE OF SPIRITUALITY AND RELIGION

Faith and Beliefs of Americans

Studies consistently indicate that more than 90% of Americans believe in God (Waldfogel, Wolpe, and Shmuely, 1998). A 1994 Gallup Poll of adults in the United States found that 96% believe in God or a universal spirit (Oyama & Koenig, 1998). Of those believers, 90% pray (1998). A study of hospital patients' beliefs (King and Bushwick, 1994) found that 98% of the respondents said they believe in God, 58% of those qualifying themselves as "strong believers" and another 35% as "somewhat strong". Kroll and Sheehan (1989) make a case that the belief in God contributes to values and therefore the formation of identity. These are some of the very issues dealt with in counseling, and they have spiritual ties. In a study in Illinois of outpatient 65-

year-olds, 80% believed that their religious faith was the most important influence in their lives (Oyama and Koenig, 1998).

In a less scientific but fairly profound example of the importance, or popularity, of spirituality, one can look to the success of the book The Road Less Traveled: A New Psychology of Love, Traditional Values, and Spiritual Growth, by M. Scott Peck. More than 3 million people have bought this book, keeping it on the best seller list for over 6 years (Butler, 1990).

Not only do most American people believe in a higher power, or God, many believe their faith has implications for their health.

Americans' Beliefs that Faith Can Heal

Levin, Larson, & Puchalski (1997) cite recent studies showing 80% of Americans believe the power of prayer can improve their health. In the growing field of complementary medicine, one in four patients use prayer as part of their therapy (Cerrato, 1998). Daaleman and Frey (1999) conclude that from the consistent data asserting the dominance and reported importance of spiritual and religious beliefs, health care decisions are influenced by these beliefs, as are, quite possibly, outcomes. Not only do studies show that patients' spiritual beliefs affect their decisions in healthcare, it is apparent that healthcare providers' spiritual beliefs affect their practice (Daaleman & Frey, 1999). One study in the United Kingdom found that psychiatrists who attended regular religious services were much more likely to refer patients to religious counselors than those who did not attend services (1999).

At a conference of family physicians in 1996, out of 296 physicians surveyed, 99% think religious beliefs can heal (Sloan, Bagiella, & Powell, 1999). Another study by King, Sobal, Haggerty, Dent, and Patton (1992) surveyed 1025 family physicians in seven states. Of the 594

that participated, 44% believed that physicians and faith healers can work together to cure some patients and 23% believed that faith healers alone can heal some patients that physicians can not.

A unique study in Puerto Rico (Koss, 1987) looked at expectations and outcomes for patients given mental health services or spiritist healing. The outcome ratings for the spiritists' patients were significantly higher than the mental health patients. However, Koss concluded the outcomes were most likely due to the significantly higher outcome expectations of the spiritists' patients. There was a much stronger belief in the spiritists' treatment, therefore greater outcome satisfaction.

Green, Fullilove, and Fullilove (1999) studied two Narcotics Anonymous (NA) groups. Their findings showed that although the NA attendees felt they had no faith in themselves, they believed that in order to recover they had to have faith in something. They felt that without faith in something, recovery was not possible because they could not put their lives and recovery into the hands of someone or something as vulnerable as they were (1999).

A strong majority of Americans believe in a higher power, most often God. Most of the believers rely on that faith for their physical and mental health. Whether science chooses to condemn these convictions, praise, acknowledge, or shove them under the laboratory carpet, they are continually and consistently represented as fact. Americans believe in God, and they believe God can heal or help heal their lives.

TRENDS OF FAITH IN TREATMENT

Historical Context of Faith in Health

Up until the 20th century, medicine revolved around religious contexts. Not only did medicine develop out of religion, physicians were clergy members who were concerned about a more holistic health (McKee and Chappel, 1992). In preindustrial societies worldwide, shamans and other similar spiritual and religious leaders were the therapists and healers (McKee and Chappel, 1992).

With the increase of medical technology, medicine, religion and psychology were pulled apart, to this day, not fully recovering into the unity that once was. Although the field of Psychology has moved into a more eclectic mix of its founders' theories with newer constructs instead of the single recipe approach, it has also moved away from one concept that the entire field of Psychology was built on: spirituality. Most people associate the mind with Psychology, not spirituality. However, the original definition of the word Psychology is "study of the soul" (Morgan, 1994). This makes it difficult to argue with the original purpose of Psychology. One of the most respected founding fathers of Psychology, Carl Jung, incorporated spiritual concepts into his famous theories and writings (Morgan, 1994). However, throughout history the recognition of the spiritual aspect of Psychology dwindled, even as it became more common in the mainstream.

Butler (1990) makes the case that psychology usurped the role of religion for many people. The purpose, to relieve human suffering, has not been effectively fulfilled. Psychology falls short in being able to address the depth of spiritual issues pertaining to human meaning (Butler, 1990). Once the immediate distress of an issue is relieved, questions of higher purpose often arise that leave counselors at a loss if they cannot incorporate their own or their clients' spiritual values. Butler's example speaks to this. "Is there a higher reason to endure certain circumstances or does one withdraw?" Turning to the spiritual aspects of healing makes sense when psychological training fails to answer questions that arise.

Current Trends

Spirituality is moving more into mainstream society (Morgan, 1994), which again proves how important it is to people in their lives. The 90's have seen the popularity of angels, massage therapy, meditation, yoga, Ti Chi, Native American totem animals, evangelic television, The Promise Keepers, psychic networks, and more. People are looking outside traditional realms of medicine and psychiatry for sources of inspiration or healing. Hospitals and mental health clinics are incorporating nontraditional healing "arts" to accommodate demands. In Eau Claire, Wisconsin, acupuncture and massage therapy are currently prescribed and performed in a traditional clinic setting by health professionals. Christian counseling is becoming more popular in outpatient clinic settings. Yet the debate goes on as to whether spirituality should be incorporated and few Universities or medical colleges across the country prepare clinicians to deal with spirituality (Sloan, Bagiella, & Powell, 1999).

Unfortunately, proponents of psychology, spirituality, and religion are often at odds instead of in collaboration. Each of these disciplines deals with how one should live, whether by following a predetermined "prescription" or an inner, or higher wisdom.

Eisenberg et. al., (1998) reported on the results of a national survey of alternative medicine usage from 1990 to 1997. They found a 47.3% increase of alternative therapy usage in the seven year period. Included in these alternative therapies were personal prayer, spiritual healing, relaxation techniques, and folk remedies. Self-prayer was the highest reported alternative therapy, and had the greatest increase, with a jump from 25.2% in 1990 to 35.1% in 1997. Only 39% of over 979 alternative therapies used were disclosed to their physicians (Morgan, 1998).

