

Running Head: USE OF SPIRITUALLY INTEGRATED INTERVENTIONS

THE USE OF SPIRITUALLY INTEGRATED INTERVENTIONS AMONG
BAHÁ'Í MENTAL HEALTH PRACTITIONERS

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DEDICATION

To the Bahá'ís of the world who believe in the oneness of all mankind. To my children, Louis-David Calicdan Apostle and Carmel Saramila Apostle, two hopeful collaborators of world peace.

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Finally, from the depth of my heart, I am constantly reminded of the seven Iranian Bahá'í prisoners who were arrested last March 2008, almost the same time that I began my classes at Penn. They are to this day still in prison. Their crime: they are Bahá'ís.

Above all, I thank God, the Fountainhead of my inspiration, the Most Great Assister. My hope is to promote a meaningful discussion on the role of religion and spirituality in the academia, research, and mental health practice.

ABSTRACT

With growing recognition of the importance of religious and spiritual concerns in mental health practice, empirical research into spiritually integrated interventions has begun to increase. However, to date, the body of research undertaken in this emerging field has been largely conducted from a Christian perspective. This study aimed to expand the scope of research by exploring the use of spiritually integrated interventions by a cohort of mental health providers who are self-identified members of the Bahá'í Faith, one of the lesser-known but fastest growing religions in the world today.

Utilizing online survey research, this first convenience sample (N=105) study of Bahá'í mental health practitioners explored participants' intrinsic religious motivation as a measure of their religious identity, their use of spiritually integrated interventions, and their beliefs about these interventions as appropriate or inappropriate for mental health practice. Results of this study indicate that Bahá'í mental health practitioners are intrinsically motivated, showing similar results in measures of motivation and direction in life (Pargament, 1997) and perceptions of practicing spiritual beliefs (Stewart, Koeske, & Koeske, 2006) or following a spiritual path in life (Derezotes, 1995). Conceptually, intrinsic motivation seems to project perceptions of spiritual strivings (Baumeister, 1991), concept of meaning and purpose in life (Frankl, 1984), belief in God (Sheridan, Wilmer, and Atcheson, 1994), and measures of religious commitment (Wimberley, 1984). Bahá'í mental health practitioners' belief in the inherent intrinsic value of a human being (e.g., client) and the synonymous parallelism that all therapeutic work is spiritual in nature were noticeably integrated into their use of spiritually integrated practice.

The Bahá'í mental health practitioners' responses to RSPBQ Index of 29 interventions showed "often" to "very often" utilization of spiritually integrated interventions in contrast with

Frazier and Hansen's (2009) original survey of professional psychologists indicating "infrequent" responses to the same index. They indicate a willingness to use some evidence-based spiritually integrated interventions to their mostly private practices. Responses to open-ended questions show how Bahá'í respondents respect the ethical guidelines for professional practice. An appreciation for the "universality of human beings' capacities" informs their practice. Viewing the client as "inherently whole and capable" instead of "someone to be fixed, controlled or cured," the Bahá'í mental health practitioners use spiritually integrated services to achieve a goal of spiritual integration in therapy while fostering "peace and confidence within" instead of adherence to a specific creed, dogma or rituals.

Future research should explore other diverse perspectives, such as those of Muslim, Hindu, Buddhist, Native American, and/or non-religious practitioners. The efficacious use of evidence-based spiritually integrated interventions as alternative ways of coping with mental health problems should also be considered for future examination.

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CHAPTER I

INTRODUCTION

The United States is one of the most religious countries in the Western world (Fuller, 2001; Hoge, 1996; Roof, 1993). Research on the prevalence of religious affiliations and religious beliefs in North America estimated that over 80% of Americans are affiliated with a religion, while over 90% have a belief in God (Baylor University Press, 2005; Shafranske, 2000) and pray at least weekly (Baylor University, 2005). Delaney, Miller, and Bisono (2007) stated that 55% of American adults describe religion as “very important.” The U.S. Religious Landscape Survey (Pew Forum on Religion & Public Life, 2004) revealed that even people who are not affiliated with a particular religious tradition are often committed to religious assumptions or beliefs and practices. This research has important implications regarding the values of clients served by mental health professions.

For the purpose of this study, religious assumptions are based on and/or contextualized within the framework of religious beliefs. These belief systems are translated into “convictions that people hold regarding such matters as God, truth, or doctrines of faith” (Gunn, 2003, p. 201). Allport (1966) states that religious assumptions can best be understood in individuals who have a proper understanding of doctrines and/or belong to a religious community of believers.

By definition, religious practice includes behaviors, activities, and other aspects of cultural beliefs and attitudes of religious individuals or communities. Depending on particular religious beliefs and principles, religious practices are illustrated in many forms, including prayer (Belaire & Young, 2002; Haley, Koenig, & Bruchett, 2001; Weld & Eriksen, 2007), scripture references (Belaire & Young, 2002; Martinez, Smith, & Barlow, 2007), mindfulness or meditation (Martinez et al., 2007), religious holiday rituals (Fiese & Tomcho, 2001), and laying-

on of hands (Richards & Potts, 1995). Previous literature (Ellison, 1992; Idler, 2008) has shown that religious practice provides one way of solving today's problems. Some social policy goals and social work programs operate within the context of a religious practice, a powerful level of practice that seems to align with solving some of the most difficult problems in this day and age.

Some individuals with mental illness seek alternate forms of therapy that include exercise, prayers, rituals, and traditional healing practices (Lukoff, Lu, & Turner, 1992). Others seek help from healing professionals, including social workers and other mental health practitioners, to address their quality of life and psychological health and well-being. In addition, issues of moral, spiritual, or religious significance may be intertwined with clients' psychological suffering or mental illness. According to Sheridan, Bullis, Adcock, Berlin, and Miller (1992), practitioners report that as many as one-third of clients who present clinical issues express concerns of a religious or spiritual nature. Recognizing that some clients have personal religious or spiritual resources to supplement other methods of coping, spiritually integrated interventions may be beneficial to promoting clients' mental health.

As defined here, spiritually integrated interventions are "appropriate assessment and intervention practice behaviors that employ informed sensitivity to the clients' personal spiritual beliefs and practices" (Murdock, 2005, p. 132). Spiritually integrated interventions include a set of behaviors utilized by a mental health practitioner that are designed to address those aspects of a client's clinical concerns that the client identifies -- perhaps with the assistance of the therapist - - as related to his or her own spiritual or religious practices and/or beliefs (M. Penn, personal communication, Oct. 20, 2010). Spiritually integrated interventions can be strategies that empower clients to draw upon their own spiritual resources as they attempt to cope with or overcome the psychosocial challenges they face. In addition to mobilizing and exploring the

client's own spiritual resources, spiritually integrated interventions may also be reflected in strategies are developed by the practitioner because of his or her own spiritual awareness, clinical or life experiences, and/or training. Such spiritually integrated interventions may include techniques designed to help clients metabolize stress, anxiety, or worry and techniques focused on bringing one's lifestyle into closer harmony with one's spiritual or religious beliefs. Interventions are utilized in a professional relationship where exploratory processes help clients recognize when their spiritual or religious beliefs may be interfering with their healthy development and/or adaptation.

Despite fears of overstepping ethical boundaries when spiritual or religious issues are raised, it seems that a good proportion of potential clients prefer spiritually integrated treatment (Pargament, 2007). In addition to standard medical care and treatment, a desire for integrated practices that simultaneously address religious concerns is preferred by 45% of clients, with 73% in one study indicating that no medical staff had spoken to them about spiritual matters (Post, Puchalski, & Larson, 2000).

Some clients seem to know what they want in therapy. If their preferences and expectations of using spiritually integrated interventions are ignored, their experiences in therapy may be unhelpful (Knox, Catlin, Casper, & Schlosser, 2005). Sullivan (2009) terms this disconnect the “religiosity gap” (p. 91). This so-called “gap” suggests that clients on average are more religious than their therapists or counselors, which may reduce the practitioner’s attunement to the impact of spirituality or religion in the client’s life (Curlin et al., 2007). A 1992 Gallup poll survey of 1,000 American men and women revealed that 66% of respondents would prefer to receive counseling from a person who shares their spiritual values, while 81% of those surveyed indicated a wish for their religious values to be respected and integrated into the

counseling process (Sperry, 2001). When clients were asked about their choice of a counselor, seven out of ten clients preferred a professional counselor or therapist who had a religious affiliation (Weaver, Flannelly, Case, & Costa, 2004). In a similar vein, Koltko (1990) noted that, while some therapists may consider religion to be a background variable of the clients, many clients consider religion to be at the forefront of psychotherapy.

With growing evidence of the importance of spiritual or religious concerns for clients and their interest in incorporating spirituality and religion into therapy, researchers wish to explore whether and to what extent mental health practitioners utilize spiritually integrated interventions in their practices. To date, some empirical research on the use of spiritually integrated interventions is slowly beginning to emerge, particularly in the fields of gerontology and work with children. However, these studies have some limitations that will be addressed in this present study. For example, in exploring the use of spiritually integrated interventions, there has been little attempt to examine the role of the practitioner's religious affiliation. Mattison, Jayaratine, and Croxton (2000) found the worker's religious background to be the most consistent predictor of clients' use of intervention. Thus, religious identification may be a key variable in understanding the use of spiritually integrated interventions.

The issue of diversity in sampling is another limitation identified in previous studies. Although the concept of spirituality may exist without reference to a formally defined religion, it is most often within the context of the Christian faith that the role of religion in mental health research and practice has been explored. As a result, researchers have unintentionally neglected the role of other religions. It is within this context that this study will explore a less commonly known religion, the Bahá'í Faith, and its relationship to mental health practice. This project will examine a largely unexplored area of religious-based practice by a cohort of religious mental

health practitioners, Bahá'í clinicians. In particular, this study will explore their use of spiritually integrated interventions, including their perception of appropriate use in mental health practice.

History of Religion in Social Work

In examining the history and roots of the social work profession, it is evident that spirituality and religion have a special place in it (Canda, 1988; Hutchison, 1999). Social work practice in the United States has its origins in Jewish and Christian religious principles and in organizations founded on religious and spiritual values. Russell (1998), Siporin (1986), and Canda and Furman (1999) have identified several phases in the development of spirituality and its relationship to social work practice in the United States. The first phase was the rise of early 20th century social services and charity organizations that addressed spirituality. Most of these institutions were based on Christian and, in some cases Jewish, values and beliefs. In 1910, for example, activities of such organizations in the United States centered on “charity and correction” or “philanthropy,” and activists were “charity workers” or “philanthropists” (Leiby, 1985). A widespread belief during this time was that the categorical relationship “among the divine commandments of love, the idea of personal and social responsibility, and the basis of public or governmental provision of help” (Leiby, 1985, p. 324) had been founded on Christian beliefs in God, as well as salvation and accountability through charity and good works. It was also during this time that the terms “social welfare” and “social work” came into being, denoting the spirit of charity and giving.

Early social work leaders who had strong spiritual or religious motivations for service intimately connected their practices with religious and spiritual traditions (Stroup, 1986). For the purpose of this study, the term “religious motivation” is conceptualized as follows: The spiritual lens seems to provide an orientation that presents motivation and direction in life (Pargament,

1997). Religious motivation becomes a compass for these spiritual strivings, an influence that empowers some people to follow those goals that they find inspiring (Baumeister, 1991), thus providing them with a sense of reason to engage life with more meaning. As religion is seen as providing some individuals with a sense of meaning and purpose in life (Frankl, 1959), these individuals must also find some authentic expression of a religious belief system in order to effectively find life's meaning. Empirical evidence seems to support how intrinsic religious motivation was positively related to Frankl's concept of meaning and purpose in life (Bolt, 1975).

One such example of a person with strong religious motivation was Jane Addams, the founder of Hull House who led the Settlement House movement. She promoted social justice through non-sectarian and humanistic approaches. Behind the Settlement House concept was a religious act of service to society (Bruce, 1966). Of particular interest was a presidential address made by Owen Lovejoy during the 1920 National Conference of Social Workers, which encouraged the participation of other religious affiliations. He said, "Regardless of formal religious commitment, the social worker and the social reformer were in the line of the devoted, the communion of those who did good works" (as cited in Chambers, 1963).

Between the 1930s and early 1960s, government systems developed and social work education gradually moved away from the idea of a spiritual/social welfare connection. The government increased the sponsorship of social service agencies devoid of reference to a particular religious doctrine.

In 1957, Spencer noted, "Anyone who attempts to discuss the subject of religion is faced with many hurdles": she was convinced that "humanity is attesting to the search for sources of security and for something to give meaning in life" (p. 519). The conceptualization of the

traditional person-in-environment configuration was the basis of the social work profession's holistic view of the person, particularly bringing to the forefront spirituality/religion as one important dimension of a person's culture. Social workers argued that neglecting this perspective could handicap the relationship between the client and the social worker (Canda, 1989; Germain, 1979; Joseph, 1988; Lowenberg, 1988).

There was a growing belief in the 1970s that moralistic judgment and religious proselytization represented threats to the separation of church and state (Canda, 2002). As a result, the concepts of spirituality and religion became intentionally diminished in the field of social work education, though services were continuously provided by sectarian agencies. An examination of the changing landscape of religious membership, belief, and behavior in the United States could attest to this phenomenon. During the late 1960s and 1970s, society experienced a large-scale decline in religious involvement among "baby-boomers," who, according to Roof (1993), viewed organized religion as "irrelevant," an obstacle to change (Ahlstrom, 1970, p. 12) and "preventing rather than facilitating a personal experience of the transcendent" (Turner, Lukoff, Barnhouse, & Lu, 1995, p. 437).

Paradoxically, regardless of a decline in their participation in traditional religious organizations, Americans did not view themselves as less religious or spiritual. Shorto (1997) reported that 90% pray, 93% of U.S. households have a Bible, and 33% of American adults say they read the Bible at least once a week. It was also during the 1970s that alternative religions and new forms of faith under the label "spirituality" became popular (Zinnbauer, Pargament, & Scott, 1999).

In contrast, the 1980s and 1990s saw a renewed interest in the spiritual perspective of social work. The term spirituality was attached to many social, political, and religious

movements. References to eastern, Native American, 12-step, feminist, goddess, men's, and earth-based or ecological spiritualities emerged as a response to declining traditional religious institutions (Roof, 1993). Bedell (1997) reported a dramatic increase in the number of American Hindus, Buddhists, and Muslims within the last three decades. Newer social action groups also developed, including Buddhist and other transpersonal organizations, while Christian and Jewish agencies continued to expand their religious-based practice.

Patterns of spiritual beliefs and practices of social workers in the 1990s imply that there were some similarities and differences in their beliefs and practice arenas when compared to the U.S. population in general. A handful of researchers would attest to this zeitgeist (Carroll, 1998; Cornett, 1992; Sermabeikian, 1994). Religious affiliation and degrees of religiosity were both reported to have strengthened or changed social workers' views (Derezotes & Evans, 1995; Sheridan et al., 1992). Individualism in American religious culture in the early 1990s gave rise to privatized and personalized religious practices that did not fall within the purview of mainstream or alternative religious institutions (Bellah, Madsen, Sullivan, Swindler, & Tipton, 1985; Miles, 1997; Roof, 1993). Professional conferences began to call for more conceptual research papers and publications in the area of spirituality and social work (Canda & Furman, 1999). Toward the end of the 20th century, professional organizations increasingly called for greater sensitivity and better clinician training concerning the management of religious and spiritual issues in the assessment and treatment of patients. Organizations that responded to this need included the American Psychiatric Association in 1989, the American Psychological Association in 1992, the Accreditation Council for Graduate Medical Education in 1994, the Council on Social Work Education in 1995, the Joint Commission on the Accreditation of Healthcare Organizations in 1996, the American Academy of Family Physicians in 1997, the

American College of Physicians in 1998, and the Association of American Medical Colleges in 1998 (Larimore, Parker, & Crowther, 2002). The Society for Spirituality and Social Work was established in the 1990s (Canda, 2002) and began to establish a network system on spirituality, articulating various kinds of approaches and spiritual interventions relevant to practice. Finally, the Council on Social Work Education added spirituality and religion to its professional standards of accreditation in 1995, and a small number of social work schools introduced courses on spirituality.

Looking forward, it seems logical to expect the formation of an international networking system that encompasses a global view and inclusive approach to spirituality in social work practice (Canda, 2006; Derezotes, 2006). However, Canda (2006) cautioned that while other countries look for leadership and direction in developing an inclusive approach, social workers must avoid “the dangers of superficial Americanization” (p. 2). One such approach is to examine spirituality and religion from a variety of religious perspectives. Since most empirical studies in social work and other related disciplines have offered a general understanding of spirituality and religion that is predominantly based on a Christian perspective, it is imperative to highlight other professionals’ religious perspectives. Of particular note are the mental health practitioners who belong to minority religions, a cohort that has been missing in the arena of mental health discourse, research, and practice. This study seeks to explore the use of spiritually integrated interventions within the perspective of Bahá’í mental health practice.

Purpose of the Study

There are several reasons for this study. First, although there has been an increase in research on religion and spirituality as it relates to the field of mental health, studies of mental health practitioners who follow a certain religious persuasion in their practice are still scarce. To

determine the degree to which there is interest in religion, spirituality, and health, Weaver, Pargament, Flannelly, and Oppenheimer (2006) conducted keyword searches on the PsycINFO database between the years 1965 and 2000. They combined the keyword “health” with different combinations of the following keywords: religion, religious, religiosity, spiritual, and/or spirituality. This study found that there is a significant upward trend for articles on spirituality and spirituality and religion, but a downward trend for articles on religion alone. This present study seeks to provide a modest contribution to the literature on spirituality and religion in social work and mental health.

Second, there have been a handful of studies on personal religiosity and spirituality with the use of religious-based interventions in social work (Hodge, 2004; Sheridan & Amato-von Hemert, 1999; Stewart, Koeske, & Koeske, 2006a). Most of these studies, however, seem to have limitations in terms of their lack of diversity across disciplines and across religious identification of their samples. Research on religion and social work has explored groups of mental health practitioners who are Christian (Derezotes & Evans, 1995; Graff, 2007; Sheridan et al., 1992). This present study will use primary data from several mental health disciplines belonging to one religious group, thus offering an examination of how practitioners from a lesser-known religious tradition apply interventions in their mental health practice.

Finally, the National Association of Social Workers (NASW) Code of Ethics (1997) states, “The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (NASW Revised, 2008). As repeated in a handful of professional discourses, “needs” may imply human needs in various dimensions: material, physical, psychosocial, and spiritual. This study seeks to

understand the extent to which self-identified religious mental health practitioners address the “spiritual” dimensions of some clients who have mental health challenges and who purposely seek the use of spiritually integrated interventions in their recovery.

Significance of the Study

The significance of this study is several fold. First and foremost is a basic individual’s inherent desire to understand human experience and their lifelong development of spiritual, physical, emotional, and social dimensions. A wide array of theorists and researchers can affirm this mind-body-spirit connection (Frankl, 1984; Lloyd & Dunn, 2007; Reid, 1989). Second, religiosity, spirituality, and psychoanalysis share a primary goal of searching for “one’s real or true self” or “self-identity,” which has meaning for both the practitioner’s and the client’s “specific religious and spiritual contexts” (Tummala-Narra, 2009, p. 85). The psychoanalytic perspective for this study is centered on the concept of the individual self as “sacred,” and societal needs are thought to be subordinate to the needs of individuals (Roland, 1996, 2005). Psychotherapy for this study means “a process of engagement between two persons, both of whom are bound through the therapeutic venture” (Corey, 2005, p. 5). This study will elucidate the nuances, similarities and differences of the Bahá’í practitioner’s use of spiritually integrated interventions when identified and compared distinguished from current literature that is predominantly Christian in perspective.

Inherent in this inquiry are questions about how participants make meaning of the soul, or understand what has been coined the “connection or synapse between the person and Creative Spirit [or God]” (Derezotes, 2006, p. 5). Understanding these meanings is integral to social work because these constructs may provide a greater understanding of religious practitioners’ collective behaviors that support some clients who have preferences for spiritual/religious

interventions. This research seeks to open up a dialogue regarding religious beliefs and values from the perspective of the mental practitioners.

A third reason for this study derives from the religious roots embedded in the history of the social work profession (Canda, 1988; Hutchison, 1999), evidence that spirituality and religion have held a significant place historically in social work practice. What lies in the future for social work may be an understanding of how spirituality and religion can best further serve the profession and the needs of the global society. Since mental health is at an important juncture in the current paradigm of societal issues, one place to start is to find out what Bahá'í mental health practitioners do. By finding these answers, the hope is that this religious-based research can move the mental health profession toward effectiveness and evidence-based practices.

