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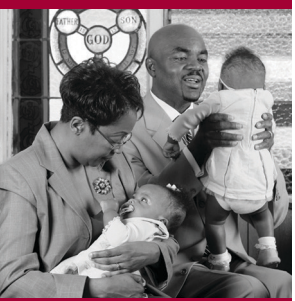




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# Christian Social Workers' Views and Integration of Clients' Religion and Spirituality in Practice

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*When the North American Association of Christians in Social Work first began in 1950, religion in social work practice was a topic that received mixed responses. Findings from the current study suggest this has changed. A total of 444 randomly selected licensed clinical social workers (LCSWs) across the United States responded to an online survey containing the Religious/Spiritually Integrated Practice Assessment Scale and various demographic items, including one item assessing respondents' religious affiliation. LCSWs reported extremely high levels of self-efficacy with integrating clients' religion/spirituality into practice, and there was no difference between Christian and non-Christian LCSWs with regard to attitudes or perceived feasibility. However, both groups reported less frequently engaging in behaviors related to integrating clients' religion/spirituality. This discrepancy between LCSWs' views and behaviors is worth further exploring; however, the fact that many feel confident including this topic in their practice is encouraging when considering their openness to future training opportunities to ethically and effectively integrate clients' religion/spirituality in practice.*

THE ETHICAL INTEGRATION OF CLIENTS' RELIGIOUS AND SPIRITUAL beliefs in social work practice has been affirmed and explored in *Social Work & Christianity* for over 40 years (Sherwood, 2002). For clinical social workers, the nexus of religion and spirituality (RS) and social work is found in dialogue with the client. To prepare new generations of practitioners for the challenge of ethically and effectively integrating

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this area of clients' lives, continued efforts are warranted to examine the clinical relationship as it attends to the RS needs of the client. Studies are finding that assessing and integrating clients' RS in practice actually contributes to a variety of positive health and mental health outcomes (Koenig, King, & Carson, 2012; Koenig, McCullough, & Larson, 2001), that clients prefer their RS beliefs be included as they relate to treatment, and that clients prefer the therapist or helping professional initiate such conversation (Leitz & Hodge, 2013; Stanley et al., 2011; Tepper, Rogers, Coleman, & Maloney, 2001).

Though definitions abound for religion and spirituality, for this paper, *religion* can be defined as a "system of beliefs and practices observed by a community, supported by rituals that acknowledge, worship, communicate with, or approach the Sacred, the Divine, God…or Ultimate Truth, Reality, or nirvana" (Koenig, 2008, p. 11). *Spirituality,* on the other hand, may be defined as a "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., 2001, p. 18). These two areas of clients' lives are often sources of great emotional support, but also have the potential to be negatively interwoven into the presenting clinical issue (Pargament, 1997), warranting appropriate assessment and attention by the social work practitioner.

Social workers account for the largest proportion of clinically trained helping professionals in the United States [Substance Abuse and Mental Health Services Administration (SAMHSA), 2010]. Among this group of helping professionals, a majority report being affiliated with a Christian denomination (Canda & Furman, 2010). Today, the North American Association of Christians in Social Work (NACSW) serves as an organization "to equip its members to integrate Christian faith and professional social work practice" (NACSW, n.d.). Though this does not explicitly indicate whether the organization is equipping its members to integrate *the practitioners'* Christian faith versus their *clients'* faith (and may, in fact, intend to mean both), there is nonetheless a lengthy conversation that has been and continues to be held by this group regarding the role of Christian faith in social work practice.

This dialogue between practitioner and client has taken place over many years, yet, only one study to date has focused on specifically assessing a national sample of Christian social workers' integration of clients' RS in practice (Furman, Benson, & Canda, 2011). Given that the largest group of social work practitioners self-identify as Christian (Canda & Furman, 2010; Oxhandler, Polson, & Achenbaum, in press; Sheridan, Wilmer, & Atcheson, 1994), it is worth further exploring the ways in which this group of practitioners attends to clients' RS in practice.

## Literature Review

### Religion/Spirituality and Mental Health

Emerging research on the relationship between religion/spirituality (RS) and health/mental health suggests that ethically and effectively integrating clients' RS in practice has the potential for improving numerous health and mental health outcomes (Koenig et al., 2001; Koenig et al., 2012). As of 2016, Mental Health America reported that 18.5% of adults suffer from some form of mental illness. Considering that family, friends, and loved ones are also impacted through supportive and caregiving efforts related to the diagnosis, mental illness impacts a significant portion of the average community. With social workers comprising the largest portion of clinically trained helping professionals (SAMHSA, 2010), often attending to various mental and behavioral health issues, it is important they are prepared to address clients' RS as it relates to treatment.

Historically, social work research and practice has simultaneously struggled alongside other helping professions' discomfort with the integration of RS in clinical practice (Oxhandler & Pargament, 2014). For example, in psychology, despite Jung (1933) pointing to the gap between psychology and religion with his warning that "there are too many persons to whom Freudian psychology is dearer than the Gospels" (p. 212), "the relationship between psychology and religion has been contentious. Attempting to establish itself as legitimate empirical science, psychology frequently disregarded religious belief as irrational" (Breuninger, Dolan, Padilla, & Stanford, 2014, p. 149). Both in counseling and service provision (see Tobin, Ellor, & Anderson-Ray, 1986), the separation between social work practice and any sort of religion or spirituality was clear, but was traced back into the literature in the late 1980s and early 1990s (Canda & Furman, 2010; Ellor & McGregor, 2011).