Research which indicates that the general public bases their approach to life on their religion more so than psychologists or psychiatrists (Bergin, 1991) may be a contributing factor to the discrepancy between reported spiritual beliefs and training and practice involving these beliefs in mental health. According to Marwick (1995), An American Psychiatric Association survey found only 43% of the respondents believe in God, which is less than half of the general public. Whereas 72% of people surveyed in the United States endorsed the statement "my whole approach to life is based on my religion", only 39% of psychiatrists and 33% of psychologists endorse the statement (Waldfogel, Wopel, & Shmuely, 1998). Morgan (1994) found that only 22 of the Canadian Psychiatric Association's 2400 members are interested in spirituality.

"There is at work an integration of medicine with religion, of spirituality with medical practice, the twin guardians of healing through the ages," said Georgetown University School of Medicine professor Dale Matthews, MD (Marwick, 1995). This is evidenced by the increase in conferences relating to the spiritual aspects of health, across disciplines. And this is no small feat.

According to Firshein (1997), 77% patients want their physician to consider their spiritual needs. Medical Colleges are coming into the awareness that they can incorporate spirituality into the curriculum. The Association of American Medical Colleges helped medical schools develop outcome measures for physician-patient communication on various issues, including spirituality. The AAMC hopes other schools will follow suit (Firshein, 1997). Whether or not they do, there is evidence of interest in spirituality in the health field. A recent national conference on spirituality and medicine was attended by over 40 medical college leaders (1997). Similarly, nearly 30 medical colleges in the United States have reportedly included spirituality and religion into their curricula (Sloan, Bagiella, & Powell, 1999). In a recent investigation by this author, it

was found that well over 50% of Wisconsin colleges that offer Master's Degrees in Mental Health Counseling or related areas include optional course work in spirituality or religion.

According to Firshein (1997), arguments against a spiritually inclusive curriculum range from the inability of such left brained students to think with their right brain, to beliefs that courses dealing with spirituality are garbage. It is this author's personal experience of fairly extensive interactions with physicians and psychologists; they are no less creative or able to think with the "other side of their brain" than anyone else is. The argument that they can not think about spirituality seems as somewhat of an insult if it is not backed up by scientific research. To this author's knowledge, it is not. Additionally, the research does continually point to the importance of spirituality to patients, as well as positive health implications for religious or spiritual people. A little education to those who are not aware of this research may help open them to the possibility that they may effectively integrate spirituality, or at the least, intelligently and respectfully communicate about it with their patients.

Only 10% of physicians ever inquire about patients' religious or spiritual beliefs or practices (Levin, Larson, & Puchalski, 1997). Lack of time and training were found to be major reasons why physicians infrequently discuss spiritual matters with their patients (Ellis, Vinson, & Ewigman, 1999). A study of psychiatry residency directors found that didactic instruction on any aspect of religion was infrequent and incomplete despite 25.2% of the residents encountering patients with significant religious issues at least weekly (Wladfogel, Wolpe, & Shmuely, 1998). Those residents who did receive training in religious issues felt more competent to address the issues with their patients, and believed the issues were important areas for treatment (1998).

In mental health counseling, it may be even trickier to incorporate and implement spiritual assessment and strategies into the curriculum. A contradiction has been noted between the importance of religion to mental health workers' own lives and how important they view it in a clinical setting (Bergin, 1991). Clients may be unable to develop spiritually beyond the level of the counselor (Ganje-Fling & McCarthy, 1996), or the therapeutic relationship may be compromised at the point the client develops beyond the counselor. However, this is an argument for learning more about where to refer clients for continued growth, as well as becoming aware of one's own limitations as a human and a professional. This does not seem to be an effective argument against including spirituality in the assessment and treatment process. Ganje-Fling and McCarthy (1997) suggest that at a minimum, counselors should be trained how to assess a spiritual history and then refer what is beyond their expertise. To this author's knowledge, formal studies on the prevalence of spiritual training in counseling-related Master degree programs have not been published. However, it is being suggested that professionals and students of the counseling field know themselves in this area, and seek further training (1997). There is mounting literature on how to integrate clients' spirituality into counseling (Chandler et al., 1992).

Certainly a possibility in the neglect of spirituality is the misperception by scholars that spirituality is synonymous with religion (Thomason & Brody, 1999). According to Thomason and Brody, this neglect is further compounded by the baggage that the word religion may carry for some, as well as a sense of being unqualified to discuss religion in a knowledgeable and unbiased way (1999). Traditionally, medicine has attempted to disassociate itself from non-empirical, philosophical disciplines (Mack, 1994).

Currently, religious and spiritual concepts are measured more frequently in nursing journals of mental health than psychology or psychiatry journals (McKegney, 1998). A founding Mother of nursing, Florence Nightingale was apparently ahead of her time in believing that "spirituality was intrinsic to human experience and compatible with scientific inquiry." Recently much of the research is indicating that spirituality is tied into health and well being.

After years of neglect of spirituality, the DSMIV has made room for spirituality by adding a diagnosis for spiritual concerns. Finally counselors and doctors have a sense of legitimacy in addressing and treating the whole person, not just the mind and body. Now the next step is increasing the coverage by insurance for patients who have this diagnosis.

The sporadic and long-standing lack of spiritual or religious acknowledgment in the medical or psychology field has apparently rubbed off on patients. Oyama & Koenig (1998) found the majority of respondents in their study felt physicians were not qualified to address their religious concerns, although they felt physicians should be qualified. Another study by King et al. (1992) found a strong majority of family physicians should consider patients' spiritual needs. King & Bushwick (1994) found that 77% of hospital inpatients surveyed believed physicians should consider patients' spiritual needs. In the same study, only 37% of those surveyed felt physicians should discuss religious beliefs more often.

There is a gap in the field of psychology, as well as medicine, between what we believe, and how we practice, as well as what our clients value and believe in their lives, and how they are treated. In other words, we are compartmentalizing what most people in the United States claim as a major influence in their lives. In compartmentalizing spirituality, we ignore what we have difficulty incorporating because of lack of training and comprehension. This is like a physician

giving an annual physical and overlooking checking the patient's heart because she feels it is inappropriate to do so unless she is a cardiologist or the patient specifically asks her to check it. However, is the glass half full or half empty? Although there is a gap, the literature shows a dramatic recovery of the mind-body-spirit connection over the past decade (Mitka, 1998).

EFFICACY OF SPIRITUAL PRACTICES IN HEALTH TREATMENT

There is great debate whether "prayer studies" and spiritual healing evidence are valid. Some have claimed the research is not scientific enough, others claim research in this area is a farce because there is no God. Others claim God can't be proven or measured scientifically. Still, some say that the research is "rigged." Regardless of the reasons people shoot down evidence that spirituality heals and helps, the data just keeps piling up, even to such a degree that only a fraction of the total are represented in this study.