There appears to be an emerging view that spiritual factors are at the essence of relations between human beings (Johnson, 1956), such that the spiritual dimension may be considered a critical component of the bio-psychosocial perspective of client assessment. In fact, psychology, psychiatry, and social work now often integrate spiritual assessment into practice. Spiritual problems and crises are now categorized under a new V-Code in DSM-IV (V62.89), where it is described as “distressing experiences that involve loss or questioning of faith [...] or questioning of values that may not necessarily be related to an organized church or religious institution” (DSM-IV-TR). Identified as a tool to help some clients recover from serious mental illness, religion at times fills a gap neglected by even some of the best practices. The results of this study might help inform the practitioners about the extent that these spiritually integrated interventions are utilized. Some scholars feel that the question for mental health practitioners is “no longer whether to address the sacred in psychotherapy with religious and spiritual clients, but rather,

when and how to address” the use of spiritually integrated interventions (Post & Wade, 2009, p. 131).

Finally, another lens for this study is the impact of how relationship between the person-in-environment framework and the ecological perspective may inform mental health practice. Some practitioners view the “professional social work relationship is a spiritual relationship” (Quattlebaum, 2002, p. 20). Understanding the human interaction between client and worker is valuable because clinical or therapeutic issues cover many facets that a mental health practitioner may be able to address. For some clients, problems that involve critical moral and ethical decision-making, crises, grief and loss, anxiety, and guilt have implications for their quality of life and mental well-being. By seeking self-knowledge, love, and happiness through a spiritually introspective process, authentic relationships with others, and a relationship with God or a Higher Being, some individuals may experience the spiritual dimension. Given the increase in research demonstrating the application of religion and spirituality with some clients who seek spiritual interventions, this study focuses on the practitioner, the other partner in the client-worker alliance of mental health practice, and the kind of spiritually based intervention(s) the practitioner uses.

Overview of the Chapters

Chapter Two will provide an overview of the substantive literature addressing the state of mental health in the United States. The literature on some clients who are recipients of mental health services offers a perspective about what kinds of spiritually integrated interventions they want and/or need. We will further clarify what spiritually integrated interventions are and provide some empirical studies that have been done to demonstrate how interventions were applied to them. To get a sense of available empirical research on the use of spiritually integrated interventions by practitioners in the field, such as social workers and psychologists, several studies will be reviewed. Chapter Three will provide a discussion of on the concepts of intrinsic motivation and finely delineate the measure of this construct as it is functionally related to mental health practitioners. A brief background of the Bahá'í Faith in Chapter Three will illuminate this study's inquiry into the religious background of the respondents and introduce their lens of what spiritually integrated interventions they utilize with clients who prefer spirituality or religion in their recovery. Chapter Four will describe the methods of this research. Chapter Five will describe the research sample, and answers to the research questions. Qualitative results of this research will be covered in Chapter Six. Chapter Seven will provide a discussion of the results of this research. Finally, Chapter Eight will provide the conclusion and recommendations for future research.

CHAPTER II

REVIEW OF THE LITERATURE

The traditional person-in-environment configuration is the basis of the social work profession's holistic view of the individual and acknowledges psychological, physical, social, and emotional dimensions to human psychosocial functioning. There is no doubt that most clinicians will encounter clients' religious/spiritual issues in their careers (Lannert, 1991). Sometimes, ignoring a client's religion and spirituality could be detrimental to the relationship between the client and the social worker (Canda, 1989). Furthermore, the practitioner's lack of knowledge regarding religious or spiritual constructs or experiences may lead him or her "to misinterpret, misunderstand, mismanage, or neglect important segments of a client's life" (Bergin & Payne, 1991, p. 201).

To facilitate this spiritual integration, a set of behaviors by mental health practitioners may provide a trajectory for enhancing the bio-psychosocial and spiritual well-being of the client who prefers spiritually integrated interventions. Practice behaviors in the form of interventions are a critical area for the incorporation of spiritual elements. Although the worker and client are partners in a therapeutic relationship, it seems that the worker alone provides the context where change may occur (Dorfman, 1996).

Spiritually Integrated Intervention Defined

Worthington (1986) offered three elements to the definition of religious/spiritual interventions. First, spiritually integrated intervention is a technique used to strengthen the faith of a religious or spiritual client. Next, it refers to secular techniques that are modified to include explicitly religious content (e.g., cognitive behavior therapy with a Christian component, a 12-Step Alcoholics' Anonymous Program with a Christian perspective, Buddhist

healing/meditation, etc.). And third, spiritually integrated intervention is a behavior or act that is derived from religious practice (e.g., the use of scriptures or sacred texts, touching clients for healing purposes, or house blessings).

According to Howe (1998), social work intervention is defined as the area of human experience created in the interplay between the individual's psychological condition and the social environment (p. 173). This person-environment interaction falls within the ecological perspective espoused by Germain (1979), who further explained that this ecological framework links the individual's therapeutic concerns to external influences, both environmental and cultural (i.e., religious). Supplanting the medical model in the ecological perspective with the person-in-environment connection, this "new thinking recognized the social milieu or network as an organic and dynamic social and relational influence in client assessment" (Calicdan-Apostle, 2009, p. 9). In some cases, religion (e.g., a religious affiliation) provides that system or network of relational dynamics between social worker and client. This relational dynamics involves what Benjamin (2004) termed "thirdness, a reciprocal, mutually influencing interaction between subjects" (p. 6). It is in "thirdness" that neither the client nor the worker individually loses his or her subjectivity. As further illustrated by Schore and Schore (2008), this subjective state has physiological and psychological descriptions of mutual regulations. This subjective state has further spiritual and moral implications in a therapeutic dynamics. Pally (2005) further described this process as follows: "When one person sees the emotional expression of another, the person receives as his own internal state the bodily process of the other and the emotional experiences of what the other feels" (pp. 195-196).

The relational process between the client and the worker is non-linear (Ganzer & Ornstein, 2004), whereby relationships are formed from an inter-subjective perspective of

“thirdness.” Since spirituality has been established as one basic human need in a relationship, the values and beliefs of both the worker and client who seek spiritual interventions are required to create a mutual interactive process where recovery can take place.

In order to address the challenge of incorporating the spiritual dimension into mental health practice, it is vital to explore the core elements that will inform our knowledge on the use of spiritually integrated interventions. They are as follows: the current status of mental health in the United States, the clients and their quest for religion and spirituality in their lives, and the use of spiritually integrated interventions among practitioners in various professional fields. Finally, the concept of intrinsic religious motivation will be discussed as an essential variable in contextualizing religious affiliation.

Mental Health in the United States

Mental illness is at the heart of a multitude of problems currently confronting humanity. In Western societies like the United States, psychiatric disorders will likely increase from 10.7% to 15% of the total disease burden by the year 2020 (Murray & Lopez, 1996). In 2009, the National Institute of Mental Health (NIMH) estimated that 26.2% of Americans ages 18 and older, approximately 1 in 4 adults, suffer from a mental disorder. This ratio translates to 57.7 million people with mental illness for all individuals aged 18 and older (NIMH, 2009). On a smaller scale, about 6% of the American population, or 1 in 17 adults, suffer from a serious mental illness. Mental disorders are the leading cause of disability in the U.S. and Canada for individuals ages 15-44. These statistics project a need to explore a connection between mental health disorders and solution-focused plans of action or systems of recovery.

Fisher and Chamberlain (2004) posited that, given the scope of mental health issues, recovery will require changes in policy, training, services, and research. In recent years, mental

health consumers have begun to take the lead in designing and implementing their own recovery in which self-determination, empowerment, and hope are actualized. This consumer-driven recovery is primarily based on a vision supported by the President's New Freedom Commission on Mental Health (2003), which states, "We envision the future when everyone with mental illness will recover" (p. 1). The Report also states "[C]are must focus on facilitating recovery and building resilience not just on managing the symptoms" (p. 5). In addition, recovery from mental illness should incorporate providing hope for the client's future using the principle of self-determination in meeting life's struggles (Deci, Connell, & Ryan 1989), developing self-esteem, and seeking a meaningful quality of life (Danesh, 1997). To a certain degree, how this recovery process looks seems to depend on how some clients may want to integrate religious or spiritual paradigms into mental health practices.

Since mental health is still a relatively young discipline, it has not reached the level of precision some of the other fields of human knowledge have achieved. In the early part of the 21st century, mental illness sometimes cannot be solved by medication alone. The science of psychotherapeutics is still in its intuitive stage (Christensen, 2011), where diverse health interventions in mental health, including those that are spiritually integrated, need further exploration. As more research shows, the practitioners' beliefs in medical-scientific and religious paradigms are equally important in integrating therapeutic practices (Wagenfeld-Heintz, 2008); actual attempts to understand the practitioners' and clients' beliefs were not yet fully understood in practice.

The Clients in Mental Health

A client's mental health is generally connected to his or her quality of life and subjective well-being. When confronted with mental illness, an individual's state of bio-psychosocial and

even spiritual homeostasis becomes disrupted. Sometimes, this state of being evokes a sense of “modern existential anxiety,” which to some, may result in a striving to find the moral foundation of life through religion and spirituality (Coates, Graham, Swartzentruber, & Oullette, 2007). When in despair or feeling helpless, a desire for balance is sought. Religion or spirituality sometimes becomes the grounding for coherence and equilibrium and even a profound personal transformation or spiritual renewal (Derezotes, 2006; Marzanski & Bratton, 2002). Studies have shown (Johnson & Hayes, 2003) that some clients seek to incorporate the religious or spiritual aspects of their lives into their problem-solving. Therapists should consider broaching these topics because they could also be a source of distress for many clients.

Clients and Spiritually Integrated Interventions

There seems to be mounting evidence that some clients with mental health challenges would like to see religion and spirituality incorporated into their treatment. To understand the gap between what some clients want in their recovery process and what mental health practitioners do to fulfill this need, a link must be drawn to examine what has been utilized so far. The following section offers a review of empirical research that focuses on clients and how spiritually integrated interventions have been used in therapy. This review is critical to an understanding of emerging interventions that have been surveyed in the field.

Weld and Eriksen (2007) surveyed adult clients (N=165) and therapists (N=32) at three faith-based Christian counseling agencies to determine clients’ preferences in terms of interventions during counseling. Most clients felt it was the therapists’ responsibility to bring up the subject of prayer as an intervention. This study also found that clients who were highly conservative and had previously received help from a Christian counselor, and clients who were more prayerful in their personal lives, had high expectations that therapists include prayer in

counseling sessions. This expectation appears to match with the therapists who advertised themselves as Christian counselors.

As well, in a study in the mid-southern region of the U.S., Belaire and Young (2002) found that expectations of Christian clients (N=100) with moderate and high levels of conservatism were similar for secular therapists. These clients, who were members of churches and religious student organizations, not only expected a secular therapist to respect their religious beliefs and values, but also preferred the use of religious interventions that included prayers and scripture references.

Clients also know whether interventions are appropriate for them or not. Sponsored by the Church of Jesus Christ of Latter-Day Saints, Martinez, Smith, and Barlow (2007) surveyed 152 Mormon students/clients in a large university's counseling center. Most participants reported the following religious interventions as both appropriate and helpful: references to scriptures, teaching spiritual concepts, encouraging forgiveness involving religious community resources, assessing client spirituality, and self-disclosure about religious/spiritual issues. The study found that the issue of timing as to when these interventions were used appropriately seemed to be important. Most clients in this study considered out-of-session religious interventions more appropriate than in-session religious interventions. However, in-session interventions were rated as more helpful. This study also described how some basic psychological practices have been integrated into the application of religious interventions. For example, borrowing from Eastern religion, mindfulness, or meditation as a stress-reduction method was applied to increase the effectiveness of the therapist's use of spiritual concepts.

On the other hand, as Mormons believe in the separation of religious functions that are typically assigned to religious leaders, some clients in the study felt it was inappropriate for a

counselor to act as an ecclesiastical leader (Martinez et al., 2007). Richards and Potts (1995) succinctly explained that a religious dilemma is presented when there is a blurring of boundaries between professional and religious roles. Other similar inappropriate interventions included blessings by the therapist (laying-on of hands), counselor-client prayer, and memorization of scriptures. Unlike “Christians’ endorsement of priesthood which encourages the laity to act as ministers to each other” (Post & Wade, 2009), the Mormon faith, which has a lay clergy, believes that laying-on of hands during a therapy session would confuse the client’s perception about the role of the counselor (Richards & Potts, 1995).

Spiritual interventions have also been applied to clients who developed mental health problems because of serious medical conditions. Cohen, Yoon, and Johnstone (2009) surveyed 168 individuals with heterogeneous medical disorders. Drawn from a quota sample, participants were in non-acute stages of their disorders or injuries (cancer, spinal cord injury, stroke, and traumatic brain injury). To explore the aspects of spirituality and religion for this group, subscales of the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS; Johnstone, Yoon, Franklin, Schopp, & Hinkebein, 2009) were used. Results showed that these individuals appeared to have used congregational support as a positive intervention that was positively correlated with spiritual coping (e.g., forgiveness). Teaching the client how to forgive has been identified as a spiritually integrated intervention (Derezotes, 2006; Sheridan, 2000).

These results seem to be consistent with McIntosh's (1995) study, which linked positive congregational support to better mental health. This finding was not surprising because individuals with serious medical conditions need some outside support; that is, they have to rely on others such as families, friends, clubs, and other social and religious networks for help. Most often, responses would come from those people who have similar beliefs as the individuals in the

study (Cohen et al., 2009). On the other hand, private religious activities (e.g., prayer, meditation) were not significant as a coping strategy. Unlike some individuals who increase prayer because of increasing problems with health (Haley et al., 2001) or who recover from illness, the researchers found that prayer for this group did not have a positive correlation with better mental health.

The inclusion of spirituality as a therapeutic component seems to enhance the recovery of persons who are diagnosed with serious psychiatric disabilities (Richards & Bergin, 2000; Seybold & Hill, 2001). In Wong-MacDonald's (2007) study, an evidence-based module was implemented in an inner-city community program with 75 adults diagnosed with serious psychiatric disabilities with some co-occurring disorders (e.g., substance abuse and psychiatric disorders). Two groups, Spirituality and Psych Rehab and Psych Rehab alone, met separately for three months. The Psychosocial Rehabilitation program emphasized skills training, community integration, psycho-education, and cognitive behavior treatments for persons diagnosed with serious mental disabilities. The Spirituality group was offered as an open-ended group where persons in the rehab program could participate. The members of the Spirituality group were given free rein in designing the spiritual pathway of their recovery process. Writings, spiritual music, and topics of interest to the participants (e.g., forgiveness) were the interventions utilized in group work. This study did not highlight the client's religious affiliation or a specific religious context in the Spirituality group. These interventions are consistent with Richards and Bergin's (1997) study on spiritual interventions that included discussion of spiritual concepts, encouraging forgiveness, referring to spiritual writings, and listening to spiritual music. All participants in the Wong-McDonald (2007) study set their rehab treatment goals for symptom management, community integration, and quality of life. This author found that all 20 participants in the

spirituality group achieved their treatment goals, compared to 16 out of 28 people (57%) who were in the Rehab group only. Anecdotal testimony of some participants in this study noted that in their psychiatric rehabilitation, the use of prayer, relaxation techniques, forgiveness, replacing risk behaviors with religious community service, and other activities was attributed to the remembrance of God or Jesus.

Spirituality in psychiatric rehabilitation as a program of intervention in the Wong-McDonald (2007) study seems promising. The study, however, indicated that some service providers were not familiar with the spiritual practices of the participants so that appropriate interventions could not be utilized. It was suggested that studies with samples of participants from diverse spiritual orientations, including those of practitioners, are needed to provide a clear picture of what works for clients and what practitioners do.

Religious conversion is another area of interest that has not been given attention when interventions are utilized. Conversion experiences of clients revealed that stress and unresolved problems, anxiety, and depression have been considered “triggers” for such experiences, and negative effects have been associated with the pre-conversion stage (Paloutzian, 1981). Paloutzian asserted that the effect of a conversion experience seems to be positive; it brings about a new direction and helps to motivate individuals while increasing a person’s meaning and purpose in life. Gillespie (1991) further explained that conversion experiences can provide changed frames of reference that have implications for ethical and moral behavior, such as change in attitudes, feelings, and core values. Ng and Shek’s (2001) study illustrates how conversion provides a “reorientation to the meaning of life” (Gillespie, 1991, p. 28).

Ng and Shek (2001) investigated the changes in the mental health status of 86 Chinese chronically heroin-addicted men in a Hong Kong drug rehabilitation program. Religion and

therapy were used as interventions to decrease depressive symptoms and sense of hopelessness, as well as increase their sense of purpose in life in this yearlong religious drug rehabilitation program. Of particular importance in this study is the participants' conversion process in the different stages of their rehabilitation. In the first stage of the program, 26 men in Group A were identified as active drug users. They attended prayer meetings to introduce them to Christian practices, including confession, repentance, prayers, worship, Bible reading, and personal testimony. Group B (N=20) followed Stage 2 of the Program with a ten-day detoxification period without medication while living communally under the teachings of Christ. Conversion typically took place within the first two months of Group B's residence. Group C participants (N = 19) were in Stage 3, a halfway house in which residents were trained to do missionary work, such as reaching out to needy people (e.g., older people, delinquents, and drug abusers). Group D consisted of former graduates of the program who served as full-time volunteer peer leaders (N= 21).

The results of the study revealed the following for all Groups A-D: (a) a decrease of depressive symptoms with groups, (b) a decrease of hopelessness symptoms, and (c) an increase of purpose in life through the different stages of the gospel drug rehabilitation program. However, Group D came out to be the most mentally healthy, removed from depression and hopelessness, and self-attuned to seeking a meaningful and purposeful life.

While heroin-addicted persons have been found to manifest psychiatric symptoms such as depression, the residential treatment program in this study seemed to reduce such symptoms to a significant degree because of a successful religion-based rehabilitation. Through the participants' conversion to Christianity, this study also suggests there may be benefits derived from religious faith that can be applied to drug rehabilitation. The participants' religious

conversion experiences gave them a new identity in life. Findings further suggest that the longer the converts stay committed within the program, the better their mental conditions. This result confirms Paloutzian's (1981) observation that converts had a higher measure of purpose in life than non-converts. This assertion was founded on the positive post-conversion changes that significantly influenced the once chronically drug-addicted persons. The findings further suggest that the longer the converts stay within the society and remain committed to a faith, the better their mental conditions (Ng & Shek, 2001).

Exploring conversion among a group of professionals is not an easy process. First, conversion research has only been increasing recently. While theoretical conceptualizations abound, there is not enough empirical data to demonstrate the significance of conversion among professionals, much less mental health practitioners. This is one reason the conversion variable is included as a background variable of this present study.

Summary

The findings from these studies highlight some important lessons regarding the use of spiritually integrated interventions. First, the use of prayer seems to be an acceptable intervention to some clients who are predominantly religious. However, there appears to be a difference in the use of prayer, and it involves two variables: the issue of timing and the client's preference of its appropriate use. Based on these predominantly Christian studies, a group of clients from one denomination preferred to use prayer during the therapeutic hour, while another denomination would consider it inappropriate to use it during the therapy session. Perhaps it was not so much the use of prayer that caused the potential impasse between client and therapist but rather the question of when the intervention should be used. While some religions do not allow overlapping roles of therapist and clergy, other religions welcome the intermingling of both roles. At the

heart of this spiritually-based practice leads us to a wider understanding of the method wherein the client is given reins to drive his/her own therapeutic process.

Second, there seem to be some differences in spiritual beliefs or theological positions that clients want to uphold during therapy. In fact, some clients appear to have the same expectations for either the secular or the religious counselor. While one may readily conclude that counselors do not need to be experts in religion, it would be helpful to understand whether practitioners, religious or not, are open to using spiritual interventions.

Third, these studies included small samples of respondents who were predominantly religious and Christian; thus, they did not necessarily apply to clients from other diverse backgrounds (e.g., religion, work, or practice setting) and groups. Spiritually integrated interventions may be different for these clients, as well.

Fourth, although religious conversion seemed to provide a positive effect in the lives of clients who were in a religious-oriented rehabilitation in one study, it is important to explore it within the context of conversion around mental health professionals who belong to a variety of faith backgrounds.

In sum, the findings of these studies suggest the need for more research in describing how these spiritually- integrated interventions are utilized with clients with specific diagnoses and by other mental health practitioners from other faith groups such as Muslim, Hindu, Buddhism, etc. As well, this study further suggests the need to measure the efficacy of the evidence-based interventions identified and described by the respondents of this research.