Further, studies have suggested a wide disparity exists between the expressions of faith among the average person in the United States when compared to that of persons from the various helping professions (Hodge, 2002; Oxhandler et al., in press; Shafranske, & Cummings, 2013; Walker, Courtois, & Aten, 2015). Today, over 90% of the American population reports a belief in a higher power, and over 80% report that religion is at least somewhat important in their lives (Pew Research Center, 2012; 2015). Therefore, it is no wonder that many individuals report utilizing a variety of religious coping skills through health and mental health struggles (Pargament, 1997; 2007). It is also worth noting that religious coping may manifest in either positive coping strategies, such as prayer for their own or others' healing (Levin, 2016), or may be negatively interwoven into the presenting issue, such as wondering whether one has been abandoned by

his or her Higher Power (Pargament, 2007). Social workers must then be keenly aware of how to distinguish between the two and the steps needed to help the client move towards health.

Recent studies have emerged that show not only do Americans consider their RS to be an important part of their lives, but many clients prefer integrating RS into health and mental health treatment. Most noteworthy is that many clients have expressed a preference for the practitioner to be the one to initiate the conversation and assess clients' RS as it relates to their presenting issue (Leitz & Hodge, 2013; Stanley et al., 2011; Tepper et al., 2001; Weld & Erikson, 2007).

Not only are clients expressing a preference for their RS to be discussed in treatment, but some studies suggest clients may have a preference that their therapist identify with some belief system, even if it differs from the client's RS beliefs. For example, in a study of 178 undergraduate students who were asked about seeking counseling from a mental health professional if needed, students reported no difference regarding the likelihood of seeing a Christian or Jewish therapist, but significantly lower levels of likeliness of seeing an atheist therapist. However, there were a number of limitations in this study, including surveying undergraduates with limited religious diversity who were not actively seeking therapy, and using vignettes which may not reflect how psychologists disclose their RS beliefs. Still, the authors concluded participants might be more concerned about whether or not the therapist believes anything, rather than the therapist's particular religious affiliation (Gregory, Pomerantz, Pettibone, & Segrist, 2008).

However, a disconnect exists between clients preferring such integration and many social work practitioners (regardless of religious denomination) not having received training on how to address clients' RS as it relates to practice. Recent studies have shown few social workers have received training on integrating clients' RS in practice, with 84% of respondents in one study reporting that RS content was never or rarely presented in their social work education (Sheridan, 2008), and 65% reportedly not receiving any content on assessing or integrating clients' RS (Canda & Furman, 2010). This is not surprising, as in 2005, Russel, Russo, and Ferraro (as cited in Barker, 2008) noted only 57 out of 171 (33%) MSW programs offered a course on spirituality in 2004, an increase from Russel's (1998) report that 17 out of 114 (15%) social work programs offered a spirituality course. Certainly, the content delivered or quality of the course is unknown, and may greatly vary across programs.

Though attention to RS has not always been clearly included in the Council on Social Work Education's (CSWE) Educational Policy Accreditation Standards (EPAS), today there are standard expectations that social work students be competent in the role in which diversity (including RS diversity) plays in clients' lives, their development, and in shaping their

identity. Additionally, social work students are taught the importance of being aware of and managing their personal values (CSWE, 2015). Further, there are current expectations within the National Association of Social Work's (2015) Code of Ethics for social workers to be culturally competent and understand diversity and oppression with respect to religion, to not exploit others for personal religious interests, to respect colleagues' religious diversity, and to not discriminate on the basis of religion. Given that many practitioners did not receive training on the integration of clients' RS in practice, and yet that research is emerging that supports such integration, the evidence-based practice (EBP) process might assist practitioners to make best practice decisions.

The evidence-based practice (EBP) process is a widely used five-step model (Thyer, 2004) by which a practitioner: 1) proposes an answerable practice question; 2) identifies evidence to answer the question; 3) critically appraises the evidence within the decision-making process as it relates to the clinical circumstances; 4) integrates "the best research evidence with clinical expertise and [client] values" (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000, p. 1); and 5) evaluates client outcomes and the effectiveness of the first four steps. Given that few social workers received training on integrating clients' RS, that research indicates including clients' RS in practice promotes positive outcomes (fitting within steps two and three), and that clients prefer helping professionals initiate the conversation on how their RS may relate to their clinical circumstance and/or treatment protocols (fitting within step four), the EBP process would be an appropriate modality for integrating clients' RS and evaluating outcomes.

## Christian Social Workers' Integration of RS in Practice

Across all levels of education, the largest religious group of social workers in the United States is Christian (Canda & Furman, 2010; Oxhandler, Parrish, Torres & Achenbaum, 2015; Sheridan et al., 1994). Prior studies have found that social workers who self-identify as Christian have engaged in spiritually-related interventions with clients at an overall higher frequency than other religious traditions (Canda & Furman, 2010).