A study among the elderly by Harold Koenig, MD, found that those who had severe disabilities and who scored high in religious coping were less likely to become depressed than those who scored low on religious coping (Marwick, 1999). Koenig went on to say that disability is one of the strongest predictors of depression but that depression was significantly less in high religious coping scorers – especially those with the most severe disabilities (1999). In a 6-month follow-up study, those who scored high in religious coping still suffered less depression (1999). These findings demonstrated both cross-sectional and long-term consistency between religious coping and depression. Finally, Koenig's research found at least 50 studies in the United States that came up with similar results (1999).

A study of 225 elderly in Connecticut who were forced to move from their homes found that those who had the strongest religious commitment were more than twice as likely to survive the two-year study period (Benson, 1996). The predictive variable for survival was the strength and comfort derived from their religion (1996).

Another study by Herbert Benson, MD, relates the well-documented phenomenon that repeating a mantra of some sort (word or phrases repeated continually), along with being passive to intrusive thoughts induces a physiological relaxation response. The relaxation response is an effective therapy for diseases including hypertension, chronic pain, cardiac rhythm irregularities, depression, anxiety, and insomnia (Benson, 1996). In the course of this study, Benson found that when given the choice of their mantra, many patients chose a prayer. But regardless whether the mantra was religious in nature or not, patients consistently reported a heightened sense of spirituality upon coming out of their relaxed state (1996). Benson's research results, including those determined serendipitously, indicated that the presence of spirituality can be linked to fewer medical symptoms (1996).

Matthews, et al., (1998) suggested from a research literature review, religious commitment can be beneficial in prevention, coping, and facilitating recovery from illness. A study of outpatients with stress-related disorders found that 25% of patients had previous core spiritual experiences, and that those particular patients had significantly better health over the ten-week period. The greatest improvement in psychological (increase in "life purpose and satisfaction") as well as physical health (decrease in the frequency of stress-related medical symptoms) was demonstrated consistently by this sub-group (Kass, 1998). However, McCullough (1999) examined data from 5 studies on religious accommodative counseling and found that there was no difference between religious accommodative counseling results and traditional approaches. Similar studies

comparing traditional to spiritually inclusive counseling may yield drastically different results. More research is needed in this area. In one study, inverse relationships with negative moods suggest that spiritual variables may influence psychological well being (Fehring, Brennan, & Keller, 1987).

Cohen (1989) found that 80% of patients he referred to spiritual healers felt better after the experience. Part of the success may be due to the fact the healers spent up to eight times longer with the patients than the average physician would. Another three studies of alcoholism treatment found that Alcoholics Anonymous was consistently more effective in achieving long-term sobriety than both medical and or other psychological treatment (McKee & Chappel, 1992). The 12-step program of Alcoholics Anonymous is based on spirituality and encourages a personal relationship with a "higher power."

McKee & Chappel (1992) reviewed the results of a study of 393 coronary care patients. This double blind study split the patients into two groups; one that would be prayed for by a designated prayer group and one that would not. Differences in severity of illness were controlled. At discharge, the group that had been prayed for had significantly better treatment outcomes on 6 out of 26 variables. Blood pressure has been found to be lower in immigrants who have strong religious convictions than those who do not (McKee & Chappel, 1992). McKee and Chappel also report religion may play a role in healing postabortion dysphoria (1992).

Mitka (1998) sites recent studies showing the benefits to health of spirituality and religion. According to Mitka, religion and faith may fight disease and generally promote health by increasing social support, improving coping skills, and giving people positive views of

themselves. One such study from the American Journal of Psychiatry found that the more spiritual or religious patients were, the quicker they recovered from depression (Mitka, 1998).

All of the above mentioned studies pertained to human courses of wellness. To satisfy the critics, studies are needed that are even more objective. In a laboratory study (Dossey, 1997), subjects were asked to direct mental concentration or intention to yeast cultures. Spiritual energy was disguised in language such as "psychokinetic," "concentration," and "mental intention." The subjects were two spiritual healers who used prayer, one physician who used prayer, and four students who had no prior experience in spiritual healing. On the outside the study looked "un-spiritual", meaning, it passed the scientific scrutiny of critics. In the results, it was shown beyond a doubt ($p<.00014$) that the spiritual healers and physician significantly affected the growth of the yeast. The students, who had little interest in prayer, scored at chance levels.

According to William Braud, Director of research at the Institute of Transpersonal Psychology in Palo Alto, California, similar studies have had success influencing bacteria, motile algae, plants, protozoa, larvae, woodlice, ants, chicks, mice, rats, gerbils, cats, dogs, and cellular preparations. Included in the cellular preparations were cancer and blood cells. In humans, eye movements, gross motor movements, electrodermal activity, plethysmographic activity, respiration, and brain rhythms have been influenced by intention (Dossey, 1997).

This studies demonstrate that not only is there evidence that spirituality can benefit – at the very least – change courses of illness, states of well-being, and completely objective laboratory specimens, but that even the harshest critics will believe it if it is in a more pleasing language to them.

Additional evidence to ‘prayer studies” is that often times respected spiritual healers serve as subjects (Dossey, 1997). That these people are willing to be examined under the microscope of scientists, sometimes quite skeptical scientists, testifies to their belief in what they do, and the efficacy of what they do.

Another argument to the efficacy of prayer research is the difficulty in controlling the dosage of prayer. How can a study claim that prayer healed or helped patients because one group had a prayer group, and another one didn’t. How can the researchers control for prayers they don’t know about? Dossey (1997) likens the prayer studies to low dosage versus high dosage, which are common in medical research. It is assumed that both groups will be about equal in terms of their personal support systems’ prayers, and prayers of the community at large. The group with the prayer treatment then is considered the high dosage group.

These are valid arguments for efficacy. Prayer research does raise unique methodological issues. Dossey (1997) describes nine unique considerations in prayer research: informed consent and patient awareness of prayer, severity of patient problems being prayed for, knowledge about dosage and response because prayer is difficult to measure, public and scientific perceptions of prayer, nature of problem being prayed on, number of prayer intercessors, beliefs of researchers on the project, variability of subjects when using human targets, and encouraging reverence.

With such unique and critical considerations, it is understandable why some results of prayer research have been ambiguous. However, ambiguity does not necessarily negate validity. It is a call for more uniform studies, as well as a greater understanding from the scientific community of the unique considerations. Evidence has not been limited to a single type of organism, proving the validity and reliability of prayer or conscious intention. Not every study has been perfect, but

the majority come up with similar results, regardless of their "targets" in prayer. Researchers are not garage scientists or religious fanatics, rather a collection of respected scientists and scholars who uphold strict ethical and scientific standards. Larry Dossey, MD, includes a biographical review of some key theorists and researchers in prayer and intention in his article "The Return of Prayer (1997)."