The Mental Health Practitioner

According to the Hoover Policy Report (Dworkin, 2010), there are 77,000 clinical psychologists; 192,000 clinical social workers; 105,000 mental health counselors; 50,000 marriage and family therapists; 17,000 nurse psychotherapists; and 30,000 life coaches in the United States. Today, there has been a more than hundred-fold increase in the number of professional mental health practitioners when compared to 1940s statistics, when there were 2,500 clinical psychologists; 30,000 social workers; and less than 500 marriage and family therapists (Dworkin, 2010). Clearly, demands for mental health services have increased, not just for those with a mental health diagnosis, but for the general population as well.

Despite the clear need, as expressed by researchers, scholars, and clients, for the integration of spirituality and religion into mental health practice, there seems to be a disparity between the public and some mental health practitioners in this regard. In Shafranske's (2000) national survey of psychiatrists, respondents were asked if they would use spiritual interventions if such interventions would improve a patient's condition. Only 37 percent of psychiatrists stated they would use such interventions, and 57 percent would refer a patient for spiritual consultation with a rabbi or minister for spiritual matters. These results seem consistent with Delaney, Miller, and Bisono's (2007) survey of 489 randomly selected members of the American Psychological Association. Relative to the general population, American psychotherapists are far less religious with regard to affiliation, attendance, beliefs, and values (Bergin & Jensen, 1990). When psychologists were asked how important religion was to them, 48 percent indicated that religion was not important to them, while 31 percent indicated it was important and 21 percent indicated it was very important. Because psychologists were also more than twice as likely than the general population to claim no religion and three times more likely to describe religion as

unimportant in their lives, they were also less likely to pray, to be a member of a church or congregation, or to attend worship (Delaney et al., 2007).

Contrary to psychologists' views of religion as unimportant in their lives, their perception of a positive relationship between religion and mental health portrays a different picture. A full 82 percent of psychologists affirm a positive relationship between these two constructs, and 69 percent rated religion as "beneficial," as opposed to 7 percent of psychologists who perceived religion to be harmful to mental health. Given the questions this present study seeks to answer, data is insufficient about the type of spiritually integrated interventions that religious psychologists use.

Social workers seem to have a more positive outlook on incorporating spirituality and religion into their practice. Social workers consider it appropriate during initial assessments to ask clients about religion and spirituality, as well as how these two constructs are applied to clients' lives (Sheridan, 2004; Wesley, Tunney, & Duncan, 2004). Sheridan, Wilmer, and Acheson (1994) reported that 30-37 % of social workers believe in God and 24-39% believe in a divine dimension in nature. Christian beliefs are prevalent in social workers' practice (Singletary, 2005). On the other hand, 65% of social workers surveyed in Utah and Idaho endorse a more inclusive belief by describing social work as a "spiritual path" (Derezotes, 1995, p. 5).

Mental Health Practitioners and Spiritually Integrated Interventions

As a growing number of Americans are becoming elderly (Thoresen, 1999), the mental health professions have been paying more attention to issues related to the aging process. Regardless of increased life expectancy, adults in their twilight years seem to naturally explore their own life spirituality. Murdock (2005) conducted a cross-sectional survey from a random sample of two national gerontological registries in the United States that explored social workers'

attitudes about spirituality in relation to their roles and use of spiritually integrated interventions in practice. The profile of a gerontological social worker in the United States is a White female whose religion is Christianity and who usually works in a religious setting. Findings from this study revealed that gerontological patients want their healthcare professionals to address spiritual concerns with them, and they expect the professional to initiate the conversation.

Client attitudes did not match those of social workers, however. The majority of the respondents considered discussing spirituality if and when the client raised the issue, presenting a dissonance in expectations between the client and the social worker. Results of this study revealed significant but weak positive correlations between the gerontological social workers' personal spiritual beliefs and their use of spiritual interventions in practice. Like Mattison et al., (2000), Murdock (2005) identified the worker's religious affiliation as the strongest and most consistent predictor of the client's religion and prayer practices. In addition, Mattison et al. (2000) paid more attention to the appropriate use of some prayer activities. In this study, the Serenity Prayer was used more frequently than any other prayer. In addition, this study also included discussions of the client's religious beliefs. This conclusion seems to indicate that the worker's religion has some bearing on the interventions that the client may be able to use. Mattison et al. (2000), however, acknowledge other factors associated with the use of these interventions.

The spiritual interventions considered to be appropriate in Mattison et al.'s (2000) study were the same as those interventions cited in Murdock's (2005) work. These interventions included reflecting on loss, considering helpful spiritual supports, referring to a specialist, gathering spiritual information, and considering helpful beliefs. The most inappropriate

interventions that were also least used include participating in client rituals and touching for healing purposes.

Reinforcing the results from Murdock's (2005) quantitative study, Wagenfeld-Heintz (2009) conducted a qualitative study examining the use of spirituality by 20 geriatric female social workers in Michigan who work in inpatient, outpatient, hospice, nursing home, and adult foster care settings. Similar to Mattison et al.'s (2000), this study's author explored the spiritual dimension of clients' issues as her theoretical framework, consistent with social work's holistic approach. The respondents' narratives are like the spiritually integrated interventions utilized in Murdock's national study, specifically in regard to engaging in prayer for guidance, the importance of God's will, and dealing with difficult situations. The respondents were clear that boundary issues with clients are important, and prayer was to be used in private or only if clients request it.

Sheridan (2004) conducted a study using a random sample of 204 licensed clinical social workers (LCSWs) who were mostly working in a private practice setting in a mid-Atlantic state. The survey used two instruments: the Role of Religion and Spirituality in Practice (RRSP) Scale (Sheridan, 2004) and the Spiritually Derived Intervention Checklist (SDIC) (Bullis, 1996; Canda & Furman, 1999). Close to three-fourths of the LCSW practitioners, 79% of whom were female and 93% White, with an average age of 50 years, identified 18 out of the 24 interventions as appropriate. In addition, over 65% reported their primary work setting as "private," while 34.5% identified their practice in a "public" work setting. While this study did not discuss the possible implication of the respondents' work setting, the fact that they are mostly practitioners in private practice could influence the extent and appropriate use of spiritually derived interventions.

The most appropriate interventions that Sheridan (2004) identified were a) helping clients reflect on beliefs about loss or other difficult life situations, b) helping clients consider ways of getting religious/spiritual support, c) gathering information on clients' religious/spiritual counseling, and e) discussing the role of beliefs in relation to significant others. Like the Murdock (2005) study, interventions considered the least appropriate included healing touch and participation in clients' religious/spiritual rituals.

In a 2006 study on personal religiosity and spirituality using religious-based intervention practices, social workers (N = 221) who were NASW members in the Southeastern U.S. responded to survey questions measuring three outcome variables: attitude toward religion in social work, the appropriateness of 15 religious-based interventions, and the utilization of these practices (Stewart et al., 2006a). The authors also measured three dimensions of spirituality, including spiritual experiences (spirituality), religious practices (organized religiosity), and religious affiliation. Results from this study showed that the attitudes toward and beliefs about religion by predominantly Christian-affiliated social workers generally favored incorporating religion into their practice. Over half of the 15-item religious-relevant intervention behaviors identified by the authors were seen as appropriate to utilize in practice, and about six of them had been utilized before. The following highly utilized interventions were cited in the study: "Refer clients to 12-step program," "Refer clients to religious or spiritual counselors," "Pray privately for a client," and "Refer clients to religious or spiritual counselors." Low-utilized or never-used interventions are "exorcism and touching for healing"; they were considered rarely or never appropriate, and they were never implemented. Fifty percent of the respondents regarded 11 of the 15 interventions as appropriate. Over 50% of social workers without any religious affiliation or those who consider themselves unbelievers (9%) reported utilizing 5 of the 15 interventions.

In addition, this group also cited “the use of religious language or concepts,” “helps clarify the client’s religious values,” and “pray or meditate with the client.”

In a study by Stewart et al. (2006), age, gender, race, and job setting were determined to be irrelevant to the utilization of religious-based interventions. Religious group membership and measures of spirituality based on the Multidimensional Measurement of Religiousness/Spirituality (MMRS) survey (also in Stewart & Koeske, 2006b) used in this study predicted the utilization of religious-based interventions. Notably, the Stewart et al. (2006) study indicated that measures of spirituality included a perception of a “spiritual person” as “trying hard to carry the religious beliefs into all my other dealings in life” and identified it “as an intrinsic aspect of religiosity as opposed to participation in church activities and religious practices” (p. 81), which did not predict any measure of religious-based practice.

In the Stewart et al. (2006) study, identifying with a religious group and not having membership in a particular denomination were important predictors of outcome measures of religious-based practice. In addition, extrinsic organized religiosity (going to church, attending church community functions, etc.) was unimportant. In this vein, Allport (1966) contrasted a superior form of faith, labeled intrinsic believer, with an inferior form, labeled extrinsic religion. The intrinsic believer “lives” his or her religion and views faith as an ultimate value in itself, while the extrinsic believer “uses” religion in a strictly utilitarian sense to gain safety, social standing, or other nonreligious or antireligious goals (Zinnbauer, Pargament, & Scott, 1999). Stewart and colleagues (2006a) suggest it is proper for social workers to utilize religious interventions based on their own beliefs.

Although Stewart et al.'s (2006a) findings imply that the practitioner may analyze professional interventions as part of her/his essential worldview, her/his spirituality may have a

direct effect on the utilization of religious interventions. The authors identified the following limitation: religious interventions are context- or study-specific, and factors that mediate the relationship between personal spirituality and utilization of interventions were not measured. This present study fills this gap and incorporates the following recommendations: (1) other factors that may mediate the practitioners' spirituality and the utilization of religious interventions in the therapeutic relationship, (2) the inclusion of a more diverse sample of participants, and (3) the exploration of other variables of religious-based practice. Furthermore, this present study uses other measures of dimensions of religiosity or spirituality that includes the dimension of "Meaning" that is missing from the MMRS survey.

Canda, Nakashima, and Furman (2004) conducted a qualitative study using constant comparative analysis to examine the spiritual beliefs of NASW practitioners. The authors asked three open-ended questions on the following topics related to spirituality: a) the value of religious and spiritual issues in social work education (n=964), b) appropriateness of using religious and spiritually based interventions (n=1,295), and c) other issues related to the topic of spirituality and religion (n= 1,398). The respondents reported the use of spiritual assessment positively as it influences the client in both positive ways. The most frequently reported interventions used by these social workers included a) referral or collaboration with spiritual or religious leaders; b) the use of prayer, meditation, and/ or visualization; and c) the use of rituals and symbols. This study used a diverse lens to explore the use of prayer. In addition, practitioners' opinions regarding broad utilization of this intervention were mixed.

Historically, psychologists have been the least likely to actively address issues of spirituality or religiosity in therapy (Rose, Westerfeld, & Ansley, 2001; Shafranske, 1996), but because many clients are reporting a preference for discussing the implications of their religion

and spirituality in psychotherapy (Rose et al., 2001), and given the profession's general response to multicultural movement (e.g., helping clients develop skills to interface with different cultures) (Hansen et al., 2006; Richard & Bergin, 1997), more interest and attention has been given to clients' needs in incorporating spirituality and religion into psychotherapy. Still, there are unanswered questions about the frequency with which clients actually raise spiritual or religious issues during psychotherapy (Hathaway, Scott, & Garver, 2004) and about the percentage of clients who want these two domains included as part of their treatment. Regardless of the lack of statistical data, all clinicians, according to Lannert (1991), will come across religious/spiritual issues of clients in their practice. This fact highlights the importance of this present study's examination of the use of religiously or spiritually informed interventions with clients who seek spiritual interventions in psychotherapy.

Frazier and Hansen (2009) identified 29 spiritual and religious psychotherapy behaviors in a quantitative survey using a stratified random sample of 300 doctoral-level APA psychologists. These 29 interventions were not attitudes and feelings, but rather actual behaviors that psychologists utilize to demonstrate the two constructs of spirituality and religion. In this mailed survey that used the Religious/Spiritual Psychotherapy Behaviors Questionnaire (RSPBQ), 32.2 % of respondents viewed the 29 interventions as slightly important on a scale from neutral to somewhat. The five most important psychotherapy behaviors identified were (a) actively communicate respect for client's religious/spiritual beliefs; (b) evaluate when one's religious/ spiritual values and biases negatively impact treatment; (c) actively seek feedback about psychotherapy provided; (d) promote autonomy and self-determination of highly religious clients, even when their values differ from one's own; and (e) self-assess one's competence to counsel clients regarding religious and spiritual issues. These behaviors suggest the hallmarks of

a sound set of psychotherapeutic principles, but they are considered by some respondents as only slightly important to their clinical work.

Two variables in the Frazier et al. (2009) study that predicted the engagement in and higher use of the psychologists' religious/spiritual psychotherapy behaviors included the level of religious/spiritual self-identification and the number of relevant continuing education hours. Respondents who self-identified strongly with religion/spirituality tended to incorporate more religious/spiritual psychotherapy behaviors, while those with weaker self-identification predicted decreased use of religious/spiritual psychotherapy behaviors. Thus, respondents' level of religious/spiritual self-identification and their continuing education hours seemed to predict use of spiritual/religious psychotherapy behaviors, or lack thereof.

The least frequently practiced items were (a) make DSIV-TR (2000) diagnosis for religious/spiritual problems (V62.80), (b) use prayers as a psychotherapy intervention, (c) cite religious texts in treatment, (d) develop and implement professional development plan to approve one's religious/spiritual psychotherapy competence, and (e) actively seek feedback on one's religious competence from colleagues (Frazier et al., 2009). To summarize, psychologists in this study did not view the 29 religious/spiritual psychotherapy behaviors as important, nor did they use them often.

Christian psychotherapists In two studies of Christian psychotherapists who are members of the Christian Association for Psychological Studies (CAPS), Ball and Goodyear (1991) conducted an exploratory study to find out what Christian psychotherapists actually do. The first study utilized a mailed questionnaire to attempt to identify what interventions Christian therapists had used that was distinctively Christian. The second study relied on structured interviews to expand on the details of the interventions used by the therapists, including those

situations that were critical to understanding their relationships with clients. Twenty-one (13%) of the 173 psychotherapists responded that there was no difference between Christian and secular counseling. The study further noted that those answering “no” versus those answering “yes” to the question about the difference between Christian and secular counseling was statistically significant.

Ball and Goodyear’s (1991) study also identified 400 interventions clustered into 15 categories, as proposed by Worthington (1986), used by Christian psychotherapists with Christian clients. The most frequently employed intervention was prayer (26.9%), with teaching the client directly (scriptures and no scriptures) representing 30% of the psychotherapists. Other less frequently used interventions were associated with aspects of Christianity (forgiveness, 6.5% and anointing with oil, 1.3%). A blend of secular interventions with Christian imagery or content such as relaxation techniques and integration techniques comprised 8% and 2.1% of the respondents respectively, and 2.6% used strictly secular techniques/interventions.

A second follow-up study conducted by Ball and Goodyear (1991) was a qualitative interview of 30 participants in California who were CAPS members. These participants were also requested to disclose some details regarding their work with specific clients, thus reflecting a more accurate portrayal of their actual behaviors than in the first study. In contrast to the first study, this follow-up study found that secular techniques (37.2%) were the most frequently used. Secular techniques here referred to “standard psychological interventions that did not seem to have religious pertinence” (p. 149). The next most frequently used intervention was the use of prayer. According to Ball and Goodyear (1991), “Prayer is recognized in many forms of behaviors such as therapist’s silent-in-session prayer” (p. 149). The third most frequently used intervention was the use of outside resources (10.7%), such as a referral to a pastor or clergy for

spiritual and theological matters. Four interventions that were not used by the participants in the second study were relaxation techniques, inner healing (an intervention similar to guided imagery and prayer), scripture memorization, and anointing of oil.

In sum, prayer seems to be the most frequently used intervention in the follow-up studies by Ball and Goodyear (1991). Neither of the studies reported instances of the laying-on of hands, which is one common practice of Christian ritual. The study further reported a perceived difference between Christian and secular counseling, which was expected because the respondents were members of CAPS, a homogeneous group. This research points to an expansion in Christian therapists' use of spiritual interventions and to the need for inclusion of these interventions in the work of Christian counselors or psychologists. This study was also done in 1991 and may not reflect the most current practices of Christian clients.

Christian-based psychology programs For many years, a large number of doctoral clinical psychology programs that were rooted in Christianity received their accreditation from the American Psychological Association (Walker, Gorsuch, Tan, & Otis, 2008). How effective these trainings were in providing curriculum competency in integrating spirituality and religion still needs further examination. In Walker and colleagues' quantitative study, 162 student therapists from Christian clinical programs were asked about their competency and use of religious and spiritual interventions. The purpose of this study was to examine several sets of training variables, including therapists' personal religiousness, therapists' graduate training, clinical training with religious clients, intervention-specific training, and therapists' personal psychotherapy in training, in relation to their self-reported frequency of and competency in using religious and spiritual interventions in counseling. Christian therapists in training were used as respondents because there has been a dearth of research conducted on the training components of

APA-accredited Christian doctoral psychology programs for Christian therapists. A specific aim of the study was to explore the extent to which doctoral trainees in explicitly Christian APA-accredited programs engage in the use of religious and spiritual interventions.

Walker et al. (2004) found a significant correlation between the majority of the sets of training variables mentioned and the self-reported use of explicitly religious and spiritual interventions in therapy. Although most of these variables were associated with therapists' explicit use of religious and spiritual interventions in therapy, "none of the remaining sets added significant variance above and beyond personal religiousness, general training and intervention-specific training" (Walker et al., 2004, p. 629). It should be noted that the authors sampled therapists who had already graduated from their training programs. With this in mind, variables like coursework that involves theology, integration of psychology and religion, and personal therapy during training appear more relevant to the research looking at use of religious and spiritual interventions while the therapists were still in school than after they had already finished the programs.

One variable in Walker et al.'s (2004) study, trainee's personal religiousness at explicitly religious training programs, did not correlate significantly with using religious and spiritual interventions. This point seems consistent with Sorenson and Hales' (2002) study of 400 evangelical Protestant psychologists trained in secular or religiously affiliated programs, which found that these graduates were less likely to use religious and spiritual interventions in therapy than those graduates who have religious commitment but were students of secular training programs. Regardless of these results, a majority of the research indicates strong correlations between therapists' personal religiousness and the incorporation of religious and spiritual interventions in therapy (DiBlasio, 1993; Hales, 1996; Prest, Russell, & D'Souza, 1999). These

studies offer encouragement for researchers to continue studying the multiple factors related to therapists' use of religious and spiritual interventions in psychotherapy.

Mattison et al.'s (2000) quantitative study explored the impact of social workers' religiosity on religious practice behaviors. They used a cross-sectional survey with a random sample of 1,278 social workers with MSW degrees who were members of NASW and who provided direct services to clients. A 10-page religiosity questionnaire was sent out with a response rate of 57.2%. Two major findings showed that social workers' religiosity has some effect on practice behaviors when using the factors of age and gender, variables that were predictive of practice behaviors. Social workers' religiosity had no effect on practice behaviors with "work auspices" (secular or non-secular agencies).

The study also reported that the more religious a social worker, the more likely he/she views religious and prayer activities in practice as appropriate professional behavior (Mattison et al., 2000). Unlike Murdock's study, Mattison et al. (2000) paid more attention to the appropriate use of some prayer activities. The Serenity Prayer was used more frequently than any other prayer. Other kinds of prayer activities included prayer at the request of a client and discussion of client's religious beliefs where the attributes of prayers were integrated. The least-accepted prayer activities identified in this study were initiating touching or laying-on of hands, client requests to pray with the therapist during counseling, and endorsing a form of healing with a religious framework.

The authors did not analyze religious affiliation as a variable to explore religiosity and the effect on behavior practices in social work. Diverse religious sampling was limited to Christians (66%). This study provided an analysis of behaviors on the religiosity scale, which has some variables that are similar to those of the RRSP (Sheridan, 2004). The authors recommended

that future research should include a social worker's examination of personal and professional awareness of spirituality, which influences social work practice.

In a much earlier national survey of the NASW, a random sample of 8,000 practicing social workers was asked to complete a 105-item questionnaire on spirituality in social work practice; 1,069 respondents returned questionnaires, a response rate of 26 percent. Results of this stratified sampling of social workers reported spiritually based "helping activities" that the respondents had utilized in practice, including their perception of appropriate and inappropriate use of these activities. Using exploratory principal exploratory analysis, this study found that Religion (R) and Spirituality (S) practice items are manifest in social work. The RS scale correlated positively with a number of religious/spiritual helping activities (Canda & Furman, 1999, p. 318). Social workers with high levels of personal spiritual involvement were more willing to introduce spirituality/religion into their own practice.