Not only do a majority of social workers self-identify as Christian, but students have also expressed their Christian faith as being a primary motivator for choosing the social work profession. Hirsbrunner, Loeffler, and Rompf (2012) found among 70 undergraduate students at a Christian and state university, 9 out of 10 self-identified as either Protestant or Catholic, with 83% of the sample reporting their religious or spiritual beliefs were at least somewhat important in influencing their career choice (57% said it was very important).

As described by Sherwood, "a Christian worldview supports the mission of social work and its Code of Ethics while simultaneously informing and critiquing it" (1999, p. 1). A social worker's Christian belief system also affects how he or she perceives and interacts with the surrounding world, including how he or she interprets the need to provide services and work for social justice for the disadvantaged (Sherwood, 1999). In essence, for some social workers, a Christian belief system may provide an additional lens through which the social worker operates and interacts with their clients to deliver the best services available. Certainly, other belief systems or cultural values may provide unique and valuable lenses to social work practice as well. However, because Christianity is the most commonly reported belief system among social workers, we were interested in exploring this group's consideration of clients' RS. Specifically, we wanted to explore whether any differences among self-identified Christian and non-Christian social workers exist with regard to their views and behaviors toward integrating clients' RS in practice through methods supported by the EBP process.

For the purpose of this study, the guiding research questions include:

1. What attitudes and levels of self-efficacy do social workers who self-identify as Christian have around integrating clients' RS in practice, and how do they compare with those who do not self-identify as Christian?
2. Do social workers who self-identify as Christian consider integrating clients' RS in practice to be feasible, and how do they compare with those who do not self-identify as Christian?
3. At what frequency are social workers who self-identify as Christian implementing steps to integrate clients' RS in practice, and how do they compare with those who do not self-identify as Christian?
4. How do those who self-identify as Christian compare with those who do not self-identify as Christian with regards to their overall scores on the Religious/Spiritually Integrated Practice Assessment Scale, measuring practitioners' self-efficacy, attitudes, perceived feasibility, integration of clients' RS in practice, and overall orientation toward this area of practice?

## Methods

### Sample

The original study was approved by the University of Houston's Institutional Review Board and consisted of a national sample of social work practitioners with public profiles on HelpPro's (www.helppro.com) National

Social Work Finder. As described in further detail in Oxhandler and Parrish (2014), 2,000 zip codes across the United States were systematically randomly selected and entered into HelpPro's Social Work Finder with a five-mile radius. Inclusion criteria were limited to individual practitioners, excluding any agencies, schools, or group practices that were advertised. A total of 1,643 individuals were identified, with 1,381 providing a mailing address, an email address linked to their profile, and an MSW. One thousand individuals were randomly selected to participate, of which, 16 were removed for various reasons described in Oxhandler and Parrish (2014). Of the 984 individuals in the sample, 482 responded to the survey, yielding a 49% response rate (Oxhandler & Parrish, 2014). A total of 469 respondents had at least three RSIPAS subscales complete. For the purpose of this study, the analysis was restricted to the 444 who responded to the general social survey item on religious preference (Smith, Hout, & Marsden, 2013). Of these 444, 168 (38%) identified as Christian (marking Protestant, Catholic, or Other and specifying various Christian denominations), and 276 (62%) did not self-identify as Christian.

**Data Collection**

Dillman, Smyth, and Christian's (2015) recommended survey methods were utilized in the original online survey. Potential participants first received a pre-invitation email, informing them of the upcoming invitation to participate. Within one week, the sample received an email invitation to participate in the online survey with the SurveyMonkey link, followed by a mailed letter about two weeks after the initial invitation email with the survey link and a $1 token incentive, and then finally, a follow-up email about two weeks after the letter, with the survey link to participate as well as a link to assess reasons for non-response. Each method of contact described the study, assured responses would be anonymous, and contained Institutional Review Board information. As described in the original study, the sampling frame was adjusted from 1,000 to 984 due to one duplicated name, one individual being deceased, one individual with technology issues, three individuals whose email and letter bounced back, and ten asking to be removed immediately after the pre-invitation email, thus, never obtaining the survey link (Oxhandler & Parrish, 2014).

The online survey included the Religious/Spiritually Integrated Practice Assessment Scale (RSIPAS; Oxhandler & Parrish, 2014), a variety of items to assess practitioner characteristics (Parrish & Rubin, 2011), one item assessing burnout (Rohland, Kruse, & Rohrer, 2004), the Duke University Religion Index (DUREL) to measure intrinsic and extrinsic religiosity (Koenig & Büssing, 2010), and three RS items from the General Social Survey that measure religious affiliation and the extent to which the respondent is a religious or

spiritual person (Smith et al., 2013). The RSIPAS measures practitioners' self-efficacy ($\alpha$=.91), attitudes ($\alpha$=.88), perceived feasibility ($\alpha$=.84), and behaviors ($\alpha$=.87) related to integrating clients' RS in practice with attention to elements of the EBP process, as well as their overall orientation toward integrating clients' RS in practice ($\alpha$=.95) (Oxhandler & Parrish, 2014). The RSIPAS has excellent reliability and established content, construct, discriminant, criterion, and factorial validity with social workers, and has since been validated with nurses, psychologists, professional counselors, and marriage and family therapists (Oxhandler, 2016).