None of these studies can prove that God exists. However, they do demonstrate the power of beliefs, prayer, and conscious intention, at the very least. Kass (1998) explains that experiences of the spiritual core can help begin to repair existential anxiety and help us develop healthier attitudes and behavior patterns.

The distinction between religion and spirituality ties into the efficacy of research. Religion is a more tangible, measurable concept and practice at this point. Spirituality is in its infancy in the scientific realm (McKee & Chappel, 1992). Scales such as the Spiritual Well Being Scale, Index of Core Spiritual Experiences, Spiritual Involvement and Beliefs Scale, and Kuhn's Spiritual Inventory are currently being used and modified to measure aspects of spiritual health. The challenge has been to remove the religiosity or Christian bias to be inclusive and objective. The challenge still remains to identify a definition that can withstand the test of time and criticism, and create a measure that is valid and reliable enough to use across a variety of situations and people.

The Spiritual Well Being Scale (SWBS) is the most popular and researched measure of spirituality or spiritual well being (Brinkman, 1989), and it was the first tool to measure spirituality (Ellison, personal communication, September 1999). More recent measures of spiritual well being such as the Spiritual Involvement and Beliefs Scale (Hatch, Burg, Naberhaus,

& Hellmich, 1998) use the SWBS to prove convergent validity, as it is an established and fairly respected instrument in this area. However, it was normed on a Christian population, particularly at Christian universities, and its validity is questioned (Ebert, 1999) on several levels. Additionally, and most relevant to this study, is that the SWBS seems to measure Christian religious value issues, which in this author's opinion, puts it in the category of a religious well-being scale. One's sense of connectedness or existential well being does not necessarily hinge on how one communicates with "God." Certainly the point being made is not that the SWBS is invalid, simply that spirituality and religion are interpreted differently. The standards created in the field of health are still in a stage of infancy, to the point where two different concepts are difficult to differentiate.

Blood pressure level, sexual dysfunction, cancer mortality, mental health, coping responses, and general health and well being in the elderly have all been found to be positively correlated with spiritual and/or religious values and practices (1992). Simple biological laboratory cultures have been influenced by prayer, or positive intention.

There truly is no longer a lack of research in spirituality or religion, including strong evidence which indicates it would be beneficial to collaborate medicine and psychological treatment with spirituality (Thomason & Brody, 1999). Increasingly, studies show that there is efficacy to the notion that faith has a positive influence on health. It is no longer a question of whether spirituality positively influences health, but *how*.

In an extensive literature search, an obvious gap presented itself: a specific investigation into whether out patient mental health clients want spiritually inclusive counseling. The purpose of this research was to identify whether mental health clients at out patient clinics in Eau Claire,

Wisconsin would prefer spiritually inclusive counseling over traditional techniques. Surveys were made available to clients at the appointment desks of randomly selected mental health clinics. Clients were asked about their experience in counseling, the severity of their current issues, and the importance of spirituality and religion in their life.

CHAPTER 3
METHODOLOGY

Subjects

Subjects were 67 volunteer mental health clients of various outpatient clinics in Eau Claire, Wisconsin. Clients were asked to participate anonymously, and without participation or input from their counselor, as they checked in for their appointments. Mental health clients were chosen to significantly control the extraneous variable that some non-clients would have been biased against counseling in general, and not spirituality specifically. Outpatient clients were chosen to reduce the possibility of collecting data from subjects with severe debilitating psychiatric disease. Sampling bias was reduced by comprising a list of all known mental health clinics in Eau Claire using the Eau Claire telephone book, and then asking each clinic to participate through the mail, and then by phone. Of the 25 clinics contacted, four clinics chose to participate. Several of the clinics that chose not to participate stated that they had a Christian counselor available for those clients with spiritual concerns, therefore this research would not be of value to their clinic. This seems unfortunate as this paper has hopefully already established the difference between practicing a religion, or even Christianity as a whole, and tackling problems with spiritual ties. This opinion expressed by clinic managers and their reluctance to participate in this research makes this study all the more important. Some other clinics chose not to participate because they already were completely religiously affiliated, and already were experiencing a demand for religious and/or spiritual counseling. Again, it is unfortunate that data was not collected from clients at a specifically designated religious counseling center.

Consequently, sampling error did exist due to the fact that the entire population did not participate in this research. This may hold true for clients who chose not to participate, although allotted time, reading ability, or interest in other reading material may have contributed to lower participation.

Eau Claire is a city of approximately 60,000 people, with suburbs increasing the population by approximately 5,000. A state university of 12,000 students and a technical college are located in Eau Claire. Industry varies from technical, light industrial, to service. Eau Claire is 90 miles from the nearest major metropolitan area, Minneapolis/St. Paul. Eau Claire is mainly Caucasian, with a significant Laotian/Hmong community. The Indochinese population in Eau Claire is approximately 2,800, the majority of those people being Hmong. Most people in the Hmong and Laotian community utilize extended family for counseling services (Her, 2000). Therefore, this population may not be adequately represented in the study's sample.

Instruments

The instrument was designed by the author to collect useful demographics and determine an accurate preference rating for a therapist with a spiritually inclusive orientation (see Appendix A). The demographics collected were sex, age, ethnicity, estimated counseling experience, where they had previous counseling, and their estimate of current problem severity. Sex was measured to determine whether education or spiritual demand was different between men and women. Age was recorded to account for priorities of various life stages. Ethnicity was recorded to determine whether there was cultural significance in counselor preference. These demographics were also collected to better describe the sample. There were five statements and three questions specifically designed to rate the clients' preferences for a spiritually or religiously oriented counselor. Clients were asked how important spirituality is in their life, how important religion is

in their life, and how interested they are in developing their spirituality. Clients also responded to rated statements identifying how much they believe spirituality plays a role in their healing, how much they want a counselor who considers their spirituality, and how much they want a counselor who works within their religious value system (See Appendix A). A Likert scale was used to insure a valid and reliable measurement of the clients' preferences. The instrument was deemed to have content validity by two graduate college professors, two mental health professionals, and one physician.

Procedures

Letters to the clinic director of every outpatient mental health clinic listed in the Eau Claire phone book were sent out two weeks prior to intended data collection (See Appendix A). Follow-up phone calls were made to the Directors from four to six days after the letters were mailed. Details for distributing the surveys were discussed with those who chose to participate. Three of the clinics chose to have the surveys available in the waiting room, and one clinic chose to hand deliver the surveys because the waiting area was shared with a medical clinic. The comprehensive research was conducted for four weeks in April and May 2000. Each of the four participating clinics had between 25 and 50 surveys to distribute. The desk clerks were informed in person by the researcher that the surveys, with a cover letter (Appendix A) including instructions, and a human subject release form (Appendix A), would be picked up at the appointment desk by clients who volunteered. The completed surveys were placed in an a manila envelope by the volunteers, located conveniently near where the surveys were completed. The surveys were picked up from the mental health clinics after four weeks, and data collection was complete.