On the Religion side of the RS scale, Canda and Furman (1999) found that Christian social workers were more likely to discuss the topic of religion with clients than social workers who consider themselves atheists or agnostics. Samples of the most utilized spiritually oriented helping activities included helping clients consider ways their religious/spiritual support systems are helpful (94.1 %), using non-sectarian spiritual language or concepts (87.2%), recommending participation in a religious or spiritual support system (81.3%), discussing the role of religion or spiritual beliefs in relation to significant others (80.7%), and helping clients reflect their beliefs about what happens after death (71.8%). The least utilized activities, according to NASW social workers, included touching clients for "healing" purposes (14.6%), participating in a client's religious/spiritual rituals as a practice intervention (18.2%), and praying with a client (28.3%). This study also revealed that a higher percentage of social workers indicated appropriate use of

activities than those who actually used them. Two-thirds of the respondents believed it is appropriate to use most of the spiritually oriented helping activities except for the following three activities: praying with a client, touching for healing purposes, and participating in a client's religious/spiritual rituals. In sum, this study confirms social workers' practice of integrating spirituality and religion, a professional practice that must attend to ethical considerations (Canda & Furman, 1999, p. 262.)

Summary

Increasingly, psychologists and social workers are observing a need to address religion and/or spirituality in their practice, including the use of spiritually integrated interventions. However, there may be a disparity between what some clients prefer in their therapy and recovery process and what some practitioners can offer. According to the research (Richard & Bergin, 2000; Rose et al., 2001; Shafranske, 1996), psychologists appear less likely to address spiritual or religious issues than any other practitioners, specifically in such areas as religious affiliations, beliefs, and values (Bergin & Jensen, 1990).

Some studies of social workers present a different picture in terms of their receptivity to incorporating spiritually integrated interventions into their practice. Higher utilization of spiritually based interventions by social workers appears to be due to greater personal religiosity. Other factors surrounding social workers' use of spiritually integrated interventions need to be explored further. Factors such as training on spirituality issues as well as diversity issues in relation to religion seem to be critical to religious-based practice.

Different scales were utilized to identify commonalities and differences of interventions as illustrated in several studies that reported repeated use of some spiritually integrated interventions. For example, prayer, referral to outside resources (including the clergy), and

utilization of readings have religious significance to clients with specific preferences for spiritual or religious interventions. Low utilization of certain types of interventions was also identified across studies. For example, laying-on of hands, exorcism, and touching for healing seem to be avoided by practitioners, including religious psychologists and therapists.

Appropriate and inappropriate use of spiritually integrated interventions is another theme that resonates in some of the studies reviewed. Although no rubric was clearly presented to define what is appropriate or inappropriate, literature suggests that this category inheres within the “context or framework of the practitioner’s beliefs, values and careful ethical decision-making process” (Canda & Furman, 1999, p. 260).

The use of non-diverse samples of practitioners, particularly a lack of diversity in terms of religious identification, limits the scope of the studies presented. This issue highlights the importance of this study. There are numerous studies from a Christian perspective. Studies of groups with diverse backgrounds other than Christianity will enrich the literature in this area of research, and will provide a fruitful perspective of what other religious practitioners do to address clients who prefer spiritually integrated interventions.

The domains of religion and spirituality play a critical role in the lives of clients struggling with mental health issues. Addressing their needs requires a high level of competence on the part of mental health practitioners. Considering the significance of the religious and spiritual needs of these clients, the growing rate of therapists who incorporate religious and spiritual domains into their practice, as well as the initial findings from a handful of intervention studies, this study seeks to expand upon the existing literature by examining religious and spiritual interventions used by Bahá’í mental health practitioners

CHAPTER III

CONCEPTS AND POPULATION

Intrinsic Religious Motivation

To devoted adherents of religions, religion and spirituality are not merely a set of beliefs, practices, and values removed from daily living or applied one day of the week. They are a way of life that is experienced, harnessed, and applied consistently. Through spiritual education and application of the world's religious teachings, human beings see themselves, other human beings, and humanity in general through a spiritual perspective (Hill & Pargament, 2003).

While measures of religion and spirituality have been largely applied to Protestants, the largest religious grouping in the United States, and more generally to members of Judeo-Christian traditions (Gorsuch, 1988), the general population is becoming increasingly pluralistic in terms of religion. It is possible for diverse religious groups to influence the language and practice issues that are relevant to mental health.

Allport (1950) distinguished between two types of religiousness: a) intrinsic religiousness is religion as a meaning-endowing framework in terms of which all of life is understood, and b) extrinsic religiousness is the religion of comfort and social convention, a self-serving, instrumental approach shaped to suit oneself (in Donahue, 1985, p. 400). Allport and Ross (1967) further expanded these two concepts by distinguishing between an extrinsically motivated person as one who uses his or her religion, while an intrinsically motivated person lives his religion (p. 434). In a meta-analytic review regarding intrinsic and extrinsic religiousness, intrinsic religiousness tends to be positively correlated with measures of religiousness, while extrinsic religiousness tends to be positively correlated with negatively evaluated characteristics. Brown (1964) elaborated upon these characteristics by suggesting that it is the outer type, or

extrinsic religiousness, that involves joining a religion for the social purpose of meeting the right group of people and establishing a social network in the community for social and economic gains. Wimberley (1984) concluded that intrinsic religiousness serves as an excellent measure of religious commitment, as distinctive from religious belief, church membership, liberal-conservative theological orientation, and other related measures. Patrick (1979) reported that intrinsic religiousness seems to have some flexibility in its use with any Christian denomination, and even with non-Christian religion. The use of a measure of intrinsic religious motivation provides a more meaningful context for religiosity that is beyond rituals and symbols; it offers the ability to measure motivation that directs some religious and spiritual practices of human beings.

High levels of intrinsic religious orientation have been associated with better mental health as reported in studies of self-esteem, meaning in life, family relations, a sense of well-being, and lower levels of alcohol abuse, drug abuse, and sexual promiscuity (e.g., Donahue, 1985; Payne, Bergin, Bielema, & Jenkins, 1991). Positive methods of religious coping, such as spiritual support, benevolent religious interpretations of life crises, and various forms of prayer (Pargament, Olsen, Reilly, Falgout, Ensing, & Van Haitsma, 1992) have been correlated with measures of intrinsic religiosity.

To explore the constructs of intrinsic motivation, it is essential to understand the basic elements of religion. Religion is “an organized, structured set of beliefs and practices shared by a community related to spirituality” (Sheridan, 1994, p. 364). Religion is an explicit expression of spirituality through codes of conduct and behavior, rituals, dogmas, doctrine, and external expressions of practice. While Joseph (1988) defined religion as “the external expression of faith [...] comprised of beliefs, ethical codes, and worship practices” (p. 44), others like Allport and

Ross (1967) and Gorsuch and Venable (1983) came up with a measure of religious orientation that divides intrinsic and extrinsic contexts.

Maslow (1964) also offered a detailed explanation of these two distinctive and profound elements of religion. In extrinsic religion, persons are disposed to use religion for their own ends. Religion is taken as other “values” which are by nature utilitarian, self-serving, and personal. Persons with intrinsic religious orientation consider their motives to be in their religion itself. To be religious in a cultural and religious context, Maslow further explains, is to negotiate this process of internalization while simultaneously working through various inner conflicting desires, wishes, goals, and experiences. This process is a key subjective element that is partly psychological rather than merely intellectual. Here, motivation is at play, which is inherently preconscious or unconscious, a belief that motivation must be understood within the integrated wholeness of a human being and in connection with others (Maslow, 1964).

Pushing the envelope further, Maslow (1971) identified the concept “farther reaches of human nature,” or self-actualization, as an aim in many facets of human life. Self-actualization as an implicit concept underlying motivation is not simply an endpoint of human reality, but rather a series of small changes that are continuously evolving along a path of life. Self-actualizing people have an enormous commitment to act based on their beliefs and core values. They seem to possess a unique, intangible spiritual nature, purpose, and values, which Maslow identified as “meta-motivators” (1964). It is the spiritual lens that provides the framing of an orientation where motivation and direction in life are established (Allport, 1950; Pargament, 1997). Thus, motivation becomes a direction for spiritual strivings, a force that has the potential to empower a professional to pursue his/her transcendent goals (Baumeister, 1991).

Mental health practitioners belong to a class of educators, leaders, facilitators, and catalysts for change, whether their work involves individuals, groups, or communities. As such, there are factors that motivate them to will to act. How motivation is applied would depend on the ability of the professional to construct and apply with the client a view, based on clients' preferences and wishes, of what it means to include religion and spirituality in intervention, treatment, and recovery.

Never before has there been an exploration of a lesser-known world religion to highlight mental health practice. Because the respondents in this study belong to a particular religious group, the next section will provide brief descriptions of the Bahá'í Faith. These descriptions are not intended to be comprehensive but offer a broad overview that may be relevant to the background of the respondents. The findings from the empirical data will open an uncharted exploration of spiritually integrated interventions, adding value to the religious-based practice of Bahá'í mental health practitioners.

The Bahá'í Faith and Mental Health

Bahá'í believe that all of the world's major religions are interconnected. The message of Baha'u'llah, the prophet founder of the Bahá'í Faith, is one of unity, that humanity is a single race and that the day has come for humanity to come together to form one global society. This faith reaffirms the core foundational and ethical principles common to all religions. Baha'u'llah also revealed new laws and teachings to lay the foundations of a global civilization. With this vision for global unity, he asserted, "The fundamental purpose animating the Faith of God and His Religion is to safeguard the interests and promote the unity of the human race" (Esslemont, 1980, p. 202).

This religion, according to Baha'u'llah (Esslemont, 1980), was not a static event or an absolute state but, rather, an organic and ongoing process. As such, this faith believes that individuals define their spiritual journey in accordance to the organic process of following the divine teachings. These ideas are critical for understanding the key constructs of the Bahá'í religion, spirituality, and human beings' relationships with themselves and others.

The Bahá'í view of the person essentially defines an individual's mental health in terms of his/her relationship to God and faithfulness to religious and spiritual laws and principles. This relationship with God serves as a guide to individuals to transform society from a turbulent stage of adolescence to an age of maturity. Furthermore, Bahá'ís divide human character in three basic ways: the innate character, the inherited character, and the acquired character, which is gained by education (Abdu'l-Baha, 1982, p. 215).

The Bahá'í Faith attempts to address a whole host of mental health problems intensified by the breakdown of family values, changing gender roles, the pervasive and invisible issue of racial prejudices, unequal treatment of women and girls, and unrelenting economic inequities. While those in the field of mental health have largely focused on the treatment of psychopathology, it seems that some professionals forget the mounting evidence that Bahá'í practitioners oftentimes see in individuals' problems: that they are the consequences of moral bankruptcy, human degradation, and meaninglessness. Bahá'ís view human beings as having a higher self and transcendent capacities, two key tenets long recognized by the major religions of the world. This spiritual dimension of the person encourages self-realization and self-actualization. A heightened sense of social responsibility is believed to transform society into what Bahá'ís assert is a new social order. To achieve this aim, Bahá'ís believe that humanity must incorporate the concept of one human family and that the problem of individual mental

illness is dependent upon the well-being and prosperity of the social system. This concept is similar to the principles and values of individual and society that social work and other humanistic and philosophical endeavors uphold.

Although Bahá'ís believe in the physical body of a human being, they also view the body as the temple of the soul which necessitates nurture and respect. Neither physical ailments nor mental illness interferes with spiritual progress (Baha'u'llah, 1976). Concerning this point, Baha'u'llah affirmed:

Know thou that the soul of man is exalted above, and is independent of all infirmities of body or mind. That a sick person showeth signs of weakness are due to the hindrances those interpose themselves between his soul and his body, for the soul itself remaineth unaffected by any bodily ailments. (pp.153-154)

Bahá'ís believe that healing and health consists of two components: a physical component and a spiritual dimension. Medical science is humanity's tool for understanding its physical nature, while offering prayers and turning to the Creator facilitates spiritual health and development:

There are two ways of healing sickness, material means, and spiritual means. The first is by the treatment of physicians; the second consisteth in prayers offered by the spiritual ones to God and in turning to Him. Both means should be used and practiced. Illnesses which occur by reason of physical causes should be treated by doctors with medical remedies; those which are due to spiritual causes disappear through spiritual means. (Abdu'l-Baha, 1982, pp. 151-152)

To date, Bahá'í mental health practitioners are engaged in many communities around the world. There are a few Bahá'í-inspired organizations but many more practitioners who provide mental health services. However, there is no known empirical data that provides the public with information about what they do and how they practice. The next section will provide a description of the research methodology, which will include the research design, problem, hypothesis, recruitment, and research sample.

CHAPTER IV

METHODS

Introduction

The purpose of this exploratory study was to examine the use of spiritually integrated interventions of Bahá'í mental health professionals who participated in this study. Based on the literature review, this study sought to discover whether Bahá'í mental health practitioners have a strong intrinsic religious motivation (religious identification) and whether they report that they make frequent use of spiritually integrated interventions (religious/spiritual behaviors) with clients that seek spirituality or religion in their mental health recovery. The methods are described here.

Recruitment and Sampling Frame

The sampling frame for this research included members of the Bahá'í Association of Mental Health Practitioners (BAMH). The population of interest was mental health practitioners, including social workers, psychologists, psychiatrists, psychiatric nurses, counselors, psychotherapists, and family therapists.

BAMH is a non-profit organization with about 250 members, but not all of them are mental health practitioners. This organization strives to elucidate the dynamic role of spirituality and its relationship to mental health. A list of members and their email addresses was procured from the organization following the approval of its Board of Directors. From a list 116 identified mental health practitioners that was received in January 2011, 105 had email access. A letter of invitation was mailed to six potential participants with mailing addresses requesting them to participate in a web survey. Five names did not have valid emails or addresses. One letter was

returned due to no known new address. Finally, the sampling frame for this survey was 105 potential respondents.

Forty-one mental health practitioners participated in the current study. Of those, three surveys were rendered unusable by participants who had completed their survey by only 50%. This survey yielded 36.2% of 105 respondents, or 39% of the sample size (116), an acceptable rate of return.

Inclusion Criteria

In order to be included in study, participants had to meet the following criteria: self-identified members of the Bahá'í Faith; born and raised in a Bahá'í household or converted to Bahá'í Faith; mental health practitioner (social worker/social work clinician, psychologist/clinical psychologist, psychiatrist, psychiatric/mental health nurse, counselor, mental health counselor, family therapist); currently working or has actively worked with clients with mental health issues for at least one year of their professional practice; a minimum of a master's degree; and 10 hours or more per week of direct mental health services for at least a year.

Research Design

The overall design approach for this exploratory study of Bahá'í mental health professionals' religious-based practices was to collect data using REDCap, a web-based survey research tool. REDCap, which stands for Research Electronic Data Capture, is a secure web survey that provides a process for building a database or online survey and has an intuitive interface for collecting and validating data that is downloadable to common statistical packages such as SPSS. REDcap's software was created at Vanderbilt University and is supported by NCRR/NIH (1ULIRR624975 NCRR/NIH). A type of computer-mediated communication (CMC), this database has its advantages (Mann & Stewart, 2002), one of which was that survey

respondents were able to complete the survey online, thus reducing the costs, time limitations, and travel and scheduling issues of both the respondents and researcher.

Once logged on, the database did not collect any identifying data about the participants. All data were stored on a University of Pennsylvania Health System-connected server and therefore were afforded the same network protection as other critical UPHS clinical information systems. REDCap itself is an application that requires user authentication to access the system. Data for each study are limited to users who are explicitly authorized to be involved with the study. This researcher has access to the data with no identifiable information of the participants. An audit trail kept track of all data accesses.

The research participants were asked to fill out two separate instruments, including a background questionnaire via web survey or mail-in response. The overall estimated time for instrument completion was 20 minutes; this estimate was based on a mock administration conducted by the researcher with two colleagues prior to the initiation of the project.

Four open-ended questions were designed to ask about religious beliefs, religious influence in professional practice, use of other interventions in mental health not mentioned in the scale that they utilize, and a brief account of their experiences in which spiritually integrated interventions were applied in practice.

Instrument Design

Two research instruments were utilized in this study: 1) The Religious/Spiritual Psychotherapy Behaviors Questionnaire, or RSPBQ (Frazier & Hansen, 2009), and 2) the Intrinsic Religious Motivation Scale, or IRM Scale (Hoge, 1972). They are described briefly here.

Religious Motivation Scale or IRM Scale

The IRM Scale (Hoge, 1972) is a 29-item instrument measuring different observable indicators of religiosity (e.g., intrinsic and extrinsic religiosity); it was developed and tested within the traditions of Christian faiths but has a wide appeal and applicability to other religious groups (Hill & Hood, 1999). Its lack of doctrinal content and open-ended definition of religion makes it usable to religions beyond Christian groups (Patrick, 1979). The index contains 10 items in a Likert-scale format. Two of the 10 items contain a reference to God, which is appropriate for Bahá'í mental health practitioners because they believe in the existence of one God. The IRM Scale excludes divisive issues of religious beliefs and behaviors; instead, it measures the motivation behind religious activities, as originally derived from the motivational aspect of Allport and Ross's (1967) Religious Orientation Scale. Hoge's (1972) assumption was that intrinsic and extrinsic faith would enable researchers to examine different ends of the same dimension. Because Likert scaling is a uni-dimensional scaling method (King & Crowther, 2004), the instrument is limited to the measurement of one dimension of religiousness: "intrinsicness."

The IRM has seven intrinsic items on one end of the dimension, with three extrinsic items on the other end of the dimension. For example, Item #7, "It doesn't matter so much what I believe as long as I lead a moral life," is an extrinsic item. If participants answered this item as closer to 1 than 4, the score is reversed to the opposite end of the scale. If the respondent's answer is 1, which is strongly disagree, the score is reversed to the opposite value, which is 4, the highest value in the intrinsic scale. In other words, participant responses on statements 7 through 9 in the IRM scale were reversed to figure out the intrinsic value of their statements.

To determine the norms of intrinsic-extrinsic orientation, Hoge's IRM Scale has been reported in two separate studies by using responses for rabbis, community pastors, and priests (Berman et al., 2004). One study reported an average score of 2.00 with a standard deviation of 1.07 for intrinsic items. Extrinsic items had an average score of 4.11 with a standard deviation of 1.08. Following Hoge's procedure, scores for extrinsic items were reversed. The reliability of the IRM Scale was .90 using the Kuder-Richardson Formula 20. A high KR-20 coefficient (e.g., >0.90) indicates a homogeneous test. High values on the scale of 0.00 to 1.00 (sometimes expressed as 0 to 100) will show that the examination is likely to correlate with a desirable characteristic (Cortina, 1993). Item-to-item correlations ranged from a low of .13 to a high of .72 (Hill & Hood, p. 136). The shortened version of this scale, consisting of six items, was administered to members of eight Protestant churches. A study by Hoge and Carroll (1978b) yielded a Cronbach alpha of .84, indicating strong psychometric properties. The validity of Hoge's (1972) original index was illustrated through participants' answers to the intrinsic-extrinsic scale.

The overall intrinsic religious motivation score of the final version of IRM Scale was .59. Later, Allport and Ross (1967) and Feagin (1964) provided correlations with these scales that ranged from .71 to .87. This researcher used the shortened 10-item Likert scale that measures the level of intrinsic religious motivation as an independent variable. One item was inadvertently left off the version sent to the web survey, so this researcher was presented with the task of isolating the original six intrinsic statements and three extrinsic statements. In doing so, true intrinsic and extrinsic scores were split and analyzed separately. Following the original scale, it was expected that the highest six intrinsic items could each have a score of 4, and the highest three extrinsic items could also have a score of 4.

Religious/ Spiritual Psychotherapy Behaviors Questionnaire, or RSPBQ

The use of religious or spiritual interventions was measured by the practitioners' frequency of utilization of spiritual behaviors in their practice. The Religious/Spiritual Psychotherapy Behaviors Questionnaire, or RSPBQ, is a 29-item survey developed by Frazier and Hansen (2009) specifically for the study of professional psychologists who were interested in addressing the spiritual and religious issues in psychotherapy. The authors identified 18 commonly cited religious/spiritual psychotherapy recommendations found in the literature. In the original index, multicultural literature and its particular relevance to religious/spiritual domains were virtually unknown. To address this lack of attention to issues of diversity, the authors provided additional items in the index such as "initiate and explore religious/spiritual differences between therapist and client." With permission from the first authors, this present study used the 29-item RSPBQ. All 29 items in the RSPBQ pay particular attention to psychotherapy-related behaviors, not attitudes or knowledge. The RSPBQ uses a 5-point Likert scale, from 5 (very often) to 1 (never), to rate how often the professionals engaged in the stated behavior when working with their clients who seek spiritually integrated interventions based on a stratified sample of APA doctoral member professional psychologists and how important each behavior is.