## Data Analysis

SPSS 22.0 was used to assess missing data and for descriptive analyses of the sample. The five-point Likert scale items were collapsed into two categories to simplify the analyses: "strongly agree/agree" and "neutral/disagree/strongly disagree" for Self-Efficacy, Attitudes, and Perceived Feasibility subscales, measuring level of agreement. For the Behaviors subscale, which measured frequency, the responses were collapsed into "very often/often" and "some of the time/rarely/never." Groups were compared based on whether the participant self-identified as a Christian (responding with Protestant, Catholic, or Other and indicating a Protestant or Christian denomination) or indicated another religious faith or background (Jewish, Muslim, Buddhism, Hinduism, None, or Other) in the General Social Survey religious affiliation item (Smith et al., 2013).

Bivariate analyses, including independent samples t-tests and chi square analyses, were used to compare the two groups with regard to their attitudes, self-efficacy, perceived feasibility, behaviors, and their overall orientation toward integrating clients' RS in practice.

Additionally, a variety of independent variables were considered to examine whether or not a difference existed between the two groups. These included age, region, race (recoded as *White* and *non-White* due to few non-White respondents), Duke University Religion Index (DUREL) Intrinsic Religiosity subscale (Koenig & Büssing, 2010), and two items from the General Social Survey measuring degree of religiosity and spirituality (Smith et al., 2013). Bonferroni corrections were used to reduce the risk of a Type I error, considering the large number of comparisons that were made, and a correction for continuity was used for the chi-square analyses, to reduce the risk of an inflated chi square in the two-by-two tables.

## Results

As shown in Table 1, the majority of respondents were female (80.2%) and White (87.4%), with both groups having an average age in the mid-

50s and about 20 years of practice experience. There were no differences between those who did and did not self-identify as Christian with regards to age, gender, highest educational degree, length in clinical practice, or length of time at their current agency. Race/ethnicity had too many cells with a cell count less than five, therefore the variable was recoded to White and Non-White, and no difference was identified. There was no difference between those who did and did not self-identify as Christian regarding whether or not the individual had a course on the subject during their MSW program, had taken continuing education on the topic, or had knowledge of empirically supported interventions that integrate RS in practice.

There was, however, a difference between the two groups with regard to the region of the country in which they lived, with fewer self-identified Christians in the Northeast and in the West ($\chi^2 = 17.43$, $df = 3$, $p < .001$). Additionally, those who self-identified as Christian had a higher level of intrinsic religiosity than those who did not self-identify as Christian ($t = 8.471$, $df = 428.64$, $p < .001$), as measured by the DUREL (Koenig & Büssing, 2010).

**Table 1: Background Characteristics of Social Workers Who Self-Identify as Christian or Non-Christian**

| | | Christian (n=168) | Non-Christian (n=276) |
|---|---|---|---|
| | *M*<br>*SD* | *M*<br>*SD* | *t*<br>*p* |
| Age<br>(n=164, 276) | 56.76<br>11.31 | 53.37<br>10.92 | -.360<br>.719 |
| Years of Practice Experience<br>(n=167, 275) | 24.15<br>11.30 | 22.37<br>11.35 | -1.597<br>.111 |
| | n (%) | n (%) | $\chi^2$<br>*p* |
| Gender<br>Female (n=353)<br>Male (n=87) | <br>130 (77.8)<br>37 (22.2) | <br>223 (81.7)<br>50 (18.3) | <br>.737*<br>.391 |
| Ethnicity<br>(n=167, 271)<br>Caucasian<br>African American<br>Hispanic<br>Asian/Pacific Islander<br>American Indian/<br>Alaskan Native<br>Other | <br><br>142 (85.0)<br>12 (7.2)<br>10 (6.0)<br>1 (0.5)<br>0 (0.0)<br><br>2 (1.2) | <br><br>241 (88.9)<br>2 (0.7)<br>9 (3.3)<br>8 (3.0)<br>3 (1.1)<br><br>8 (3.0) | <br>**<br><br><br><br><br><br> |
| Region (n=164, 272)<br>Northeast<br>Midwest<br>South<br>West | <br>51 (31.3)<br>40 (24.4)<br>49 (29.9)<br>24 (14.6) | <br>115 (42.3)<br>39 (14.3)<br>54 (19.9)<br>64 (23.5) | <br>17.43<br>.001 |

| | | Christian (n=168) | Non-Christian (n=276) |
|---|---|---|---|
| Prior Continuing Education on RS Integrated Practice: Yes (n=168, 276) | 84 (50.0) | 114 (41.3) | 2.854* .091 |
| Prior Continuing Education on RS Integrated Practice: Yes (n=168, 276) | 84 (50.0) | 114 (41.3) | 2.854* .091 |
| Prior Courses on RS Integrated Practice: Yes (n=168, 276) | 23 (13.7) | 31 (11.2) | .620 .773 |
| To what extent do you consider yourself a religious person?: Very/ moderately religious (n=164, 275) | 103 (62.8) | 60 (21.8) | 72.190* .000 |
| To what extent do you consider yourself a spiritual person?: Very/ moderately spiritual (n=168, 275) | 155 (92.3) | 210 (76.4) | 18.170* .000 |

Note: RS = religion/spirituality. *A continuity correction was used to reduce the risk of an inflated chi-square statistic. **Ethnicity had too many cells with an expected frequency less than 5 to report non-parametric statistics.