CHAPTER 4
RESULTS

Demographics

A total of 67 clients completed surveys for participation in the research for a rate of response of 53%. 125 surveys were made available at the participating sites which were a university counseling center, a public health clinic, a private mental health clinic, and a charitable organization's counseling center. Tables 1 through 3 report demographic characteristics of the sample of clients. More than 75% of respondents were female.

Table 1: Client Sex

		Frequency	Percent
Valid	Male	16	23.9
	Female	51	76.1
	Total	67	100.0

Table 2: Client Ages

		Frequency	Percent
Valid	18-29	24	35.8
	30-39	16	23.9
	40-49	17	25.4
	50-59	7	10.4
	60 and over	3	4.5
	Total	67	100.0

Table 3: Ethnicity

		Frequency	Percent
Valid	Caucasion/White	65	97.0
	Native American	1	1.5
	Other	1	1.5
	Total	67	100.0

Client Counseling Experience and Severity of Presenting Problems

Items 4 through 6 requested information on clients' experiences with counseling and perceptions of the severity of their presenting problems. Those results are reported below.

Table 4: Counseling Experience

		Frequency	Valid Percent
Valid	None	4	6.1
	Very Little	18	27.3
	Moderate	34	51.5
	Extensive	10	15.2
	Total	66	100.0
Missing	9.00	1	
Total		67	

Table 5: Counseling Providers

		Frequency	Valid Percent
Valid	Private Outpatient	31	73.8
	Medicade or Social Service	4	9.5
	12 Step or Related	2	4.8
	Hospital or Inpatient	2	4.8
	Pastor/Clergy	3	7.1
	Total	42	100.0
Missing	9.00	25	
Total		67	

Table 6: Extent of Problelms

		Frequency	Percent
Valid	Mild	8	11.9
	Manageable	32	47.8
	Serious	17	25.4
	Life-Long	10	14.9
	Total	67	100.0

Client Attitudes about Religion, Spirituality, and Counselor Preferences

Clients seem to believe that spirituality plays a helpful role in their healing. 89.6% either agreed or strongly agreed with this statement. In fact, over half of those that agreed, reported to strongly agree. 97% of respondents reported that spirituality is important to them. 59.7% of those marked Very, whereas only 35.8% reported that religion is very important to them. Another 46.3% reported that religion is somewhat important to them.

Of respondents, 83.6% want a counselor who understands their spirituality. 56.1% want a counselor that understands their religion. 91.1% of respondents are interested in developing their faith or spirituality.

Table 7 through 9 report means and standard deviations for Likert type items dealing with importance of religion and spirituality in client lives.

Table 7: Want a Counselor Who Understands My Spirituality

	Mean	Std. Deviation
Counselor Who Understands My Spirituality	1.9552	.9282

It should be noted that having a counselor who understands my spirituality was a five-point scale of agreement in which 1 represented Strongly Agree and 5 represented I'm not spiritual. Two respondents indicated that they were not at all spiritual.

Table 8 reports respondents' mean and standard deviation of the importance of religion and spirituality in their lives. This was a 4 point Likert scale with 1 representing Not at All and 4 representing Very.

Table 8: Importance of Religion and Spirituality

	Mean	Std. Deviation
Importance of Religion	3.1194	.8443
Importance of Spirituality	3.5522	.6101
Interest in Developing	3.3881	.6953

Table 9 reports respondents' preferences for spiritual and or religiously inclusive counselors. A 4-point Likert scale with 1 representing Strongly Agree, 2 Agree, 3 Disagree, and 4 Strongly Disagree was used. According to the results, clients report to strongly agree to agree that spirituality will help in their healing. Having a counselor who understands their religion and helps them within that value system was a statement they agreed with, but it was .11 point away from disagreement (m=2.39). A counselor that understands their spirituality and helps them within that value system was a more solid agreement (m=1.95).

Table 9: Counselor Orientation to Religion/Spirituality

	Mean	Std. Deviation
Counselor Orientation Includes My Spirituality	2.1667	.8336
Counselor Understands My Spirituality	1.9545	.7531
Counselor Understands My Religion	2.3939	.8015
Belief in Spirituality Helping	1.6716	.7465

Important Relationships among Variables

Demographics related to counseling experience and perceptions of severity of problems follow.

Table 10: Client Sex * Counseling Experience Crosstabulation

Count

		Counseling Experience				
		None	Very Little	Moderate	Extensive	Total
Client Sex	Male	1	8	6	1	16
	Female	3	10	28	9	50
Total		4	18	34	10	66

This analysis was not statistically significant. Sex was not significantly related to counseling experience, nor was it significantly related to counseling providers they have used, or extent of their current problems.

Table 11 reports sex in relationship to attitudes toward religion and spirituality. Interestingly, men were more interested in counseling understanding religious and spiritual matters, as well as spirituality playing a helpful role in their healing. However, none of these sex differences were statistically significant when examined by t tests for independent samples.

Table 11: Sex Related to Attitudes and Religion and Spirituality

	Client Sex	Mean	Std. Deviation
Counselor Who Understands Spirituality	Male	1.8125	.5439
	Female	2.0000	1.0198
Importance of Religion	Male	3.0625	.6801
	Female	3.1373	.8949
Importance of Spirituality	Male	3.5625	.5123
	Female	3.5490	.6423
Interest in Developing	Male	3.2500	.6831
	Female	3.4314	.7001
Counselor Orientation Includes My Spirituality	Male	2.5333	.7432
	Female	2.0588	.8345
Counselor Understands My Spirituality	Male	2.2500	.6831
	Female	1.8600	.7562
Counselor Understands My Religion	Male	2.4667	.7432
	Female	2.3725	.8237
Belief in Spirituality Helping	Male	1.8125	.8342
	Female	1.6275	.7200

Client age was not significantly related to experience in counseling, provider, or extent of perceived problems.

When client ages were examined in relationship to various attitudes about religion and spirituality by one-way analyses of variance, one issue emerged as statistically significant. For the issue, "I believe my spirituality will play a helpful role in my healing," those clients who were 30 to 39 were significantly less in agreement than those younger (18-29) or older (50-59) ($F=5.16$; $df=4, 62$; $p=.049$).

> In examining the relationships between clients' experiences with counseling and their attitudes regarding the importance of religion in their lives, analyses of variance were conducted. One analysis was statistically significant. Those clients who rated themselves as having extensive experience with counseling indicated

that religion was significantly less important in their lives than those with very little or those with moderate counseling experience (F=2.92; df=3.62; p=.04).