In addition, with permission from the original proponent of the scale, the RSPBQ Index was modified for the purpose of this study. A minor modification was made by incorporating "appropriate" and "inappropriate" use of interventions, instead of asking the respondents about the level of importance of each behavior intervention. The letters *A* and *I*, which stood for Appropriate and Inappropriate, were indicated in a multiple-choice format after each item on the scale to indicate appropriate or inappropriate use of the 29-item behavior index. Thus, this study

revealed whether such interventions were reported as utilized appropriately or inappropriately by the Bahá'í respondents. Please see Appendix.1B.on page 131)

Background Questionnaire

The Background Questionnaire (Appendix 1B Section I on page 131) is a 20-item survey designed to obtain routine demographic data; it also contains some exploratory questions related to the respondents' exposure to spirituality and conversion. This questionnaire comprised the first part of the survey and took approximately five minutes to complete. Information such as age, gender, and racial identity, level of education, professional background, and practice setting were obtained.

Open-Ended Questions

There were four open-ended questions that explored the beliefs and experiences of the study participants. These questions included other interventions not mentioned in the scale, as well as religious beliefs that may have influenced the participants' practice in the field of mental health. (See Appendix 1B Section III)

Variables

The variables of interest in this study were intrinsic religious motivation and the use of spiritually integrated interventions. Religious motivation was measured by the Intrinsic Religious Motivation Scale (Hoge, 1972), while use of spiritually integrated interventions was measured by Religious/Spiritual Psychotherapy Behaviors Questionnaire, or RSPBQ self-report questionnaire (Frazier & Hansen, 2009).

Procedure

A letter was written to the Bahá'í Association of Mental Health Practitioners explaining the purpose and benefits of the study. The BAMHP Board of Directors approved the intent and

process of the survey research in late January 2011. This researcher received a mailing list via email from the Board secretary. After getting the approval from the Institutional Review Board of the University of Pennsylvania, the survey was sent out to potential participants using the REDCap program. A brief introduction regarding the study was provided in the body of the email (See Appendix B). Participants were provided with a letter of consent, which preceded the survey. This consent explained the risks and benefits of the research and persons to contact for further questions (See Appendix C). Consent was given by answering the question of agreement to participate in the survey.

Potential respondents were also informed about the consequences if they decided to participate. Any program or agency for which they worked would not know whether or not they participated. The respondents could choose to stop participating at any time by logging out of the survey. Furthermore, this researcher offered some assistance by providing respondents with her name and other contact information should they experience any risks during the course of answering the survey. Resources were available for the respondents, as well as contact information of the researcher's dissertation mentor, who would provide answers to questions regarding this research, including their right to withdraw from the study.

This study obtained approval from the Institutional Review Board of the University of Pennsylvania. Instead of individual compensation that is normally offered to research participants, this researcher contributed \$300 to the Bahá'í Association of Mental Health for their participation in this project.

Confidentiality

Participant information was kept strictly confidential. This researcher was only interested in collective information, and the database did not collect any individually identifying data of the

participants. All data are stored on a university system-connected server and therefore are afforded the same network protection as other critical clinical information systems. This researcher has access to the data with no identifying information of the participants.

Following the above procedures, a REDCap web address was sent to the potential respondents inviting them to fill out the 67-question survey entitled, “A Survey of Bahá’í Mental Health Practitioners.”

Research Questions

The following central research questions guided this study:

1. What is the general description or profile of Bahá’í mental health practitioners who participated in this study?
2. Are Bahá’í mental health practitioners intrinsically religiously motivated?
3. To what extent do Bahá’í mental health practitioners use spiritually integrated interventions in mental health practice?
4. What spiritually integrated interventions do Bahá’ís identify as appropriate and inappropriate?

Analysis of the Data

The analysis of quantitative responses used the following general statistical measures: descriptive statistics that included mean, frequencies/percentages, and standard deviations. To answer all questions, mean frequencies/percentages and standard deviations were used. Cronbach Alpha was also used to calculate reliability for the Intrinsic Motivation Scale. Several categorical variables were identified to provide a general profile of the respondents, including Male/Female, Racial Identity, Professional Level of Education, With/Without License, Practice Setting, Field of Practice, and Type of Graduate School Attended. Selected spirituality-related variables, such

as Born into a Bahá'í Household, Religious Conversion, issues related to spirituality in education, and whether the participants' beliefs influenced their mental health practice, were included to understand participants' use of spiritually integrated interventions.

Four open-ended questions were included in the survey instrument. These included the following: 1) "Did your religious beliefs influence your decision to practice as a mental health practitioner?" 2) "How if at all does your religion influence you in your mental health work?" 3) "Can you think of a situation where you utilized a spiritually integrated intervention with your client who has a spiritual/religious concern? What was the outcome of this intervention? Please describe your experience," and 4) a comment question. This final question was designed to elicit responses that were pertinent to the present and future studies on mental health and spirituality.

Since there has been no prior empirical data to substantiate a set of knowledge on the topic, thematic analysis was used to guide the data-collection process. Thematic analysis is a qualitative research process of searching through data to identify any recurrent patterns of responses among survey participants (Denzin & Lincoln, 1994; Strauss & Corbin, 1990). In this essentialist or realist method (Boyatzis, 1998; Hayes, 1997), it was critical to explore the experiences and the reality of Bahá'í participants' spirituality within the context of their mental health practice. Themes guide data extraction and analysis by finding what is prominent and obvious for the participants. Based on the question "How if at all does your religion influence you in your mental health work?" this researcher captured important information from the Bahá'í participants by looking for initial patterns of issues of interest in the topic of research while the data was being collected. Reading the data repeatedly allowed the researcher to become more familiar with the strength and extent of the participants' responses. After searching for patterns and meanings, this researcher started the process of coding. Patterns were identified and the

meanings of these patterns were formed. Carefully taking note of the issues that emerged from participants' responses, initial themes were investigated by categorizing and coding the responses. This researcher proceeded to write down the ideas that emerged from the participants with the objective of creating coding schemes.

The process of coding is part of analysis (Miles & Huberman, 1994) and organising the data into meaningful groups (Tuckett, 2005). In the next step, the researcher identified the salient aspects in the data items, which formed the basis of repeated patterns (themes) across the data set. The researcher proceeded to code the data set by manually writing notes on the previously examined texts and using coloured pens to indicate potential patterns. All actual data were coded and collated jointly within each code by copying extracted or parts of data from individual transcripts. Each code was collated in a colour-coded file. This researcher sorted the different codes into potential themes by writing a brief description or names of each code on the board and organizing them into different themes. This process of creating a coding scheme provided further contextualization after all initial themes were re-examined and redefined for the next stage of thematic analysis. A category of themes and sub-themes emerged and subsequently, this researcher identified individual themes that were reasonably sufficient to the research inquiry. The next phase involved a review and refining of the codes to create the meaningful substance of a thematic map. No further coding was implemented since no other new themes emerged. The researcher filed an initial report of the themes, including a write-up of the description and selected quotations from the respondents' experiences. This step provided an accurate collection of the data set in its entirety and helped clarify the responses to the research questions.

CHAPTER V

FINDINGS

This chapter reports the findings of this exploratory study. The following three areas will be presented and discussed: a) demographic descriptive about the sample, b) statistical data on the two scales used in the study, and c) results of the qualitative analysis.

Description of the Sample

Gender and Age

Of the 38 participants, nine (23.7%) males and 29 (76.3%) females comprised the sample in the study. With respect to age, there were no individuals aged 21 to 25 years, one (2.6%) individual aged 26 to 30, five individuals (13.2%) aged 31 to 40, two individuals (5.3%) aged 36 to 40, four individuals (10.5%) aged 41 to 45, no individuals aged 46 to 50, six individuals (15.5%) aged 51 to 55, seven individuals (18.4%) aged 56 to 60, six individuals (15.8%) aged 61-65, and seven individuals (18.4%) over the age of 65. For the entire sample, the mean age was between 51 and 55 years old (actual mean=7.03, N=38). Table 1 below illustrates the age category, number of respondents, and percentage of respondents.

Table 1

Age of Bahá'í Mental Health Practitioners

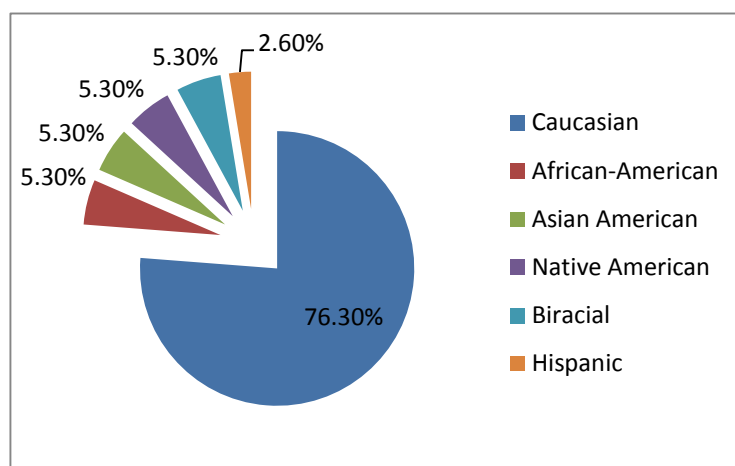
Age	Number of Participants	Percentage of Participants	Mean Age	SD	Median	Range	N
Between 21-25	0	0%	7.03	2.509	8.00	8.00	38
Between 26-30	1	2.6%					
Between 31-35	5	13.2 %					
Between 36-40	2	5.3%					

Between 41-45	4	10.5%
Between 46-50	0	0%
Between 51-55	6	15.8%
Between 56-60	7	18.4%
Between 61-65	6	15.8%
Over 65	7	18.4%

Race

Most of the participants (29, or 76.3%) were Caucasian. The remaining 23.7% included two (5.3%) African American, two (5.3%) Native American, two (5.3%) Biracial, two (5.3%) Asian, one (2.6%) Hispanic and zero (0%) Other individuals, as shown below in Figure 1.

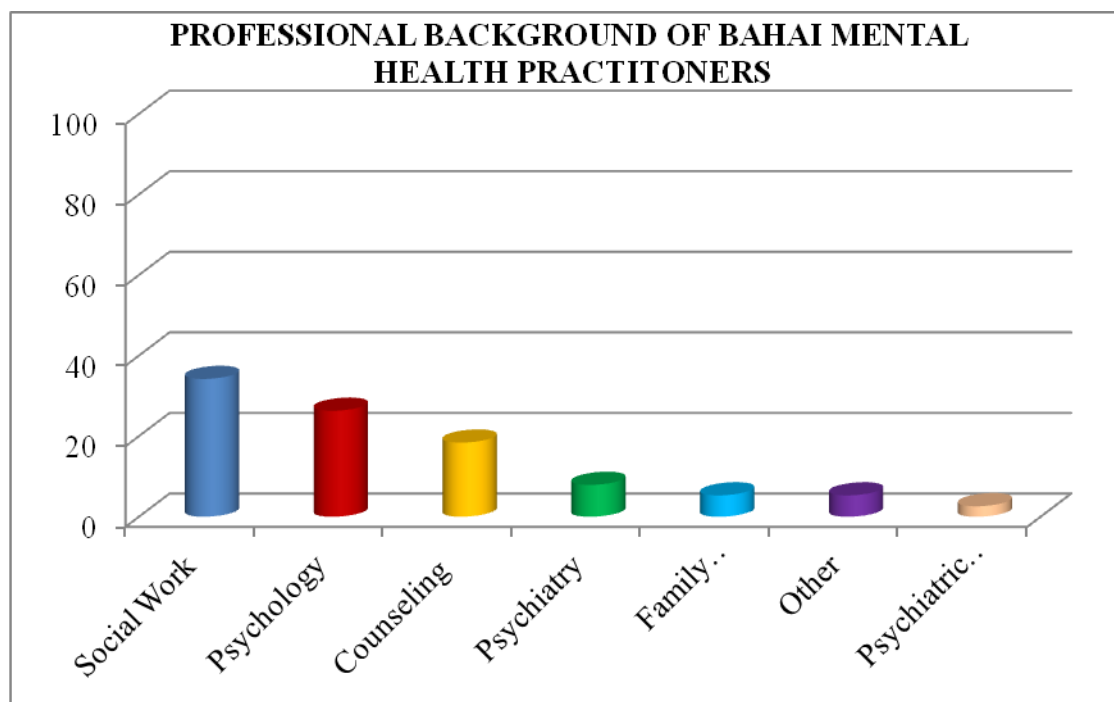
Figure 1. Race or ethnicity of Bahá'í mental health practitioners.



Professional Background

The professional background of Bahá'í mental health practitioners is as follows: Thirteen individuals are employed in social work (34.2%), ten in psychology (26.3%), seven in counseling (18.4%), three in psychiatry (7.9%), two in family therapy (5.3%), two in “other” (5.3%) professional backgrounds (education and mental health intern), and one in psychiatric nursing (2.6%). Figure 2 below illustrates the professional background of the respondents.

Figure 2. Professional background of Bahá'í mental health practitioners



Highest Level of Professional Education

Participants' highest level of educational attainment included 21 individuals with MS/MA/MS (55.3%), seven individuals with a PhD/DSW (18.4%), four individuals with other

degrees (10.5%), three individuals with an EdD (7.9%), and three individuals with an MD (7.9%). None of the study participants received a Doctorate in Ministry or its equivalent.

Professional Licensure in the United States

Participants were asked whether they have a license to practice their respective professions. Nearly the entire sample (71.1%) reported being licensed to practice in the United States. Twenty-seven practitioners (71.1%) have a license, while 11 individuals (29.8%) do not have a license.

Current Practice Setting

The current practice settings of the respondents are as follows: 17 individuals (44.7%) work for private for-profits, eight individuals (21.1%) work for public nonprofits, and five individuals (13.2%) work for private nonprofits. In addition, four individuals (10.5%) work within the Other category (one works with the elderly, one helps executives and managers, two are retired, and one is currently without a job), while three individuals (7.9%) work for public for-profits.

Current Field of Practice

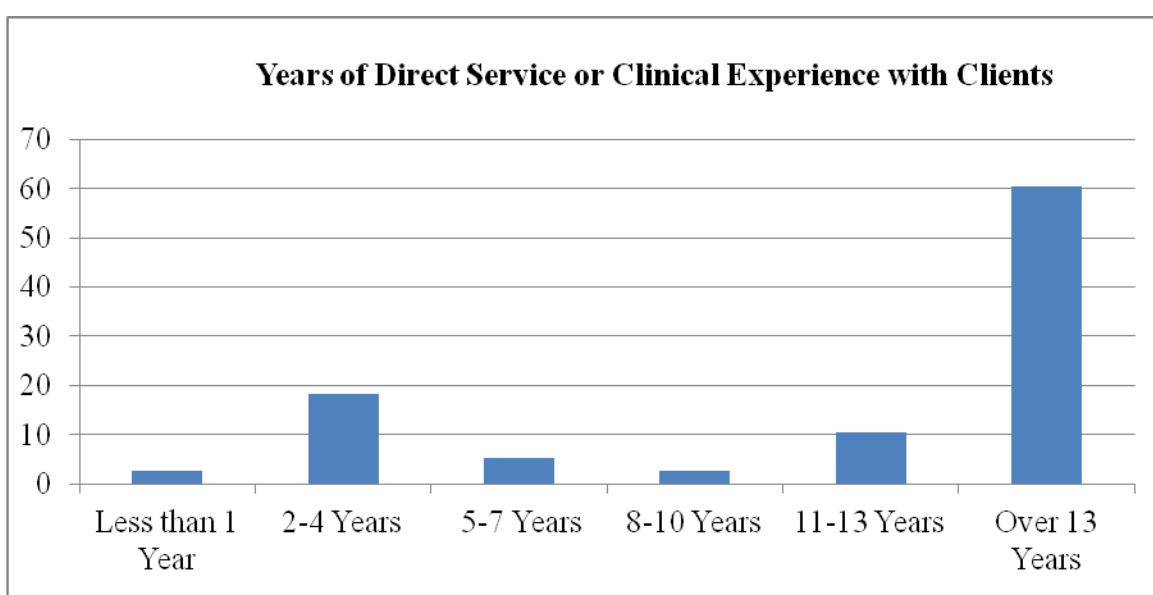
With respect to their current fields of practice, 26 Bahá'í mental health practitioners (68.4%) work in the mental health field, six individuals work within the Other category, two individuals (5.3%) work for Child Services, two individuals (5.3%) work in private practice, and no individuals work within the following areas: Health Care, Family Services, Gerontology, Substance Abuse, or Corrections.

Years of Direct Service or Clinical Experience with Clients

Bahá'í respondents identified themselves with reference to direct service experience in the following manner: at the time of the study, one (2.6 %) had less than one year of experience,

seven (18.4%) had 2-4 years of experience, two (5.3%) had 5-7 years of experience, one (2.6%) had 8-10 years of experience, four (10.5%) had 11-13 years, and 13 (60.5%) had over 13 years of experience. For the entire sample, the mean years of experience was 10-11 years (mean value=4.8, SD=1.72, N=38). Figure 4 below illustrates the years of direct service experience of Bahá'í mental health practitioners.

Figure 3. Years of direct service or clinical experiences with clients by Bahá'í mental health practitioners.



Type of Graduate School Attended

Bahá'í mental health practitioners also identified the types of graduate schools they attended to complete their highest degrees. Thirty-four respondents (89.5%) identified their graduate schools as “secular,” while two respondents (5.3%) identified their graduate schools as “religious.” Two respondents (5.3%) did not know the type of graduate school they attended.

Spirituality-Related Variables

To assess the profile of a Bahá'í mental health practitioner, the researcher selected spirituality-related variables for the current sample. The following variables provide the description for each variable, including their descriptive statistics.

Born in a Bahá'í household. Nearly all members of the sample (89.5%) in this study were not born into a Bahá'í household. Thirty-four respondents did not have any household influence on their religious choice, while four respondents (10.5%) were born in a Bahá'í household.

Converted from another religion. Twenty-seven respondents (71.1%) had converted from other religions, while eleven respondents (28.8%) did not. The Bahá'í Faith was the first and only religion of choice for these 11 respondents. The majority of the respondents had been members, followers, or believers of other faiths before becoming Bahá'í. Some of these religious groups included Christianity (Catholic, Baptist, Presbyterian, Episcopalian, Anglican, Mennonite, and Eastern Orthodox), Judaism, and Buddhism.

Spirituality or religion given attention in professional education. Of 37 Bahá'í respondents, 13 individuals (34.2%) “very often” give attention to spirituality in their professional education. Seventeen respondents (44.7%) “often” give attention to spirituality or religion in professional education, while seven participants (18.4%) “sometimes” give attention to spirituality in professional education. No respondents “rarely” or “never” give attention to spirituality in professional education (see Table 2 below)

Table 2 Number and Percentage of Participants Who Gave Attention to Spirituality or Religion in their Professional Education

Frequency	Number of Participants	Percentage of Participants
Very Often	13	34.2 %
Often	17	44.7 %
Sometimes	7	18.4 %
Rarely	0	0.0 %
Never	0	0.0 %

N=37

Attendance at continuing education workshops/conferences on spirituality in mental health. Nine respondents (23.7%) “very often” attend continuing education workshops/conferences dealing with spirituality in mental health. Fifteen respondents (39.5%) “often” attend workshops/conferences dealing with spirituality in mental health, while 12 respondents (31.6%) “sometimes” these events. No respondents “rarely” attend continuing education workshops on spirituality, and one “never” attends continuing education workshops on spirituality, as shown in Table 3 below.

Table 3

Number and Percentage of Participants who Attended Continuing Education Workshops/Conferences on Spirituality in Mental Health

Frequency	Number of Participants	Percentage of Participants
Very Often	9	23.7 %
Often	15	39.5 %

Sometimes	12	31.6 %
Rarely	0	0.0 %
Never	1	2.6 %

N= 37

Frequency in reading professional journal articles or scholarly writings on spirituality and mental health. Twenty-one respondents (55.3%) “often” read professional journal articles or scholarly writings that deal with spirituality and mental health practice. Fourteen respondents (36.8%) “sometimes” review professional journal articles, one (2.6 %) “rarely” reads these materials, and two (5.3%) “never” read professional journals on spirituality and mental health. These data are shown in Table 4 below.