## Missing Data and Assumptions

Data was missing completely at random (MCAR) and was minimal; however, the behaviors subsection had up to 5.8% missing data, exceeding Tabachnick and Fidell's (2013) recommended 5% cutoff, but still considered MCAR and not problematic across background items (Oxhandler & Parrish, 2014). For the purpose of this study, self-identified Christian and non-Christian groups were compared with regards to missing data and there was no difference.

## Findings

Here are the findings, based on the four research questions:

1. ***What attitudes and levels of self-efficacy do social workers who self-identify as Christian have around integrating clients' RS in practice, and how do they compare with those who do not self-identify as Christian?***

As shown in Table 2, Christians reported extremely high levels of self-efficacy, with about three out of four agreeing with every statement, except for item 3 ("I know what to do if my client brings up thoughts of being possessed by Satan or the Devil"). Nearly all Christians reported the

ability to recognize when clients utilize positive coping strategies, as well as negative coping strategies, and consider the unique needs of diverse clients with different RS backgrounds in their practice.

Both Christians and non-Christians reported extremely high levels of self-efficacy. Across all self-efficacy items, a higher percentage of social workers (1%–19.2%) that self-identified as Christian agreed with the statement; however, only three self-efficacy items were significant after a Bonferroni correction to reduce the risk of a Type I error. These three items include 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"), 8 ("I feel confident in my ability to integrate my clients' religious/spiritual beliefs into their treatment"), and 9 ("I know when it is beneficial to refer my client to pastoral or religious counseling").

**Table 2: Frequencies of Responses to RSIPAS Items: Self-Efficacy with Regard to Integrating Clients' RS in Practice***

| SELF-EFFICACY WITH REGARD TO INTEGRATING CLIENTS' RS in Practice (Strongly Agree/Agree) | SELF-IDENTIFIED CHRISTIAN (n = 168) | NOT SELF-IDENTIFIED CHRISTIAN (n = 276) | $\chi^2$ | $p$ |
|---|---|---|---|---|
| 1. I know how to skillfully gather a history from my clients about their religious/spiritual beliefs and practices. (n=442) | 137 (82.0) | 220 (80.0) | .16 | .688 |
| 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=441) | 149 (89.2) | 237 (86.5) | .48 | .489 |
| 3. I know what to do if my client brings up thoughts of being possessed by Satan or the Devil. (n=440) | 111 (66.5) | 159 (58.2) | 2.62 | .106 |
| 4. I consider the unique needs of diverse clients with different religious/spiritual backgrounds in my practice. (n=442) | 159 (95.8) | 257 (93.1) | .89 | .344 |
| 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=443) | 163 (97.6) | 263 (95.3) | .95 | .330 |
| 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=441) | 129 (77.7) | 161 (58.5) | 16.05 | .000 |
| 7. I feel as though I have the skills to discuss my clients' religious/spiritual strengths. (n=443) | 150 (89.8) | 229 (83.0) | 3.41 | .065 |

| SELF-EFFICACY WITH REGARD TO INTEGRATING CLIENTS' RS in Practice (Strongly Agree/Agree) | SELF-IDENTIFIED CHRISTIAN (n = 168) | NOT SELF-IDENTIFIED CHRISTIAN (n = 276) | $\chi^2$ | $p$ |
|---|---|---|---|---|
| 8. I feel confident in my ability to integrate my clients' religious/spiritual beliefs into their treatment. (n=440) | 151 (89.9) | 212 (77.9) | 9.44 | .002 |
| 9. I know when it is beneficial to refer my client to pastoral or religious counseling. (n=439) | 144 (86.7) | 196 (71.8) | 12.37 | .000 |
| 10. I feel as though I have the skills to discuss my clients' religious/spiritual struggles. (n=441) | 139 (84.2) | 211 (76.4) | 3.37 | .066 |
| 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=443) | 160 (95.8) | 245 (88.8) | 5.71 | .017 |
| 12. I know what to do when my client has religious/spiritual beliefs that I am unfamiliar with. (n=442) | 168 (85.7) | 274 (84.7) | .03 | .872 |
| 13. I am comfortable discussing my clients' religious/spiritual struggles in therapy. (n=441) | 155 (92.3) | 239 (87.5) | 1.96 | .162 |

Note: A continuity correction was used to reduce the risk of an inflated chi-square statistic.

Regarding their attitudes toward integrating clients' religion/spirituality in practice, at least half of those who self-identified as Christian agreed with each of the attitudes items in their appropriate direction, with items 5, 6, 7, 9, and 12 (after reverse coding) eliciting at least 90% agreement (see Table 3). Compared with those who did not self-identify as Christian, a majority of both groups agreed with each of the statements, with the exception of Attitude 10 "Empirically-supported religious/spiritually integrated therapies are relevant to my practice." The only item that was significantly different between the two groups after a Bonferroni correction was item 4 ("Integrating clients' RS beliefs in treatment helps clients meet their goals"), with Christians having a higher level of agreement ($\chi 2 = 9.143$, $df = 1$, $p = .002$).