Counseling experience was examined in relationship to extent of current problems using Chi Square analysis. The analysis was statistically significant, with severity of problems increasing with increasing experience with counseling (Chi Square=23.48; df=9; p=.005). This result makes common sense. Table 12 reports those findings.

Table 12: Counseling Experience * Extent of Problems Crosstabulation

Count

		Extent of Problelms				
		Mild	Manageable	Serious	Life-Long	Total
Counseling Experience	None		2	2		4
	Very Little	3	11	4		18
	Moderate	3	16	11	4	34
	Extensive	1	3		6	10
Total		7	32	17	10	66

Examining relationships between severity of current problems and attitudes regarding the importance of religion in their lives, a couple of interesting significant results emerged. Analysis of variance indicated that those who saw themselves as having problems that are life-long processes saw religion as significantly less important in their lives than those with mild, manageable, or serious problems (F=3.29; df=3,63; p=.03). Also, severity was related to having a counselor who understands their religion and helps them within that value system. Those with life-long problems were significantly less interested in counselors understanding their religion than those with mild (p=.03) or serious (p=.03) problems (F=2.59; df=3,62; p=.06).

Relationships between attitudes and the kinds of counseling providers used previously by clients was not examined since almost all clients had used primarily private outpatient providers.

Table 13: Correlations among all Attitudes

	Counselor Who Understands Spirituality	Importance of Religion	Importance of Spirituality	Interest in Developing	Counselor Orientation Includes My Spirituality	Counselor Understands My Spirituality	Counselor Understands My Religion	Belief in Spirituality Helping
Counselor Who Understands Spirituality	1.000	-.109	-.437**	-.372**	.266*	.350**	.106	.241*
	.	.380	.000	.002	.031	.004	.395	.050
Importance of Religion	-.109	1.000	.370**	.359**	-.165	-.138	-.522**	-.177
	.380	.	.002	.003	.186	.271	.000	.151
Importance of Spirituali	-.437**	.370**	1.000	.630**	-.392**	-.279*	-.194	-.428**
	.000	.002	.	.000	.001	.023	.119	.000
Interest in Developing	-.372**	.359**	.630**	1.000	-.561**	-.377**	-.254*	-.335**
	.002	.003	.000	.	.000	.002	.040	.006
Counselor Orientation Includes My Spirituality	.266*	-.165	-.392**	-.561**	1.000	.739**	.487**	.556**
	.031	.186	.001	.000	.	.000	.000	.000
Counselor Understands My Spirituality	.350**	-.138	-.279*	-.377**	.739**	1.000	.541**	.575**
	.004	.271	.023	.002	.000	.	.000	.000
Counselor Understands My Religion	.106	-.522**	-.194	-.254*	.487**	.541**	1.000	.298*
	.395	.000	.119	.040	.000	.000	.	.015
Belief in Spirituality Helping	.241*	-.177	-.428**	-.335**	.556**	.575**	.298*	1.000
	.050	.151	.000	.006	.000	.000	.015	.

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Refer to Table 13, Correlations among all Attitudes. Noteworthy from those correlation results, respondents who reported a belief that spirituality would help in their healing had a high probability of wanting a counselor whose orientation included spirituality r=.556 (p<.01). There seemed to be a stronger correlation between the importance of spirituality and interest in developing spirituality r=.630 (p<.01) than the importance of religion and interest in developing spirituality r=.359 (p.<.01). However, there seemed to be more correlation between an importance of religion and wanting a counselor to work within that value system r=-.522 (p<.01) than between an importance of spirituality and wanting a counselor to work within that value system r=-.279 (p<.01). It should be noted that both correlations were significant, however, only the degrees of relationship varied. A negative correlation represents opposing scales on the questionnaire, not opposing opinions. The questions and corresponding scales were not worded parallel to each other, thus making a negative correlation mean agreement, not differences.

There was no correlation between the importance of religion and belief that spirituality would help with healing. There was a strong correlation between the importance of spirituality and belief that spirituality would help with healing r=-.428 (p<.01). The negative correlation is a result of inverted scaling, not an actual opposite correlation of ideas. Because the statements and their corresponding Likert scaled responses were worded opposite each other a negative correlation represents agreement.

There was no correlation between respondents who identified themselves as religious and wanting a counselor who understood them spiritually or integrated spirituality. Similarily, there was no correlation between the importance of spirituality and integrating religion or having the counselor understand their religion.

VI.
VII.
VIII. CHAPTER 5
IX. CONCLUSIONS AND RECOMMENDATIONS

Summary

Due to the apparent presence of spiritual issues in mainstream society and scientific research, as well as the reported importance of spirituality in health care, outpatient mental health clients were surveyed on their preferences for religious or spiritually inclusive counseling. Descriptive in nature, this study was able to determine whether a particular sample of mental health clients prefer a counselor with a spiritual, religious, or traditional orientation, and cross reference that data with demographics such as age, gender, counseling experience, and depth and scope of problems. Because the consumers of the counseling services were surveyed directly, providers can more confidently make decisions regarding their services, and seek training where they are lacking in this area. The conclusions are further discussed below.

Conclusions

One hundred twenty-five surveys were distributed to 4 distinctly different counseling centers in Eau Claire. Of these surveys, in a 4-week period of data collection, 67 were completed. This constitutes a 53% rate of response. This may be considered good rate of response considering the surveys were not mailed or handed directly to clients, nor was there any incentive or reward for participation. Surveys were simply left on a table in plain site in the waiting area with instructions, a release, and a return envelope. A larger sample would have likely been collected had more agencies agreed to make the surveys available. In phone interviews with clinic managers, there was often a hesitancy to participate due to the “sensitive nature” of spirituality and religion, and a preconceived and seemingly unshakable notion that when one is spiritual, they are also religious, and when they are religious, they are Christian. Of those managers with this idea, they either already felt their Christian counselor was enough, or they did not want to

entertain the idea of branching out with their services. Therefore, only 4 clinics of the 28 contacted participated. Those four covered a broad market however. A private outpatient mental health clinic, a counseling center affiliated with a Christian and religious organization, a University counseling center, and a public medical clinic with mental health serices were the participating sites.

The demographics of the sample are approximately 75/25% female to male ratio. It is not known whether more females than males were willing to respond to the survey, or if the gender ratio in counseling is similar to that in the rate of response. Virtually all respondents were Caucasian. The largest minority population in Eau Claire, Hmong and Laotian people, generally seek counseling services through extended family and cultural elders. This is the probable reason they are underrepresented in this study.

Ages varied, with the youngest being 18 and the oldest being over 60. Approximately 85% being between the ages of 18 and 49.

Approximately 50% of respondents indicated they had moderate experience in counseling. 27% had very little and 15% had extensive experience. 40% of respondents felt they had serious or life-long problems and almost 50% classified their problems one step down from serious, which was manageable. Only 12% felt their problems were mild. Most counseling experience had taken place in a private outpatient clinic.