Table 4

Number and Percentage of Participants Who Frequently Read Professional Journal Articles or Scholarly Writings on Spirituality and Mental Health

Frequency	Number of Participants	Percentage of Participants
Very Often	0	0.0 %
Often	21	55.3 %
Sometimes	14	36.8 %
Rarely	1	2.6 %
Never	2	5.3 %

N=38

Bahá'í religious beliefs. One additional question in the third section of the survey asked whether or not the Bahá'í mental health practitioners believed that their religious beliefs influenced their decision to practice as mental health practitioners. Of the 38 respondents to the survey, 35 (98.4%) responded to this question. Of the 35, 25 respondents (71.4%) affirmed that their religious beliefs had influenced their decision to practice in the field of mental health. Ten respondents (28.6%) answered “no” to this question.

Answers to Research Questions

This section provides answers to the research questions originally posed for this study. The central research questions for this study are as follows:

1. What is the general description or profile of Bahá'í mental health practitioners in the United States?

Bahá'í mental health practitioners who are members of the Bahá'í Association of Mental Health Professionals and who responded to this survey are predominantly female (76.3%), Caucasian (76.3%), ages 51 and older, with a masters level of education (55.3%). They are mostly licensed (71.1%), attended secular graduate schools (89.5%), and have over 13 years of clinical experience (60.5%). They are primarily social workers (34.2%) but secondarily psychologists (26.3%). Bahá'í mental health practitioners predominantly practice in private for-profit settings (44.7%) and somewhat in public non-profit settings (21.1%).

2. Are Bahá'í mental health practitioners intrinsically religious motivated?

The participants of the study were asked whether they were intrinsically religiously motivated. Most respondents chose the highest intrinsic variable, “My faith involves all of my life,” which had a mean score of 3.79 (SD=0.577). Not far from this mean score are two

variables, “One should seek God’s guidance when making every important decisions” (Mean=3.76) and “My religious beliefs are what really lie behind my whole approach in life” (Mean=3.71). On the other hand, the variable, “I try hard to carry my religion over all my other dealings in life” had the lowest intrinsic mean score of 3.63 (SD=0.675). The mean average score of all six variables was 3.69 on a Likert scale of 1 to 4. This score (3.69) indicates a very high motivation on the six-variable intrinsic scale. The score was obtained by finding the sum of all intrinsic mean scores divided by six. Table 5 below lists the six intrinsic variables from Hoge’s (1972) Intrinsic Religious Motivation Scale. Table 5 below shows the scores of six variables on a Likert scale of 1-4.

Table 5

Mean and Standard Deviation Scores of Intrinsic Religious Motivation (Intrinsic Variables)

Variable	I/E	Mean	SD
1. My faith involves all of my life.	I	3.79	0.577
2. One should seek God’s guidance when making every important decision.	I	3.76	0.590
3. In my life I experience the presence of the Divine.	I	3.63	0.675
4. Nothing is as important to me as serving God as best I know how.	I	3.66	0.708
5. I try hard to carry my religion over all my other dealing in life.	I	3.63	0.714
6. My religious beliefs are what really lie behind my whole approach in life.	I	3.71	0.694

N=38; I means intrinsic and E means extrinsic

On the other hand, Hoge's Intrinsic Motivation Scale has three extrinsic statements. Bahá'í mental health practitioners rated these three variables with low scores. In this case, the lowest intrinsic score was 1 and the highest extrinsic value was 4 because of the reversal of the last three statements of the IRM Scale. This strategy was used by the author (Hoge, 1972). The respondents identified the lowest extrinsic variable as "Although I am a religious person, I refuse to let religious considerations influence my everyday affairs," with a mean score of 1.34. The variable, "It doesn't matter so much what I believe as long as I lead a moral life" had the highest extrinsic mean score of 2.16. The mean average of these three extrinsic variables is 1.74. This mean value is closer to the "intrinsicness" value of 1 than the extrinsic value of 4, as demonstrated in Table 6 and Figure 7 below.

Table 6

Intrinsic Religious Motivation Scale (Extrinsic Variables)

Variable	I/E	Mean	SD
7. It doesn't matter so much what I believe as long as I lead a moral life.	E	2.16	0.886
8. Although I am a religious person, I refuse to let religious considerations influence my everyday affairs.	E	1.34	0.627
9. Although I believe in my religion, I feel there are many more important things in life.	E	1.74	1.083

N=38

Bahá'í mental health practitioners are highly intrinsic as represented in the intrinsic scores on Tables 5 and 6. These practitioners' responses to all six intrinsic statements expressed high mean averages from 3.71 to 3.79, while their responses to three extrinsic statements showed scores that are closer to "intrinsicness" which showed mean values from 1.74 to 2.16.

3. To what extent do Bahá'í mental health practitioners use spiritually integrated interventions in mental health practice?

Respondents were asked to indicate which of the 29 interventions they had used with clients. The respondents identified their use of these interventions on a Likert scale from 1 to 5. Table 7 (Appendix 2.B) provides a breakdown of participants' responses from the highest to the lowest mean frequencies and standard deviation scores of all 29 spiritually integrated interventions.

The five most frequently practiced behaviors were items 1, 2, 3, 4, and 5 in Table 7 (Appendix 2.B). They include (a) actively communicate respect for clients' religious/spiritual beliefs, (b) actively seek client feedback about psychotherapy provided, (c) accurately determine when religious/spiritual beliefs are adversely affecting the client's well-being, (d) ask religious/spiritual questions to assess clients' religious/spiritual involvement, and (e) help clients explore their religious/spiritual questions in therapy.

The five least frequently used practice interventions were items 25, 26, 27, 28, and 29 in Table 7: (a) refer a client to a more religiously/spiritually qualified provider; (b) initiate and explore religious/spiritual differences between therapist and client; (c) promote autonomy and

self-determination of highly religious clients, even when their values differ from one's own; (d) develop and implement a professional development plan to improve one's religious/spiritual psychotherapy competence; and (e) make *DSM-IV-TR* (2000) diagnosis.

4. What spiritually integrated interventions do Bahá'ís identify as appropriate and inappropriate?

Bahá'í mental health practitioners were asked to evaluate the appropriateness of all 29 interventions in their practices. Out of 29 spiritually integrated interventions ranked in appropriate-inappropriate categories, eight interventions were found to be 100% appropriate, but their rankings according to mean frequency scores or frequently practiced behaviors vary. These interventions included (a) help clients explore their religious/spiritual questions in therapy (ranked 5th for the most often used intervention). (b) seek out religious/spiritual-informed case consultation (ranked 8th); (c) use extra-therapy resources to inform oneself about a client's specific religious/spiritual beliefs (ranked 10th); (d) refer to local community resources (e.g., church, synagogue, religious professionals, etc.) (ranked 12th); (e) modify treatment plan to account for clients' religious/spiritual concerns (ranked 13th); (f) include religious/spiritual dimensions in case conceptualization (ranked 16th); (g) refer a client to a more religiously/spiritually qualified provider (ranked 25th); and (h) promote autonomy and self-determination of highly religious clients, even when their values differ from one's own (ranked 27th). (See Table 8 on p. 148).

The first two interventions selected by Bahá'í practitioners with the highest mean frequency scores also have the lowest scores for appropriate use. Over 60% of respondents actively communicate respect for clients' religious/spiritual beliefs (63.2%) and actively seek client feedback about psychotherapy provided (60.5%).

There is only one spiritually integrated intervention that had a low score on appropriate use. The intervention “Initiate and explore religious/spiritual differences between therapist and client” had a mean score of 2.94 and was ranked 26th in frequency of use of spiritually integrated interventions by Bahá’í mental health practitioners. Again, as explained previously, the basic tenet of the Bahá’í Faith is “unity”; therefore, it is reasonable that seeking differences would be the last among BMHPs’ chosen interventions.

As previously mentioned in the findings, eight out of 29 interventions were identified by Bahá’í mental health practitioners as 100% appropriate, but their rankings according to their mean frequency scores or frequently practiced behaviors vary. Two of the interventions identified as least-utilized were ranked as most appropriately used. These interventions include “referring a client to a more religiously/spiritually qualified provider” and “to promote autonomy and self-determination of highly religious clients, even when their values differ from one’s own.”

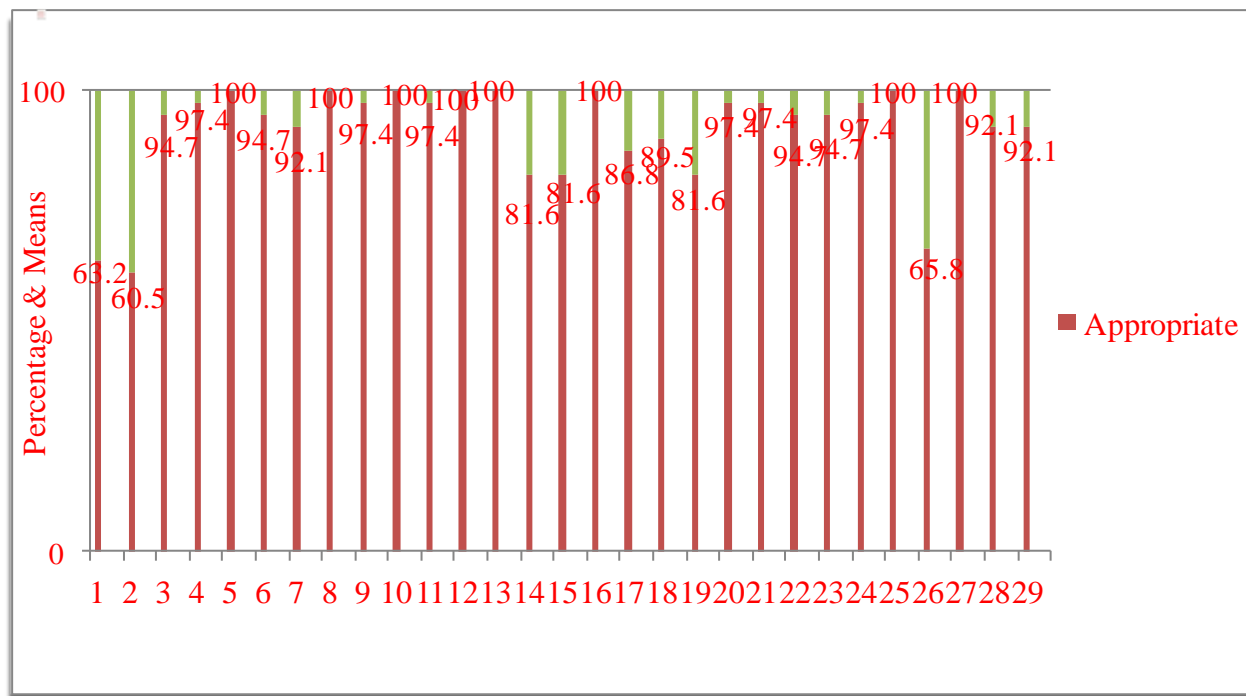
There is only one other least-utilized spiritually integrated intervention that also had a low score on inappropriate use. The intervention “Initiate and explore religious/spiritual differences between therapist and client” had a mean score of 2.94, and was ranked 26th on the frequency of use of spiritually integrated interventions by Bahá’í mental health practitioners.

Finally, it is interesting to note that, except for one intervention, there is no clear trend between the most frequently utilized and the appropriate use of spiritually integrated interventions.

Figure 4 below shows the mean frequency scores of spiritually integrated interventions and their appropriate and inappropriate categories. The appropriate category is highlighted in red, while the inappropriate category is highlighted in green.

Figure 4

Mean Frequency of Appropriate and Inappropriate Use Spiritually Integrated Interventions



Other Spiritually Integrated Interventions Identified by

Bahá'í Mental Health Practitioners

Bahá'í mental health practitioners were asked about other spiritually integrated interventions that they utilized in their mental health practice. Out of 38 respondents, 23 BMHPs responded to this question. However, only 12 respondents ranked their responses on a Likert Scale from 1 to 5. Bahá'í respondents who “very often” used some spiritually integrated interventions mentioned the following methods:

Four respondents use prayers and meditation. Meditation was used in conjunction with prayers. Another respondent used meditation as mindfulness-based therapy, which specifically

encompasses teaching meditation. One respondent utilized the Family Virtues Guide as an intervention; Family Virtues Guide is a tool employed to assist couples and families.

Religious coping was also identified as an intervention that was “very often” used by one respondent with clients who have strong religious/spiritual beliefs. Another respondent focused on specific behaviors that were spiritually inspired. This respondent believed that such behavior could be expressed in the following way: “Looking at things from the other's perspective, not blaming, not backbiting, or gossiping, inviting clients to stop, reflect, learn, respect, and embrace differences. I do these very often.” One respondent frequently used acceptance and Commitment Therapy, but he/she did not explain how this intervention was applied to clients.

Bahá’í respondents who “often” used some spiritually integrated interventions identified interventions related to values, authenticity, worksheets, and materials that had been specifically designed for clients to explore their spiritual beliefs and values. They further expounded the use of Dialectic Behavior Therapy (DBT) as developed by DBT practitioners or people who have been involved with Alcoholics Anonymous in-group settings, where people typically have multiple spiritual beliefs. In doing grief work, one respondent asked about spiritual beliefs and explored spiritual/religious issues when addressing clients’ concerns about death and dying.

Similarly, during the initial intake process of history-taking, spirituality was included in one practitioner’s assessment. The assessment often included a question about spirituality at intake and took cues from clients in including spiritual language in treatment. Exploration of the family’s thoughts on spirituality and religion by questioning whether the child and family attend religious services was often used. To preserve family unity and boost the participation of youth, encouraging families to take their youth to youth groups as an intervention strategy was often

mentioned. This intervention also includes a 12-step concept (referring to Alcoholics Anonymous).

Only one Bahá'í respondent “sometimes” used the spiritually integrated intervention of utilizing stories derived from several religious traditions. The researcher was not provided with an example of what this meant.

CHAPTER VI

QUALITATIVE RESULTS

Overview

Questions to Bahá'í mental health practitioners that led to qualitative responses were as follows: (1) "Do your religious beliefs influence your work in mental health?" The answer to this question was also addressed in the quantitative section of the findings. (2) "How, if at all, does your religion influence you in your mental health work?" Even though it was expected that the 25 practitioners who affirmed their beliefs would answer this question, 28 Bahá'í mental health practitioners explained that their religious beliefs influenced their decisions to practice as mental health practitioners. Ten practitioners did not respond to this question. Key themes are presented below. The themes that emerged from the responses of the Bahá'í practitioners provided some generalized ideas about their faith.

Figure 5

Bahá'í mental health practitioners' spiritual orientation toward practice

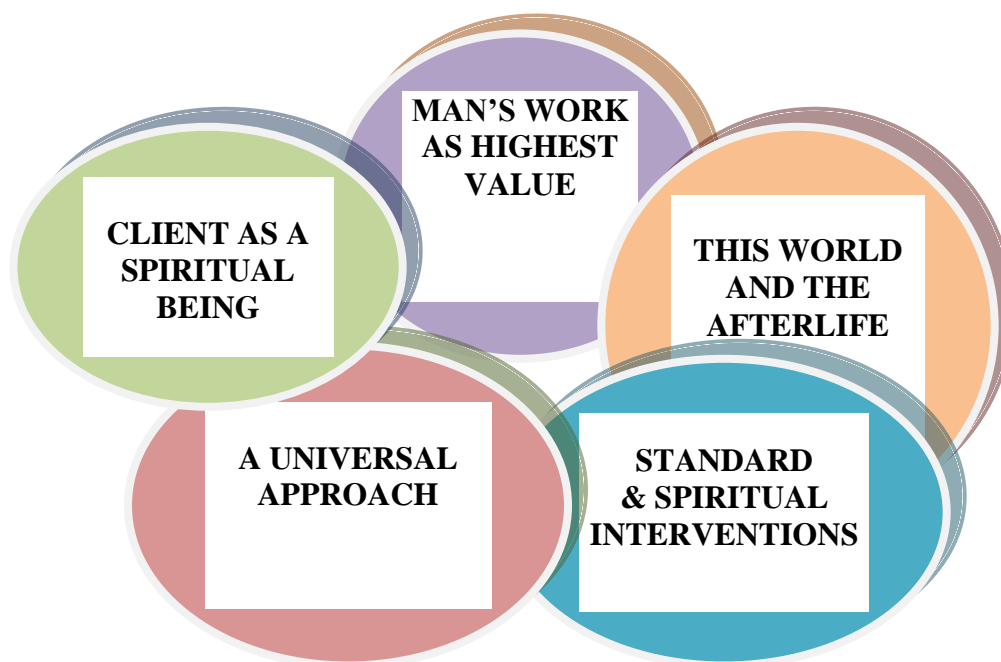


Figure 7, as shown above, indicates the general themes revealed by the Bahá'í mental health practitioners regarding how their faith has influenced their mental health work.

Theme One: “Client as a Spiritual Being”

For 22 of the Bahá'í mental health practitioners who responded to this question, the client is viewed as a spiritual being by nature, a human being with the existence of a soul embodying life. As one respondent said, “Man is by nature a spiritual being. This is in itself the essence of why my faith influences my work in mental health.” Similarly, another respondent affirmed, “My religion informs how I see my clients (i.e., as spiritual beings and ‘gems of inestimable value’).” Responses from two practitioners stressed the value of human life within the framework of a bio-psychosocial view of humanity. As one respondent stated, “There are plenty of spiritual insights and practices that can be framed in the language of psychology and neuroscience. I choose this path. My faith led me to this integration.” Four other practitioners stated that the Bahá'í faith provides them with an integration of the human and the spiritual such that his/her journey to wholeness is essentially a spiritual goal.

Practitioners also elaborated on how good mental and spiritual health can be synonymous. This framework for mental health development, according to one respondent, revolves around “an increased awareness of the capacities of the soul and the inherent, intrinsic value of a human being.” Another respondent elucidated, “All therapeutic work is spiritual in nature, since I believe we are spiritual beings having a human experience.” What resonates chiefly among Bahá'í practitioners is the explicit depth of their beliefs. One respondent summarized this perception in the following statement: “Regardless of spiritual beliefs, the client has the capacity to discover the wisdom, peace, and confidence within.” Finally, one Bahá'í practitioner regards his/her clients “as my fellow souls on a spiritual path, not pathological

patients whom I am supposed to fix.” It seems that Bahá’í practitioners are deeply grounded in the belief that humanity is by nature spiritual. The foundation of this belief influences one’s professional behaviors. Such beliefs, to the Bahá’í practitioner, are the lexicon of nobility in aligning oneself with a client who is on the road towards recovery. This action clearly signifies an expression of the worth and dignity of human beings within a spiritual perspective.

Theme Two: “This World and the Afterlife”

Four Bahá’í practitioners believe that this life affects the next and that resolving issues in this life may allow the next to be more positive. One other respondent explained that, as a Bahá’í practitioner, the goal is to assist in healing within the perspective that people’s journey to wholeness is essentially a spiritual goal. Two respondents whose work focuses on loss and grief issues support the belief of an afterlife or life after death. The Bahá’í Faith asserts a belief that human nature is essentially spiritual. If Bahá’í practitioners help cultivate the spiritual side that life offers, the individual client may develop or advance his or her inner capacities and qualities-attributes where human happiness emanates. This is perhaps the reason five Bahá’í practitioners strive to help discover their clients’ inherent capacities and encourage them to identify their strengths and overcome their weaknesses. Such effort speaks about the connection between the lofty goal and the reality of life.

Theme Three: “Man’s Work as Highest Value”

Two Bahá’í practitioners view work as a way to live out their highest values. These Bahá’í practitioners were quite explicit about the influence of their faith, particularly in their perspective of work. The value of work as worship and service to God is integral to their value of service to their clients. One respondent explained work as service from his conversion experience: “I was not a Bahá’í when I became a mental health practitioner ... and yet my

religion today affects my work all the time. The way I treat people, the way I work with them, the way I look for their capacities and try to help them build them into excellence.” The Bahá’í value of “work done in the spirit of service is the highest form of worship” (Abdu’l-Baha & Chamberlain, 1918, p. 83) has an extended effect on what it means to be influenced by a belief while working in the mental health field. Another respondent reinforced the first view with his/her desire “to serve humankind, especially those in need, and do mental health work.”

Teaching clients by example resonated in one respondent’s reason for why the Bahá’í faith has influenced his/her mental health work. On the other hand, another Bahá’í practitioner is motivated to continue to strive for excellence in his/her work, which is explicitly aligned with his/her view of service to others. One respondent explains:

The betterment of the world is accomplished through pure and goodly deeds, commendable and seemly conduct [referring to the Bahá’í religion] [...] influences work is worship; worship is service to His Creation. Also, influences ethical understanding and behavior. I work with trauma victims and rely on God to assist healing of victims and keep them strong. Tests are gifts [...] I support that concept when a client approaches the question, "Why me?" Dealing with grief, I support the notion of an afterlife and connection between those in this life with those in the afterlife.