**Table 3: Frequencies of Responses to RSIPAS Items: Attitudes Toward Integrating Clients' RS in Practice ***

| ATTITUDES TOWARD INTEGRATING CLIENTS' RS IN PRACTICE | SELF-IDENTIFIED CHRISTIAN (n = 168) | NOT SELF-IDENTIFIED CHRISTIAN (n = 276) | $\chi^2$ | $p$ |
|---|---|---|---|---|
| 1. It is essential to assess clients' religious/spiritual beliefs in practice. (n=444) | 106 (63.1) | 173 (62.7) | .00 | .999 |
| 2. Integrating clients' religious/spiritual needs during treatment helps improve client outcomes. (n=441) | 127 (76.0) | 183 (66.8) | 3.83 | .050 |

| ATTITUDES TOWARD INTEGRATING CLIENTS' RS IN PRACTICE | SELF-IDENTIFIED CHRISTIAN (n = 168) | NOT SELF-IDENTIFIED CHRISTIAN (n = 276) | $\chi^2$ | $p$ |
|---|---|---|---|---|
| 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=443) | 97 (58.1) | 149 (54.0) | .55 | .458 |
| 4. Integrating clients' religious/spiritual beliefs in treatment helps clients meet their goals. (n=444) | 121 (72.0) | 158 (57.2) | 9.14 | .002 |
| 5. I am open to learning about my clients' religious/spiritual beliefs that may differ from mine. (n=442) | 160 (96.4) | 269 (97.5) | .13 | .720 |
| 6. Attending to clients' religious/spiritual needs is consistent with the principles of meeting the client where he/she is at. (n=443) | 156 (93.4) | 248 (89.9) | 1.23 | .268 |
| 7. Sensitivity to clients' religious/spiritual beliefs will improve one's practice. (n=442) | 154 (92.8) | 258 (93.5) | .01 | .927 |
| 8. I am open to referring my clients to religious or pastoral counseling. (n=441) | 144 (86.2) | 205 (74.8) | 7.51 | .006 |
| 9. Attending to clients' religious/spiritual beliefs is consistent with my profession's code of ethics. (n=443) | 148 (91.2) | 235 (95.7) | .42 | .519 |
| 10. Empirically-supported religious/spiritually integrated therapies are relevant to my practice. (n=444) | 87 (51.8) | 110 (39.9) | 5.55 | .018 |
| 11. There is a religious/spiritual dimension to the work I do. (n=441) | 113 (67.7) | 170 (62.0) | 1.19 | .275 |
| 12. I refuse to work within my clients' religious/spiritual belief system if it differs from my own. (n=442) | 1 (0.6) | 2 (0.7) | .00 | .999 |

Note: A continuity correction was used to reduce the risk of an inflated chi-square statistic.

### 2. *Do social workers who self-identify as Christian consider integrating clients' RS in practice to be feasible, and how do they compare with those who do not self-identify as Christian?*

As shown in Table 4, at least 80% of those who did and did not self-identify as Christian agreed with the various items on assessing the feasibility of integrating clients' RS in practice, in the appropriate direction. The one item that fell to 55% of Christian and 51% of those who did not self-identify as Christian was item 6 ("I have been adequately trained to integrate my clients' RS into therapy.") Across perceived feasibility items, there were no significant differences between the groups after a Bonferroni correction.

**Table 4: Frequencies of Responses to RSIPAS Items: Perceived Feasibility to Engage in RS Practice ***

| PERCEIVED FEASIBILITY TO ENGAGE IN RS INTEGRATED PRACTICE | SELF-IDENTIFIED CHRISTIAN (n = 168) | NOT SELF-IDENTIFIED CHRISTIAN (n = 276) | $\chi^2$ | *p* |
|---|---|---|---|---|
| 1. I have enough time to assess my clients' religious/spiritual background. (n=444) | 137 (81.5) | 227 (82.2) | .003 | .953 |
| 2. I have enough time to identify potential strengths or struggles related to my clients' religion/spirituality. (n=443) | 146 (86.9) | 236 (85.8) | .032 | .857 |
| 3. My primary practice setting does not support the integration of religion/ spirituality into practice. (n=442) | 5 (3.0) | 16 (5.8) | 1.260 | .262 |
| 4. I don't have enough time to think about incorporating a religious/spiritually integrated approach to practice. (n=442) | 12 (7.2) | 6 (2.2) | 5.440 | .020 |
| 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=443) | 157 (93.5) | 240 (87.3) | 3.641 | .056 |
| 6. I have been adequately trained to integrate my clients' religion/spirituality into therapy. (n=443) | 93 (55.4) | 139 (50.5) | .785 | .376 |

***3. At what frequency are social workers who self-identify as Christian implementing steps to integrate clients' RS in practice, and how do they compare with those who do not self-identify as Christian?***