Client Attitudes

Clients responded strongly to wanting a counselor who understands their spirituality. (See Table 7) On a 5-point scale of agreement, the mean was just under 2 (m=1.95). It is speculated that the

two respondents who chose 5 on the scale, representing “I am Not Spiritual” may have brought the average down slightly. However, 1.95 is still in the Strongly Agree category. This is significant. Clients strongly feel their counselor should understand their spirituality, but counselors are not routinely trained in the area of religion or spirituality. Therefore, they are most likely inadequately trained to address issues through a spiritual lens with the client, and may not even have the support to do this from their management.

Of interest, spirituality was rated as more important than religion. (See Table 8) Religion averaged out as Somewhat in importance and spirituality averaged out as closer to Very (m=3.55). Respondents were somewhat interested in developing their faith in general. Interestingly, those who rated spirituality higher than religion in personal importance were more likely to be interested in developing their faith. Those who related religion as more important than spirituality were less likely to be interested in developing their faith. One possibility for this discrepancy is religion tends to be more concrete, based on a shared set of beliefs and history. In a sense, it has already been developed for people. Spirituality is more personal and up to the individual to shape and develop. Therefore there may be more people who feel the need or desire to develop their personal beliefs and practices.

Age seemed to be a significant factor in the belief that spirituality plays an important role in their healing. Clients whose age was between 30 and 39 were significantly less likely to believe their spirituality would play an important role in their healing than those age 18-29 or 40 and older. Further research may help determine the reasons behind the difference between age brackets. An obvious possibility with the older age bracket may be the increasing importance of spiritual matters with aging and health issues. Not only are there health and death and dying issues relating to the self, but to parents, spouses, and older siblings. A more discrete explanation for

the 18-29 age bracket may be this is the most common time to start a family, and as child birth is often referred to as a “miracle”, those in that age bracket may have more situations where they feel they must rely on faith. They may be more likely to rely on faith when such major life circumstances as birth are out of their control.

Clients who rated themselves as having extensive counseling experience were significantly less likely to rate religion or spirituality as important in their lives than those with moderate or little counseling experience. The reason for this discrepancy was not identified in this research, however possible explanations can be speculated. Those with extensive counseling experience are most likely those with extensive problems. This was proven to be the case with the respondents in this research, using Chi Square Analysis. It seems sensible that for many who have extensive problems, developing a faith or religion may be a luxury they feel they can not afford, or do not have the energy to pursue. Struggling and coping ties up one’s personal energy. Whatever energy is left over may not be used to pursue spiritual matters or go to a religious service. At this point we can only speculate why religion and spirituality are less important to those with extensive counseling experience e.g., extensive problems. It could be that people lose faith when they have extensive problems, they simply do not have the time or energy to develop faith, or that they come from families where this was not encouraged or even discouraged outright. It may be that those who do not have a strong spiritual faith see their problems as more severe and obtain more extensive help because they do not have an added source of support and security that spirituality might offer. Those with extensive counseling experience may have been through the wringer enough that they have felt abandoned by a Higher Source and therefore have made spirituality a lower priority and have relied on other sources for healing. Certainly research in this area would be useful.

Interestingly, this finding coincides with the fact that those who had more extensive counseling were less likely to want a counselor who understood their religion. This means, regardless if a stronger spiritual base or religion would be helpful in healing, those clients with more extensive problems are not as interested in having counseling which integrates faith into the therapeutic process as clients with less extensive problems. Again, questions arise. Are they not interested in spiritual or religious integrated counseling because they have lost faith due to the seriousness and longevity of their problems? Have they never developed a faith? Would it help them if they did have a stronger faith? Do they feel their religious leaders are the only people competent to address their religious or spiritual concerns? Or finally, do their problems seem more severe because of a lack of faith?

Respondents who reported a belief that spirituality would help in their healing had significantly more importance placed on spirituality in their lives. There was no correlation between importance of religion and belief that spirituality would help with healing. This difference is interesting. Why would religious people not believe spirituality would help in their healing and spiritual people believe that it would? The questioning was direct and worded in a very basic manner (See Appendix), which seems to rule out a flaw in the survey design. Possibly, those respondents who marked religion as very important and then disagreed that spirituality would play a role in their healing felt that the question insinuated they could manipulate or accelerate their healing simply by having certain thoughts or beliefs. Whereas what they may have really believed is that their Higher Power determined those things regardless of what they did or thought. Another possible explanation for the lack of correlation between the importance of religion and the belief that spirituality helps in their healing may be threaded into the basis of their religion. Are they religious because of family tradition or a marriage, without having put much thought into it? Might they find religion important but not see its application in their daily

lives in such ways as offering comfort, direction, and assistance? This again must be looked at more in depth to determine the basis for discrepancies between importance of religion and spirituality and belief in its healing elements.

Finally, the question is, do outpatient mental health clients want a counselor whose style includes his or her personal spirituality? The answer is yes. The vast majority of the respondents strongly agreed to agreed that they want a counselor who includes their spirituality in the therapeutic process. The question was asked twice in the survey, worded differently in each question and the correlation between the two was extremely high. $r=.739$ ($p<.01$). Most clients not only feel spirituality is important to them, they are also interested in developing their faith. This does not mean that the job description for a counselor must change to "Spiritual Developer", but it does point to the importance of opening the spiritual avenues to integration in healing and daily life.

The results of this study indicate that people who categorize themselves as religious may also want a counselor who integrates spirituality into the counseling process, regardless of how important religion is in their life. They tend to prefer a counselor who understands their religion as well. People who categorize themselves as spiritual tend to want counselors that integrate spirituality, even when they indicate that spirituality isn't extremely important to them. Spiritual people tend to want to develop their faith more than religious people in this study. There were no significant correlations between the importance of spirituality and wanting a counselor who understands their religion, or between the importance of religion and wanting a counselor who understands their spirituality. This highlights the distinction between religion and spirituality, and the need for agencies and counselors to make that distinction as well. Religion and spirituality are not exactly the same, as evidenced by the respondents' variations in desires.

Recommendations for Application of Research

The implications these results have on counseling are significant. Certainly a practitioner should not assume that every client wants spirituality integrated into the counseling process, even though the vast majority in this study do. However, it would be prudent to ask. This can be done in the initial intake session, and or in the psychosocial history. Counselors can assist clients by opening up lines of communication on issues pertaining to faith such as existential concerns of purpose and meaning, or issues that may be better resolved by integrating faith such as death and other loss, trust, etc. Practitioners can also give the client room to explore spiritual or religious issues in a nonjudgmental impartial setting. Finally, outcome measures may be significantly more positive when clients are getting a more well rounded treatment which specifically includes their own spiritual tenets. Whether clients actually heal faster and more completely as a result of integrating spirituality, or are simply more satisfied because their counselor-client raport was stronger by integrating personal spiritual beliefs, the bottom line is a happier client in the end. And this seems to be the common goal of counseling to begin with.