The above quotation briefly synthesizes the Bahá’í practitioner’s moral and behavioral principles in conducting professional work. Reliance upon God and accepting tests and difficulties as the necessary nature of human reality develop resilience and patience in a practitioner’s relationship with clients. Ultimately, such work contributes to the service of a global society.

Theme Four: “Standard and Spiritual Interventions”

Twelve Bahá’í mental health practitioners who responded to this question reported that they draw from a broad array of disciplines in their work, including science, Western therapeutic techniques, non-Western psychologies, Bahá’í writings, and other Holy Scriptures. They express

a methodological and scientific integration of techniques that have a conscientious respect for the human dignity and the principles and ethics of their profession. While most of the respondents consider therapeutic work to be spiritual in nature, various spheres of knowledge appear to be universal rather than compartmentalized.

Eight Bahá'í practitioners reported that they do not utilize one specific method in their therapies; rather, their work is based on a comprehensive approach to mental health and behaviors of intervention where diverse perspectives are practiced. Expressing the need for a scientific outlook, these Bahá'í practitioners support the use of tools such as Family Virtues Guide; Holy Scriptures; and Bahá'í writings, meditation, and prayers in tandem with evidence-based interventions such as strengths-perspective, mindfulness-based, and solution-focused approaches. Also included are Adlerian psychology and non-Western psychologies. The following examples represent some of their responses:

[The Bahá'í Faith] strengthens my commitment to achieve excellence in my profession, [...] enables me to be comfortable in dealing with terminally ill clients, requires me to have a scientific outlook, encourages me to look into non-western psychologies [...] I chose to get my MA in Adlerian psychology, which has many values that are similar to Bahá'í values.

When practicing [...] I work from the "strengths perspective," assessing strengths, encouraging participants to identify and use those strong points to overcome challenges in weaker areas. I drew from various theorists anything in accordance with these Teachings [referring to Bahá'í teachings].

Four Bahá'í practitioners also brought to the forefront the importance of ethical behaviors in relation to the therapeutic relationship. One respondent summed up this importance as follows: "As expressed by Bahá'ís, 'religion that teaches coercion in matters of faith is unethical.'" These same respondents expressed the importance of relationship in the therapeutic process. The foundation of this relationship is based on opportunities where the acquisition of skills and

development of virtues strengthen the character of both the client and the therapist. As one respondent states,

I feel that it is the responsibility of the therapist to build a relationship of trust with a client; the therapist must find positive qualities in the client and sincerely affirm those qualities. To do this, one must cleanse one's own heart of biases and prejudices and train one to recognize admirable qualities, even in a person whose personal character is undeveloped. I believe that this requires prayerful reflection upon one's own internal response to a client and a deep respect for the client's own religious values.

It is from this perspective that one Bahá'í mental health practitioner encourages authenticity or an authentic relationship in which both parties (referring to the client and therapist) learn from one another and grow in a therapeutic process. Another respondent in particular puts it, "I frequently check in with the client to see how we are doing in that regard (therapeutic process). If we are off-base, I learn from that feedback."

Theme Five: "A Universal Approach to Mental Health"

Five Bahá'í practitioners reported that they utilize a universal approach to mental health. Such an approach embodies an unconditional positive regard for the diligent task of serving clients from diverse backgrounds. In mental health practice, Bahá'í clinicians encourage an approach that is founded on relationships animated by unity and authenticity and that seek to encourage social and moral progress as critical components of the maintenance of good mental health outcomes. "It is not enough just to do therapy because a woman has a mental problem, but one must apply approaches that empower women," noted one clinician. Another respondent wrote, "[The Bahá'í Faith] assists me to relate to people of diverse background, stresses the value of each human life [...] and encourages me to empower women." An example of the commitment to unity as important to mental health is reflected in the effort to unite children and their families in the course of therapy. One respondent affirmed, "I strive to incorporate Bahá'í

values in my approach to family and couples counseling. For example, I strive to ascertain how much clients value family unity, and if they highly value this, I strive to incorporate interventions that will promote this.”

BMHPs’ Experiences Using Spiritually Integrated Interventions in their Practice

Only 25 out of 38 Bahá’í mental health practitioners (66%) responded to the question, “Can you think of a situation where you utilized a spiritually integrated intervention with your client who has a spiritual/religious concern?” The respondents were also questioned about the outcome and description of the interventions they utilized by relating their particular experiences.

One respondent admitted that he/she could not think of anything, while another asked for clarification of the meaning of the term “spiritually integrated intervention.” Of 23 experiences recounted, 15 included the outcomes of their experiences; two of these reported experiences with negative outcomes. Below are some of the practitioners’ experiences validating most of the spiritual integrated interventions identified previously by the respondents. For the remaining Bahá’í practitioners’ experiences please see Appendix 2.A.

I have also worked with clients who found the religious communities they grew up in to be very abusive, including several clients who were molested by religious leaders, and often explore with these clients what their faith in God is, and help them explore different religions and philosophies to find their paths to God. [*Clarifying the role of client’s faith*]

My client's husband was approaching death. I used the Bahá’í metaphor of an embryo in the womb and a person in this realm preparing for the next life. My client was greatly relieved and thanked me profusely for the intervention. It was satisfying and reassuring for me and for my client, and relieved her considerable anxiety. [*Use of spiritual metaphors*]

Most of my counseling was during the earlier years of my career, in public institutions. Discussions on religion or spirituality were discouraged, so I drew a solid line between my spiritual life and my work life. Later in life, as I began my private practice, I included questions about religion and spirituality in the early

assessment stages. This led to more opportunities to integrate spirituality into the treatment plan. [*Spiritual assessment*]

I sometimes use sound therapy and chant, and knowing the client's spiritual roots helps me to tailor the chants to their tradition. In one case, a Native woman who had been badly abused was able to cry and release repressed emotion when I began using Native chants. [*Spiritual practices (e.g., Native American chants, sound therapy)*]

Encouraged two clients who were angry with God to start meditating, and they gradually came to a more accepting place (towards themselves, God, and others). [*Meditation*]

A woman who had lost her grown son in a medical accident was deeply distressed and angry that God would have allowed her son to die before her. I suggested that she write a letter to God regarding her anger with Him. Later, after she experienced relief from this action, I suggested that she write herself an answer to that letter. This answer was prompted by prayerful reflection on how God would have seen her situation. She experienced this response as tender and genuinely concerned with her pain. [*Letter writing as a self-reflection tool*]

Working with a woman who has negative self-esteem, was depressed, despairing, and suicidal. She openly spoke of her Christian faith, had recently starting attending church again, and her thinking that God would be OK, would understand her ending her life. Over several sessions and a couple months of gently challenging her giving herself permission to commit suicide, with references to God's love for us, that our lifespan is God's prerogative, we are given our life to serve God by serving others. So far, she has reached out to others in her church community and has begun the process for volunteering with the Red Cross on the local Army base to help others, especially those affected by domestic violence. [*Belief in God by encouraging acts of service*]

One Bahá'í mental health practitioners related how spiritual interventions either failed or were inappropriate in the following experiences:

One adult client who abused his children had spiritual/religious concerns of a delusional nature, refused psychotherapy, and was non-compliant with all parts of his treatment plan. I did not address these delusions directly, as I did not feel religion was at the core of the problem. [*Spiritual intervention was not used with an abusive client with a delusion*]

BMHPs' Responses in the Comments Section

Out of 38 participants, 22 (58%) provided feedback in the comments section. The researcher classified the respondents' remarks under three categories: 1) explaining in detail what they do, 2) seeking clarification about the content of the survey, and 3) giving positive impressions of the study.

Seven Bahá'í mental health practitioners further explained what they do. The first respondent clarified how clients seek him out because of his respect for all faith traditions. He added, "As a Bahá'í, whatever faith a client is pursuing that is helpful to them, I am responsible in reinforcing that belief." The second respondent elucidated a similar stance. He said, "My use of religious beliefs and spiritual guidance are used indirectly (e.g., I use principles[,] interweave concepts without particularly stating it is a religious belief). If the concept is pertinent, it is integrated without drawing attention to it necessarily. I do not bring up religion; I follow the client's lead and respond with concepts in a general sense." A third respondent provided a short discourse on the intersection of trauma with spirituality. He explained, "I created a course in Spirituality and Trauma for the X Center in Y State associated with Z Hospital. It is continuing. When people are traumatized, they often ask life questions that are spiritual in nature, like what is the meaning of suffering, how could a good Creator let bad things happen, why did this happen to me, etc."

The use of pharmacology was mentioned by the fifth respondent, who disclosed that she did provide other interventions mainly due to a therapeutic practice that is principally driven to use pharmacotherapy along with some supportive psychotherapy. Under a similar view, another respondent expressed a wish for a systematic training in the use of spiritual resources in therapeutic intervention, but from a source that was not in any way dogmatic.

Interestingly, the seventh respondent provided an explanation for a question regarding religious conversion. She shed light on this topic by explaining, “I did, in fact, convert from Christianity to the Bahá’í faith, though I don't technically believe in the concept of conversion. I believe, especially from a Bahá’í perspective, that the more correct term for me would be that I ‘expanded’ upon my faith as a Christian to become a Bahá’í, since I still believe Jesus was a manifestation of God.”

Eight Bahá’í mental health practitioners asked for more clarification regarding the survey. Four respondents questioned the meaning of the “appropriate” and “inappropriate” variable. One respondent argued that the appropriateness of an intervention would depend on the setting, even if she thought it would be a good intervention for the client. Another respondent noted that the appropriate/inappropriate category would depend on the client. He explained, “Appropriate/inappropriate really depends on the client. For some clients, having a discussion about God's purpose for their life is very appropriate—it fits their belief and language constructs, but another client may have no connection to God, and such a discussion would be inappropriate.”

Two respondents had questions about the “frequency” dimension of the variables. One explained, “The questions were hard to decipher. The response 'very often' seemed confusing. I did not know if it meant - does the situation come up in my therapy often or if it meant - when it comes up, I very often respond that way. This would be a hard survey to formulate questions for and I think the later questions began to get at measureable aspects of spiritually integrated therapy.” The second respondent remarked that the questions were not clear and suggested that the survey should only be asking for “frequency” and not “appropriateness.” Finally, one respondent concluded that not all questions apply to every practitioner.

Eleven Bahá'í mental health practitioners provided a few positive impressions about the survey. A majority of these respondents wrote that this study should be known in academia and to mental health practitioners. They felt it contained very good questions and a great line of inquiry. All were interested in the results, and some had suggested that they be presented to the Bahá'í Association of Mental Health Professionals.

CHAPTER VII

DISCUSSION

One broad purpose of this study was to address gaps in the literature regarding the use of spiritually informed practices in the promotion of mental health. To date, this project represents the first reported study of mental health practitioners on the use of spiritually integrated interventions by a group that belongs to the Bahá'í Faith. Specifically, the study provided the following results: a) a general description or profile of Bahá'í mental health practitioners (BMHPs) in the United States; b) information about the intrinsic religious motivation of Bahá'í mental health practitioners; c) Bahá'í mental health practitioners' use of spiritually integrated interventions in mental health practice; and, d) information about Bahá'í mental health practitioners' appropriate or inappropriate use of spiritually integrated interventions.

Who are the Bahá'í Mental Health Practitioners?

Much is still unknown by either the general public or academics about the Bahá'í religion, much less Bahá'í mental health practitioners. In fact, only two articles on counseling Bahá'í clients (Maloney, 2006a; Maloney, 2006b) were found in the mental health literature and these articles did not include the perspective of Bahá'í practitioners. Who Bahá'í mental health practitioners are and what they do matters to the mental health community because they provide valuable services to vulnerable populations. The interventions that the Bahá'í practitioners utilized, as succinctly demonstrated through their brief experiences with clients in this study, provided us a glimpse into their contributions. Tapping the only existing Bahá'í mental health professional organization in the United States yielded first-time data, a product that was not easy to find. This research provides a baseline for the organization's future explorations in the field of spirituality and mental health practice. Examining spirituality around mental health issues has

been a challenge because it poses questions about ethical values and principles that may have implications for the delicate balance between the practitioner's personal spiritual meaning and fulfilling one's professional role. The Bahá'í mental health practitioners are unique in their openness in sharing their practice and taking the time to explore their spiritual beliefs (Decker, 1995).

Parallel to the studies by Sheridan (2004), Stewart et al. (2006a), and Frazier and Hansen (2009), a majority of Bahá'í mental health practitioners who served as subjects in this study were social workers and psychologists rather than counselors, psychiatrists, family therapists, or other professionals. While this fact reflects the present population of mental health service providers in the United States, future discussions should also include an increasingly growing number of counselors, family therapists, psychiatrists, and other professionals who provide therapeutic interventions with clients. Are they also incorporating spirituality into their work? Similarly, it would be important to explore the perspectives of practitioners of other faiths. Only a handful of researchers, including Hodge (2005b), Hodge (2005c), Sheridan (1992), and Stewart (2006), have explored the works of mental health practitioners who are from predominantly Christian faiths. To confirm similar data on the use of spiritually integrated interventions, qualitative research will have a major role in understanding the insights and narratives of Bahá'í practitioners, as well as other practitioners whose faiths play a crucial role in mental health practice.

The subjects for this study were drawn from two strong professional groups (social work and psychology) with well-established national and global affiliations and an altruistic, justice-centered, and autonomous professional history. For example, extant literature describes how early social work leaders with strong spiritual motivations for service intimately connected their

practice to religious and spiritual traditions (Stroup, 1986). We have found outstanding examples of these pioneers in the field of social work, such as Jane Addams, the founder of Hull House, who promoted social justice through non-sectarian and humanistic approaches. Yet, behind the Settlement House concept was a religious act of service to society (Bruce, 1966). It is indeed undeniable that the roots of social work were often animated by spiritual or religious commitments. Reinforcing the purpose of this study has been the added value of exploring how Bahá'í mental health practitioners express their spiritual or religious beliefs in clinical practice.

The primarily private for-profit practice of BMHPs is comparable to the predominantly private practice of social workers in the United States, as previous studies have indicated (Sheridan, 2004; Stewart et al., 2006). Private practice allows for greater flexibility in the application of spiritually informed interventions with clients. This type of practice could also account for the Bahá'í practitioners' frequent use of spiritually integrated interventions. In addition, the BMPHs have over 13 years of experience, a factor that is highly valued in this society, wherein professions in mental health with many years of experience and practice in the field are favored. Numerous spirituality research studies by psychologists, professional counselors, and social workers (Heyman, Buchanan, Musgrave, & Menz, 2006; Mattison et al., 2000; Sheridan, 2004) have also revealed respondents who have had more years of experience and have been older.

Spirituality-Related Variables

Contrary to other studies (Delaney, 2007; Stewart et al., 2006) of mostly Christian-schooled respondents, the Bahá'í mental health practitioners in this study attended secular schools for professional training, are mostly converts from other religions, were more "secular" in training, and used spiritually integrated interventions more frequently. Further exploration of

these variables suggests that it is most likely the personal religiosity of the therapist rather than the type of graduate school program that indicates a strong correlation for incorporating spiritual interventions in therapy (DiBlasio, 1993; Hales, 1996; Prest et al., 1999).

Similar to the literature on religious conversion (Gillespie, 1991; Paloutzian, 1981), BMHPs tended not to be born into Bahá'í households that may have otherwise influenced their choice of adopting the Bahá'í faith. Multiple psychologies of conversion abound in the literature, but there is a shortage of empirical data on respondents who are professionals and who belong to one religious affiliation. Further insights into the general conversion experiences are limited to anecdotal statements of the Bahá'í respondents. What is notable about Bahá'í conversion is that it differs significantly from the colloquial understanding of religious conversion in the United States. Some think conversion means -- a born-again experience or some phenomenon that occurs in a revival meeting. Bahá'í conversion, it seems, tends to be motivated by attraction to a belief system that values unity, as expressed by some respondents. Hatcher (1980) expounded on an integration of science and religion, a commitment to both rationality and mysticism, and so forth, which may help clarify reasons for Bahá'í conversion. Furthermore, this conversion is about developing what Emmons (1999) describes as spiritual intelligence. Psychologists have been working on identifying the roots of human motivation, or the springs of action that drive us (Rambo, 1998). Rambo further explains that these motivational structures -- e.g., to become a better person, to work on personal attributes -- are fundamental human needs that lead us to enter a new religion by different options or avenues, whether intellectually, emotionally, or through love in our hearts. The conversion process from the Bahá'í perspective is another area that needs further attention.

Similar to two studies (Murdock, 2005; Sheridan, 2004) that confirmed the importance of attending professional development where spirituality or religion is concerned, it seems quite clear that BMHPs have very often given a great deal of attention to spirituality or religion in their courses or fieldwork. In addition, they have often attended continuing education workshops/conferences on spirituality in mental health and read professional journal articles or scholarly writings that deal with spirituality and mental health practice. Contrary to previous research on the lack of attention to professional education in spirituality, however, (Furman, Benson, Grimwood, & Canda, 2004; Murdock, 2005; Sheridan, 2004; Sheridan & Amato-von Hemert, 1999; Sheridan et al., 1992; Sheridan et al., 1994), BMHPs in this study were evidently attuned to enhancing their skills by staying current with issues on spirituality and religion.

Two considerations regarding professional practice are relevant here. One, regardless of professional background -- e.g., social work, psychology, counseling, family therapy, or psychiatry -- Bahá'í practitioners seem to show strong fidelity to their Code of Ethics. Mostly licensed, they are obligated to follow their professional Code of Ethics, which encourages competence within the boundaries of their education and training. Furthermore, the Code succinctly explains that social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, *religion*, immigration status, and mental or physical disability" (NASW *Code of Ethics*, Cultural Competence and Social Dignity section (1.05c), p. 199) (emphasis added by author). The Bahá'ís did exactly what had been prescribed — they focused on education or training in order to understand the role of religion in their jobs. Second, in this 21st century practice, religion and spirituality have permeated the global community such that by learning about a diversity of

faiths, Bahá'í mental health practitioners enhance their commitment to preparing for the challenges ahead. This recognition reinforces the guidelines for a culturally competent mental health practice for broader society.

High Intrinsic Motivation

Encouraging the participation of other religious affiliations or religious diversity in research, while uncommon, is not a new concept in the research on spirituality. As Lovejoy (1920) asserted, “Regardless of formal religious commitment, the social worker, and the social reformer were in the line of the devoted, the communion of those who did good works” (as cited in Chambers, 1963). In this regard, the Bahá'í professionals' motivations are not far from those of the eminent founders of professions like social work. Although measures of past research on religiosity or religious commitment were based on more explicit expressions of religiosity, such as attendance in church and participation in religious activities, expressing intrinsic motivation for this research provides another approach to understanding how religious identity is articulated.

Bahá'í mental health practitioners' choices of the highest intrinsic variables, such as “My faith involves all of my life” or “One should seek God’s guidance when making every important decision,” indicate the depth and breadth of their religious commitment to their faith. But Bahá'í mental health practitioners seem to explore other avenues of religious motivation as indicated in their high extrinsic response, “It doesn’t matter so much what I believe as long as I lead a moral life.” This extrinsic statement seems to express the BMHPs’ openness to beliefs other than their faith, as long as they follow their internal moral compass. Now, considering that the Bahá'í Faith promotes the oneness of religion, this statement may have some impact *on the promotion of this principle* or perhaps, an expression of confidence and flexibility in approaching human reality. That reality, as expounded in the Bahá'í Faith, also urges its members to follow moderation in

thoughts and actions; it discourages the believers to be fanatical in their expression of faith. As previously mentioned, the BMHPs had more years of life experience. As with people who have been through life experiences, their approach through life perhaps becomes more practical and their beliefs, while steadfast, may have become more gentle and compromising with age.

In addition, Bahá'í mental health practitioners also evidenced high intrinsic motivation by explaining that their religious beliefs influence their mental health work. Their belief in the inherent intrinsic value of a human being (e.g., client) and the synonymous parallelism that all therapeutic work is spiritual in nature were noticeably integrated into their practice.