Regarding self-identified Christian's behaviors related to integrating clients' RS in practice, only three items (4, 6, and 8) elicited over half of the sample responding with "often" or "very often," as shown in Table 5. However, 26% or fewer self-identified Christians reportedly engaged in the behaviors mentioned in items 1, 2, 3, and 5 at least often. Those who did not self-identify as Christian held similar responses, with lower levels of engaging in behaviors as compared to their responses to the prior subscales. The only item in which Christians reported a significantly higher frequency of engagement was item 3 ("I read about research evidence on RS and its relationship to health to guide my practice decisions")

**Table 5: Frequencies of Responses to RSIPAS Items: Behaviors Related to Integrating Clients' RS in Practice ***

| BEHAVIORS RELATED TO INTEGRATING CLIENTS' RS IN PRACTICE | SELF-IDENTIFIED CHRISTIAN (n = 168) | NOT SELF-IDENTIFIED CHRISTIAN (n = 276) | $\chi^2$ | *p* |
|---|---|---|---|---|
| 1. I seek out consultation on how to address clients' religious/spiritual issues in treatment. (n=440) | 19 (11.4) | 26 (9.5) | .244 | .621 |
| 2. I read about ways to integrate clients' religion/spirituality to guide my practice decisions. (n=443) | 44 (26.3) | 59 (21.4) | 1.175 | .278 |
| 3. I read about research evidence on religion/spirituality and its relationship to health to guide my practice decisions. (n=443) | 42 (25.0) | 39 (14.2) | 7.461 | .006 |
| 4. I involve clients in deciding whether their religious/spiritual beliefs should be integrated into our work together. (n=441) | 109 (65.3) | 150 (54.7) | 4.318 | .038 |
| 5. I use empirically supported interventions that specifically outline how to integrate my clients' religion/spirituality into treatment. (n=443) | 24 (14.3) | 33 (12.0) | .303 | .582 |
| 6. I conduct a full biopsychosocialspiritual assessment with each of my clients. (n=440) | 96 (57.1) | 155 (57.0) | .000 | .999 |
| 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=439) | 78 (47.0) | 105 (38.5) | 2.746 | .097 |
| 8. I help clients consider ways their religious/spiritual support systems may be helpful. (n=440) | 113 (67.7) | 165 (60.4) | 2.025 | .155 |
| 9. I help clients consider the religious/spiritual meaning and purpose of their current life situations. (n=441) | 82 (49.1) | 115 (42.0) | 1.856 | .173 |

4. ***How do those who self-identify as Christian compare with those who do not self-identify as Christian with regards to their overall RSIPAS scores, measuring practitioners' self-efficacy, attitudes, perceived feasibility, and integration of clients' RS in practice, as well as their overall orientation toward this area of practice?***

As shown in Table 6, independent t-tests compared the responses among social workers who did and did not self-identify as Christian using listwise deletion. Using a Bonferroni correction to reduce the risk of a Type I error, those who self-identified as Christian had significantly higher self-efficacy (t = 2.84, p = .005) and self-reported behaviors scores (t = 2.80, p = .005). There was no difference between the two groups with regard to their attitudes toward integrating clients' RS in practice or perceived feasibility. The two groups' overall orientation scores approached significant difference, but was not significant after a Bonferroni correction.

**Table 6: Mean Differences between Christians and Non-Christians on Scale and Sub-Scale Scores**

| | SELF-IDENTIFIED CHRISTIAN (n = 168) | | SELF-IDENTIFIED NON-CHRISTIAN (n = 276) | | | |
|---|---|---|---|---|---|---|
| | *M* | *SD* | *M* | *SD* | *t* | *p* |
| Self-Efficacy | 53.98 | 6.01 | 52.08 | 8.03 | 2.84 | 005 |
| Attitudes | 48.86 | 6.01 | 47.66 | 7.02 | 1.84 | 066 |
| Perceived Feasibility | 24.08 | 3.43 | 23.97 | 3.91 | .317 | 744 |
| Self-Reported Behaviors | 29.14 | 6.22 | 27.34 | 6.75 | 2.80 | .005 |
| Orientation Toward RS in Practice | 156.06 | 18.33 | 151.04 | 22.78 | 2.55 | .011 |

Note: RS = Religion/Spirituality; RSIPAS = Religious/Spiritually Integrated Practice Assessment Scale

## Discussion

Acknowledging the role in which one's understanding of spirituality, regardless of religious faith or background, may carry out into all dealings of one's life is an important step to consider in social work training and education efforts, especially as they relate to considering clients' RS in practice. In Oxhandler et al. (2015), intrinsic religiosity across a variety of faith backgrounds was, in fact, the largest predictor of whether or not clinical social workers integrated clients' RS in practice. Intrinsic religiosity reflects a variety of the aspects of personal beliefs and their impact on the application of religious or spiritual values, regardless if one self-identifies as Christian or not. Given that the largest proportion of social workers self-identify as Christian, and that many social work students report their Christian beliefs influence their career choices (Hirsbrunner et al., 2012), this study sought to build upon Furman and colleagues' (2011) study by using a standardized instrument to examine four unique constructs between

these two groups—their self-efficacy, attitudes, perceived feasibility, and behaviors—as well as their overall orientation toward integrating clients' RS into practice.