If there are implications on counseling, then there are implications on training. It does not seem wise to send counselors out into the field and give them full reign on discussing and probing into spiritual matters and personal beliefs without ethical guidelines and training. It is not easy for everyone to detach from their own spiritual and/or religious beliefs to objectively help someone else with theirs. This issue must be addressed in ethical standards as well as organizational policies. Additional training in world religion and spiritual development across the lifespan should be included in curriculum for counseling programs. Hands-on experience should be acquired in discussing spirituality and religion in the intake sessions to help counselors themselves become comfortable with those issues. Educators in this area should facilitate the

exploration of whether counselor trainees feel comfortable with spiritual and religious issues and how they would handle various situations.

From a profit standpoint, providers of counseling as well as insurance would do well to incorporate what clients say is so important to them. Clients are currently either going outside the system and paying out of pocket for services which include their spiritual needs, or are receiving services and not necessarily getting what they want on this level. Agencies should not claim to have all the bases covered simply by having a religious counselor on staff, because not all clients, even highly spiritual ones with spiritual concerns, want religious counseling. However, there is enough demand for religious and spiritual counseling according to this research, to indicate the need for both. If counselors were trained to address and incorporate spiritual issues and beliefs, and if spiritually integrated counseling were covered and accepted by more insurance agencies and mainstream clinics, they could have the business, not to mention increase outcome satisfaction and quite possibly clinical outcomes as well.

The results of this study are directly applicable to mental health clients in Eau Claire, WI. Results may be inferred to cities in the Midwest of similar size and demographics. College educators, insurance providers, mental health practitioners, and physicians in Eau Claire or similar areas can use the results to adjust treatment and training strategies to suit the demand of their clients.

Recommendations for Future Research

Some possible extraneous variables unaccounted for in this research were as follows: attitudes of clients who chose not to participate in the research; possible sabotage of the research by filling out false information or more than one survey; the mental health of the subjects; attitudes of clients who were not included in the sample, and; attitudes or biases of the words “spirituality”

and “religion”. Any of these variables could have affected the results. Lack of differentiation between religion and spirituality could raise significantly different feelings toward counselors trained in spirituality. Using the term spirituality could have affected subjects’ opinions in a way that the actual concept or operational definition may not have. A larger sample size and rate of response above 70% would have helped account for these variables. A duplicate or similar study could help confirm these results.

Further research could be done to determine whether mental health clients would choose a counselor who integrates spirituality over a counselor who does not. It would also be useful to know why religious people were reportedly less interested in developing their faith and in having a counselor who integrates their spirituality than spiritual people.

Because the ethnic distribution in this study was predominantly Caucasian, it would be helpful to repeat this research in a more metropolitan area with a broader range of cultural diversity. Cultural diversity often brings with it spiritual and religious diversity.

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APPENDIX A

COVER LETTER AND CONSENT FORM

University of Wisconsin-Stout
Menomonie, Wisconsin 54751-0790

April, 2000

Dear Participant,

In conjunction with UW-Stout Guidance and Counseling, Mental Health Program, I am conducting research to determine what mental health clients such as yourself prefer in a counselor.

This study is completely confidential. No names are recorded, and your clinic does not view the survey you complete. Your participation is voluntary, and extremely appreciated! It is our hope that this research will help counselors better meet your needs and desires.

If you wish to participate, simply follow the instructions on the survey and return it to the designated drop box. This should take only a moment before or after your session. Please fill out only one survey per person.

Thank you in advance for your cooperation in this study. Feel free to make any comments on the back of the survey.

Sincerely,

Melissa Brightstar Ebert
UW-Stout graduate student

Consent Form

I understand that by returning this questionnaire, I am giving my informed consent as a participating volunteer in this study. I understand the basic nature of the study and agree that any potential risks are exceedingly small. I also understand the benefits that may be realized from the successful completion of this study. I am aware that the information is being sought in a specific manner so that confidentiality is guaranteed. I realize I have the right to choose not to participate in this study and that my right will be respected without coercion or prejudice.

NOTE: Questions or concerns about participation in this research should be addressed first to the researcher or research advisor and second to Dr. Ted Knous, Chair, UW-Stout Institutional Review Board for the Protection of Human Subjects in Research, 11HH, UW-Stout, Menomonie, WI 54751, phone (715)232-1126.

APPENDIX B

MENTAL HEALTH CLIENT SURVEY

Mental Health Client Survey

Directions: Please indicate which description best describes you by marking the line next to that item. You may return the survey to the drop box when you finish. Thank you!

About You

Sex

____Male ____Female

Age

____18-29 ____30-39 40-49

50-59 60 and over

Ethnicity

____Caucasian/White ____Hispanic African-American/Black

____Native American ____Asian-American ____Bi-Cultural _____Other

Counseling Experience

How much experience have you had as a client in counseling?

____None ____Very little Moderate Extensive

If you marked "None", skip this next item.

My counseling experience in the past was with (check all that apply)

Private outpatient provider Hospital or inpatient treatment

Medicaid or Social Services provider Pastor/Clergy

12-step or related meetings Therapy groups in community

I think the problems I am receiving help for right now are.

mild, and won't take too long to resolve.

manageable, but may take a little while to resolve.

serious, and may take a while in counseling to resolve.

may be a life-long recovery process.

-OVER-

Religious and Spiritual Background

For this section, use the following definitions: **Spirituality** is a personal connection to inner strengths or to any source which enhances your sense of purpose or meaning. **Religion** is the organized worship of a Higher Power, shared with a group of people, that is guided by rules and codes of conduct.

I want a counselor who understands my spirituality.

Strongly agree ____Agree

Disagree Strongly disagree I'm not spiritual

How important would you say religion is in your life?

____Not at all ____Not very Somewhat ____Very

How important would you say spirituality is in your life?

____Not at all ____Not very ____Somewhat ____Very

How interested are you at present in developing your faith or spirituality?

____Not at all ____Not very ____Somewhat ____Very

If I had a choice, I would choose a counselor with an orientation to counseling that included my personal relationship with a Creator, God, or Higher Power and issues of life purpose, meaning and connectedness.

Strongly agree Agree Disagree Strongly disagree

I want a counselor who understands my spirituality and helps me within that value system.

Strongly agree ____Agree ____Disagree Strongly disagree

I want a counselor who understands my religion and helps me within that value system.

Strongly agree ____Agree Disagree Strongly disagree

I believe my spirituality will play a helpful role in my healing.

Strongly agree ____Agree ____Disagree Strongly disagree

APPENDIX C

APPROVAL PROCEDURES AND IMPLEMENTATION OF RESEARCH