Nearly equal numbers of social workers that identify as Christian or indicated another religious faith or background (Jewish, Muslim, Buddhism, Hinduism, None, or Other) held positive views and attitudes toward integrating at least some aspect of RS into their practice. Further, the two groups similarly find few barriers (e.g., time, training, or competing clinical issues) to considering this area of clients' lives. These results are encouraging, suggesting that both groups are open and willing to consider this sensitive area of clients' culture and that the transition of the 1990s has been successful, communicating the need to pay attention to RS as it relates to practice.

However, there are some differences between the two groups. Those who self-identified as Christian reported higher levels of self-efficacy related to integrating clients' RS, compared with those who did not identify as Christian. Possibly the most direct variable under this subscale is Self-Efficacy item eight ("I feel confident in my ability to integrate my client's religious/spiritual beliefs into their treatment"), in which nearly 90% of Christians agreed, versus 78% of non-Christians. Still, these numbers are remarkably high for both groups, especially with only 11-14% of respondents having taken a course on this topic. Self-efficacy items six and nine also had higher levels of agreement among Christians; however, these items relate to referring clients to religious resources or pastoral counseling, which Christians may feel more confident in because of their own personal connections to religious organizations.

Though this sample of Christians may feel more confident given their connection to their own religious organization, their beliefs, practices, and organizations may not be appropriate for all clients. In fact, a recent comparison shows social workers' and clients' beliefs and practices are vastly different (Oxhandler, et al., in press). Therefore, as in any other area or aspect of culture in which the social worker has not yet developed competence, when the client speaks of a matter of her or his faith the social worker is unfamiliar with, considering referral and connecting clients with the necessary, appropriate, and culturally-tailored resources is important. Since less than half of either group reported engaging in these behaviors under behavior item seven, an increased emphasis on training future social workers about referring to RS or pastoral counseling and linking clients with RS resources is critical.

Another difference between these two groups is in their responses to the behaviors subscale. Those who self-identified as Christian generally reported engaging in the behaviors more frequently; however, across both groups, less than half reported engaging in six out of the nine items often

or very often, suggesting a discrepancy between their attitudes, self-efficacy, and perceived feasibility with their behaviors. Though some of the behavior items might be context-specific and/or depend on client preferences, other items are less context-specific. For example, 38.5-47% link clients with RS resources when it may potentially help them. As noted in Oxhandler and Giardina (in press), though 31% of this sample reported nothing prevents them from integrating clients' RS in the qualitative portion of this study, 35% listed a variety of practitioner-related limitations that further training might alleviate. Some of these include a lack of training, discomfort/fear on how to discuss the topic, discordance with their personal beliefs, and a lack of familiarity with various faith traditions (Oxhandler & Giardina, in press).

It is clear that significant progress has been made in developing the efficacy of social workers in addressing RS issues. However, the discrepancy between their views and responses to the behaviors items suggests that there is more work to be done. If nine out of ten adults in the United States believe in a God or Universal Spirit and a large majority consider religion to be at least somewhat or very important (Pew Research Center, 2015), then there is a need for clinical social workers to be equipped to assess and address the religious and spiritual needs of their clients as they relate to social work practice. This should be true regardless of the social workers' belief systems. Practitioners need to address the unique RS needs of clients and respect the clients' RS traditions, which may involve integration of religious beliefs and practices outside of the social worker's own worldview.

Social work training teaches basic social work values, cultural awareness, self-awareness, active listening techniques, community practice insight, and public policy insights. On many of these topics there is some agreement among educators as to what should be taught. Though certainly not a new topic, RS has emerged as a critical component worthy of assessment and exploration in mental and behavioral health treatment. Not only is there discourse on the use of religion in coping (Pargament, 2007) and impact of RS on health and mental health outcomes (Koenig et al., 2001; Koenig et al., 2012), but standing mandates to include RS in practice are facilitated by the connection between RS and culture within the National Association of Social Work's (NASW, 2008) Code of Ethics, the Council on Social Work Education's (CSWE, 2015) Educational Policy Accreditation Standards, and the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013).

Though our study moves the discussion related to the integration of clients' RS into practice forward, particularly with regard to the role of Christian social worker's faith tradition, there certainly are limitations. First, our sample included LCSWs on HelpPRO, which includes practitioners who were primarily in solo, private practice (Oxhandler et al., 2015) and able to pay an annual fee of about $75-$100 (HelpPRO, n.d.);

thus, practitioners who were not on this site were excluded. However, the demographics within our sample of licensed social workers closely mirror those of NASW members being predominantly older, white women (Center for Health Workforce Studies, 2006). Still, groups of practitioners from other minority backgrounds or those who are not primarily in solo-private practice might have responded differently.

## Conclusion

Though there has been an increase in discourse and need for attention to clients' RS matters in social work, and though this national sample's views are encouragingly positive, fewer LCSWs are engaging in behaviors related to integrating clients' RS in practice. Interestingly, regardless whether the LCSW identified as Christian or not, there was not a difference between the two groups with regard to their attitudes, perceived feasibility, and overall orientation toward integrating clients' RS. However, those who self-identified as Christian reported higher levels of self-efficacy and indicated that they engaged in behaviors related to RS integration more frequently. Yet, the fact that both groups are less frequently assessing for and integrating clients' RS, despite openness to it, warrants an increase in training on this area of practice and the need to evaluate such training. ❖

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