Frequent Utilization of Spiritually Integrated Interventions

The RSPBQ of 29 interventions fit well with the behaviors that this study wishes to explore. We have found that Bahá'í practitioners “often” to “very often” utilize spiritually integrated interventions in contrast with Frazier and Hansen’s (2009) original survey of professional psychologists, rating them as only “infrequently” ($M=2.67$, $SD=0.6$) used. The most-often used and the highest-ranked interventions in the Bahá'í study were almost similar to the highest scores in Frazier and Hansen study. Four other most frequently practiced behaviors when ranked together as a cluster of behaviors were indisputably client-centered. The respondents chose these behaviors or activities with more consideration for the client’s input and choice for how their therapy should be regarded. This critical evidence of client choice of using spiritually integrated interventions is central to this research. Two examples are worth mentioning here. Bahá'í practitioners who participated in this study tended to recognize the importance of gathering information about the client’s spiritual commitments and concerns during the initial intake process of history-taking. They also reported the tendency to explore the family’s thoughts on spirituality and religion. These interventions mirror the same activities of

studies done by Sheridan (2000), Sheridan, Bullis, Adcock, Berlin, & Miller (1992) and Derezotes (1995).

Concerning the five least frequently used practice interventions on the RSBPQ Index, Bahá'í practitioners identified “referring a client to a more religiously/spiritually qualified provider” as least practiced, contrasting with numerous studies (Canda, 1999; Mattison et al., 2000; Murdock, 2005; Sheridan, 2004) that found this intervention as more frequently used. It is probable that Bahá'í mental health practitioners are secure with their skills and qualifications in providing spiritual interventions. Their high frequency in giving attention to professional education (e.g., courses or fieldwork, attendance at workshops/conferences on spirituality in mental health, and reading professional journal articles or scholarly writings) may have boosted their confidence in meeting the challenges, subtleties, and nuances of religious practices. Rather than referring clients to providers with specific religious orientations, the BMHPs utilized their skills with a much more open approach to incorporating spirituality into their practice. This demonstration of self-assurance seems to solidify the Bahá'í religious orientation of embracing all faiths and implementing its core value of “unity of all religions.”

Adding up to the Bahá'ís practice on the principle of “independent investigation of truth” (Bahá'í International Community, 2011) is that the practice of no designated “spiritual leaders” or hierarchical systems of clergy, which could also affect the BMHPs’ concern in referring clients to providers with specific religious orientations. As well, the BMHPs may be exercising some prudence in their referrals to clergy or spiritual leaders. One Bahá'í practitioner briefly discussed a client’s trauma because of a clergy member’s or spiritual mentor’s abuse. On the other hand, not referring a client with specific religious needs to a religiously oriented provider may halt or impede the momentum of the client-worker relationship, resulting in the loss of the

BMHP's opportunity to fully assist the client with his or her spiritual issues and questions. The practitioner's professional competency could potentially be questioned in the process. Consultation with the clergy or other religious providers might be supportive in implementing spiritual interventions where the clients' spiritual practices match those of their spiritual providers.

Unlike in the Frazier and Hansen study (2009) in which the intervention "to initiate and explore religious/spiritual differences between therapist and client" was ranked as a highly utilized behavior, the BMHPs ranked this intervention as least-utilized. Again, the BMHPs may be looking for areas in which to find commonalities or points of unity rather than differences in order to move the therapeutic process forward. Therefore, this intervention was not considered high on their list of most utilized techniques.

Related to the BMHPs' practice, one study (Sheridan et al., 1992) found a similar level of utilization of the intervention "to promote autonomy and self-determination of highly religious clients, even when their values differ from one's own." This least-utilized intervention seems to present a gap in exercising the principle of client self-determination as espoused in the NASW's (1999) or the American Psychological Association's (2002) Codes of Ethics. If not used, this intervention could present some important ethical and boundary issues, which need to be examined more closely.

Similar to Frazier and Hansen's study (2009), the BMHPs identified the intervention "to develop and implement a professional development plan to improve one's religious/spiritual psychotherapy competence" as least-utilized. It appears that the BMHPs have somewhat overlooked the role of professional development in their practice. This neglect becomes a potential double-edged sword; while the BMHPs' self-belief in the utilization of spiritually

integrated interventions was consistently high throughout the study, not being mindful of the importance of professional planning and competence could be an issue for this group. Several studies (Hodge, 2004; Mattison et al., 2000; Sheridan et al., 1992,) find spiritual practice an important resource to support the bio-psychosocial and spiritual needs of clients, indicating that social workers and other mental health practitioners should develop a sound professional knowledge from a multicultural perspective (Hage, Hopson, Siegel, Payton, & DeFanti, 2006).

The last least-used intervention by the BMHPs was to “make *DSM-IV-TR* (2000) diagnosis (2.36),” a behavior similarly identified as least-utilized in Frazier and Hansen’s study (2009). This response contrasts with the Lukoff et al. study (1996), in which the researchers reported 60% of social work respondents provided attention to and familiarity with *DSM-IV-TR* (2000). The Lukoff et al. study (1996) further concluded that because the respondents were familiar with the DSM Code, they were able to bring one-third of their clients with religious or spiritual issues into their practice. Using the DSM Code is critical to assessment particularly with problems that are associated with spiritual questions but do not pertain to organized faiths or issues of conversion to a new faith. This intervention falls within the domain of therapists regardless of their religious or non-religious affiliations. Furthermore, attending to clients’ spirituality or faith issues in general also strengthens the professional sensitivity to diverse worldviews that are continuing to emerge in a global society. Unless the BMHPs have another way of providing a universal alternate assessment of understanding the typology or nature of clients’ spiritual problems, “making a *DSM-IV-TR* (2000) diagnosis” may still be the primary and conventional way to satisfy the requirements of a managed healthcare program. This convention may not be an issue if the Bahá’í practitioner’s practice, which is predominantly private, does not rely on managed care for fees. This area needs to be studied further.

Utilization of Other Spiritually Integrated Interventions

BMHPs utilize other interventions that were not included in the RSPBQ. Because this study represents the first mental health research on Bahá'í practitioners, the inclusion of some of these spiritually integrated interventions in their practice may not necessarily reveal behaviors that are distinctively Bahá'í. In fact, out of 19 additional spiritually integrated interventions identified by BMHPs as frequently utilized, this study revealed three interventions that have not been mentioned in any other previous research. The following interventions are included: (a) Using the Family Virtues Guide (Popov, Popov, & Kavelin, 1997) with couples and families, an evidence-based intervention tool that has reached a global grassroots level in some countries of the world;(b) Using some worksheets and materials that explore clients' spiritual beliefs and values developed by practitioners of Dialectic Behavior Therapy (DBT), an evidence-based intervention that assists in client regulation of emotion by combining mindfulness and stress reduction; and (c) Using Somatic Experiencing, an evidence-based brief stabilization model now called the Trauma Resiliency Model™ (TRM) (Leitch, Vanslyke, & Allen, 2009) and a neurobiology-based somatic approach to working with trauma on clients (Heller & Heller, 2004).

Interestingly, BMHPs currently utilize evidence-based interventions in their mental health practice. Competency in mental health is now moving in the direction of evidence-based practice where intuition, accessibility, sound, and careful evaluations are indispensable ingredients to a successful implementation of interventions. In social work practice, for example, there is a gap in the use of evidence-based interventions that brings about confusion in the profession. The absence of a framework for an effective evaluation denies the essential intuitive character of social work (England, 1986). BMHPs seem to be on the right track in providing empirically validated interventions to their clients. How these interventions are utilized within

the same gold-standard testing and evaluation for evidence-based practice is an area that needs to be researched in the future.

The “use of prayers” has repeatedly been reported as an intervention by some Bahá’í practitioners. This activity is sometimes used along with meditation and mindfulness. Prayers are used at different times by Bahá’í practitioners. Several studies support the use of prayers (Mattison et al., 2000; Richards & Bergin, 2005; Wagenfeld-Heintz, 2009) as an intervention. However, other studies question how the intervention used. This intervention is a study in itself that must be explored in the future.

Limitations

Findings of this initial research must be interpreted from the point of its limitations. These limitations primarily involved sampling issues, data-collection methods, and scales used. First, the study utilized a purposive sampling of a group of practitioners who have a religious affiliation that has not been known in the field of academia, research, or mental health. This fact posed a challenge as to where to get a good enough sample to draw acceptable participation of a specialized group. This researcher relied on the membership of only one existing Bahá’í professional organization that is known in North America. It is likely there are many more Bahá’í mental health practitioners who are not members of the Bahá’í Association of Mental Health Practitioners. For this study, the target population was only a little over 100 members. Not all of them met the criteria for this research. As an example, practitioners who may have had years of experiences but did not have a masters degree were eliminated from the study. The sample was a small, predominantly female, Caucasian, and significantly older group of respondents. As such, the respondents may not be representative of all Bahá’í mental health practitioners.

Secondly, although the sample size of the group includes an acceptable number of participants (36.2% of all those solicited for participation), the relatively small sample size does not permit generalizability of findings. Those who responded may have more interest on the topic since the research involves their faith in relation to professional practice. On the other hand, those who did not participate may have done so for personal as well as professional reasons -- e.g., too busy to fill out the survey or did not meet the criteria for this research. This researcher also sensed that some respondents “rushed through” some of the questions or did not finish completing the survey. In fact, three questionnaires had to be thrown out because of their incomplete responses.

Thirdly, the use of REDCap, a web-based survey tool, produced data based solely on self-reports of Bahá’í mental health practitioners as opposed to an approach that incorporated observable behaviors. In addition, this study did not include the perspective of the practitioners’ clients, who otherwise could provide this research with a second view to affirm what the practitioners utilize from the client’s view. As with any methods that involve a self-reporting system, this research could embody a social desirability bias. Specifically, it might have been limited by respondents’ ability to go online, possibly eliminating those respondents who may have been “technologically challenged.” In the past, social science professionals were more oriented toward face-to-face conversations or pen-and-paper surveys. An online web survey could have been daunting to these respondents.

Fourth, the formatting of the RSPBQ scale used in the survey may not have been user-friendly for all the respondents. Some respondents missed filling out the appropriate/inappropriate categories because they were placed in the same row as the Likert scale for each of the spiritually integrated interventions. Had this researcher repeated the scale, with the first part asking the

respondents about their use of the spiritually integrated intervention and the second part asking about the appropriate or inappropriate use of intervention, this problem could have been prevented.

Fifth, the survey format itself, particularly the two sections just described that involved the use of spiritually integrated interventions, could have been piloted to a larger number of people, instead of only four persons. This step could correct possible biases or improve on the survey format. As it turned out, a few respondents offered suggestions and questions regarding the RSBPQ only after the survey was filled out.

Sixth, while this research identified the frequency and appropriate uses of spiritually integrated interventions, it is not clear whether these interventions were effective for the clients. Seeking feedback from clients about the effectiveness of these interventions would be a critical next step for future research.

Finally, during the REDCap data entry, the researcher inadvertently excluded one of the intrinsic statements based on Hoge's 1972 Intrinsic Motivation Scale. Hoge's intrinsic scale consists of 10 statements, seven intrinsic and three extrinsic. To determine the validity of the scale in spite of this limitation, Cronbach alpha was generated. Table 7, shown below, provides previous validity results from scales where Hoge's scale was originally used, adapted, or modified.

Table 7

Validity of Various Forms of Hoge's Scale

Allport and Ross's Religious Orientation Scale (1967) and adapted by Hoge in 1972	Cronbach alpha= mid .80's
Hoge and Carroll Six-Item Intrinsic Religious Motivation Scale (1972)	Cronbach alpha = .84
Hodge's Religious Orientation Scale and adapted scale of Allport and Ross (2003)	Cronbach alpha= mid .80's
Hoge's Intrinsic Motivation Scale with One Item missing (1972)	Cronbach alpha =. 81

Based on the above table, there does not appear to be any significant difference between the four scales. Hoge's scale with one missing item has strong validity with scores that are close to the first three studies' Cronbach alphas (Allport & Ross, 1967; Hoge & Carroll, 1972; Hodge, 2003).

CHAPTER VIII

CONCLUSION

One hundred five Bahá'í mental health practitioners (BMHPs) working in the United States responded to a questionnaire that explored three areas—religious motivation, use of spiritually integrated interventions, and spiritual beliefs. Findings from this pioneering exploratory study of BMHPs revealed that these professionals' outlook on and use of spiritually-integrated interventions are similar to those of the more widely studied Christian-based practitioners, and in a few ways, different. Specifically, Christian and Bahá'í practitioners *actively communicate respect for clients' religious/spiritual beliefs and ask religious/spiritual questions to assess clients' religious/spiritual involvement*—interventions that help build rapport and establish the client-worker relationship. Similarly, the *use of prayer as a psychotherapy intervention* is equally common for Bahá'í and Christian practitioners. One of the least utilized interventions for both groups, however, is *the promotion of autonomy and self-determination of highly religious clients, even when these values differ from the practitioners*. Another least utilized intervention identified by both groups is to *develop and implement a professional development plan to improve one's religious/spiritual psychotherapy competence*. A final least utilized intervention for Christian and Bahá'í practitioners is *to make the DSM-IV-TR (2000) diagnosis*, a behavior that is critical to client assessment and intervention.

There are differences between Christian and BMHPs in their selection of interventions. Christian practitioners often *initiate and explore religious/spiritual differences between therapist and client* while Bahá'ís identified this intervention as least utilized. Likewise, Bahá'í practitioners do not frequently *refer a client to a more religiously/spiritually qualified provider*—an intervention that is often used by Christians.

BMHPs work for practical reasons. They use spiritually integrated interventions (i.e., conventional therapeutic modalities and interventions grounded in research and evidentiary-informed practice), which promote science and realism on the one hand, while valuing the spiritual attributes of their clients and embracing their own intrinsic spirituality on the other hand. Bahá'í practitioners attempt to provide mental health within a framework that promotes the harmony of science and the use of evidence-based interventions as well as the religion and/or spirituality of both the client and the worker.

There is growing awareness across the field of mental health that clients may need assistance tapping into their spirituality in successfully addressing their mental health challenges. Indeed BMHPs, like other professions in social work, counseling, and psychology, are increasingly exploring the role of spirituality and religion in their work as therapists. For BMHPs, the assumption of the client as a spiritual being underlies the client-worker relationship; thus, it is an important factor in mental health practice. As one Bahá'í practitioner articulates, “I see clients as ‘spiritual beings’ or ‘spiritual beings having a human experience.’” Indeed, these practitioners see the spiritual well-being of clients as an indispensable component of total wellness. BMHPs recognize the inherent intrinsic value of human beings in relation to the capacities of the soul. Another respondent succinctly refers to clients as “my fellow souls on a spiritual path, not pathological patients whom I am supposed to fix.” This expanded perspective on how mental health practitioners might view clients is a significant contribution of this research.

The BMHPs interviewed in this study also indicate that they recognize the inherent intrinsic value of *a spiritual self*, that searching for *authenticity*. If Bahá'í practitioners help cultivate the spiritual side that life offers, the individual in therapy may develop or advance his

or her inner capacities and qualities—attributes where human happiness emanate. The reason Bahá'í practitioners strive to develop themselves is so they may discover or unlock the mysteries, capacities, and psychosocial and spiritual strengths inherent in their clients.

Several new themes emerge from this study of Bahá'í practitioners. One example is a description of mental health practice as service. These practitioners articulate therapy more as service to others than a job or a vocation. Bahá'í respondents describe the value of their mental health work in the highest terms, the ability to help others as almost a form of worship. This new way of thinking about how a job may be accomplished from a spiritual perspective is a recurring theme throughout their discussion. This is an area worthy of further exploration in that it could potentially impact the goals of the client-worker therapeutic relationship.

Similarly, when Bahá'í practitioners provide service to their clients, they also think about the afterlife as an approach to creating an organic paradigm about how life should be perceived. Respondents see their and their clients' lives as connected to the afterlife, working synergistically in a process of discovering both their paths and journeys in this world and beyond. This perception of connectedness in life and the afterlife considerably impacts a client-worker relationship.

At the same time, the Bahá'í practitioners studied here also hold firmly rooted respect for empirically based practice. This balance of work as worship with work *informed by science* may be unique in the field of mental health. Further study is needed to see if other practitioners see their work similarly.

Understanding the mutual relationship between worker and client is a critical component to therapy. Baha'is, like all practitioners, can increasingly benefit from open explorations of their client's spiritual needs and related professional development in matters of client mental

health. As such, this study suggests that the values and beliefs of both the worker and client who seek spiritual interventions are important in assisting the latter in establishing a therapeutic process. Thus, this research highlights how a mutually enhancing interactive process is paramount in mental health practice, particularly when spiritually integrated interventions are utilized. This study of BMHPs provides us with anecdotal experiences that might inform future practitioners. A beginning framework on how a relational process may be employed with spiritually integrated interventions is presented here. The framework is based on the themes and issues that emerged from the review of literature and content analysis of this study's respondents. (Please refer to Figure 6 below.) In summary, the use of spiritually integrated interventions, by definition, not only includes strategies, tools, and techniques, but also behaviors and perspectives that bring about an active pursuit of an authentic relational process.

Future Research

Bahá'í mental health practitioners appear more likely to meet the requirements of continuing education in the area of education in spirituality and religion. Further research is needed to explore the reasons for this phenomenon, including a comparison study of how other mental health practitioners act in response to meeting the requirements of continuing education in spirituality and/or religion.

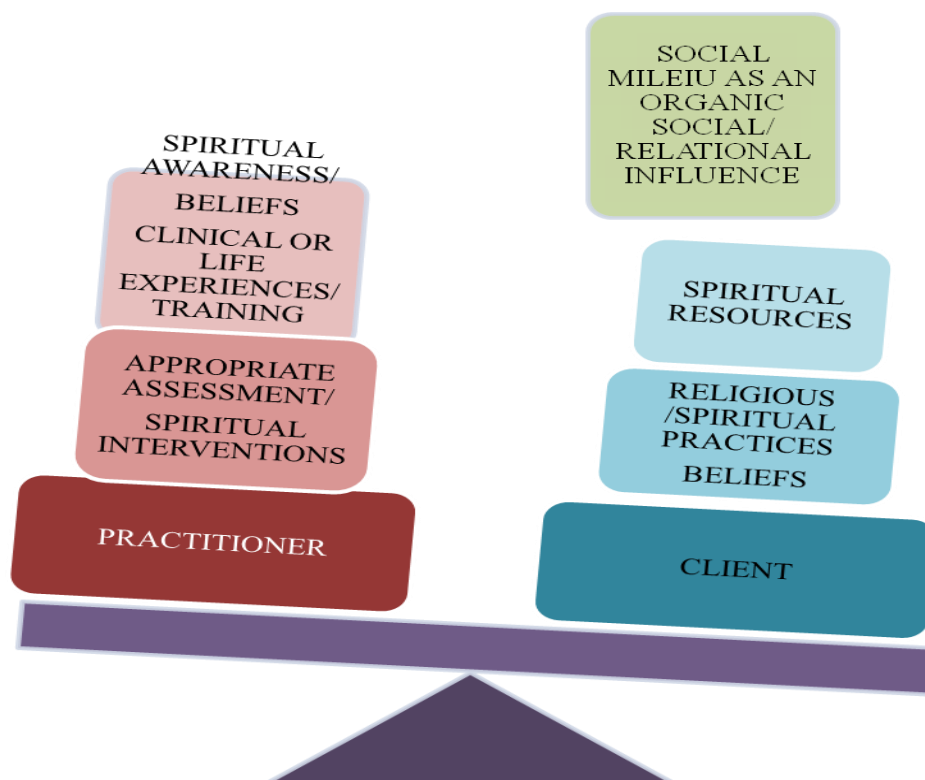
Bahá'í mental health practitioners seem to show a high utilization of spiritually integrated interventions, according to the scale used for this study. Furthermore, the Religious/Spiritual Psychotherapy Behaviors Questionnaire or RSPB that was originally used for a cohort of psychologists seems to be sufficient for the goals of this study. Expanding the scale to include other interventions that were identified by the Bahá'í practitioners would further enhance the application of the scale, a goal that needs further research with a larger sampling of respondents.

Further research is needed to see whether their high intrinsic religious motivation and/or other variables have some impact on their frequent use of interventions. On the other hand, because of a lack of patterns or norms in BMHPs' appropriate use of interventions, this study cannot make strong generalizations as to whether they judge such interventions as appropriate or not appropriate. Again, a rubric of this category needs to be explored. Future research should also ask for anecdotal experiences of those clients who have requested for spiritually integrated interventions from Bahá'í mental health practitioners. This exploration should fill the gap of the framework that has been suggested in this research.

While BMHPs seem to be attuned to the importance and implementation of evidence-based interventions in their practice, future research should also explore other spiritually integrated interventions mentioned in this study in order to elevate professional credibility backed up by a sound evidentiary practice. For example, how is the use of DSM IV-TR useful as a spiritually integrated intervention? Is the use of prayers (by both clients and workers) an effective tool in mental health? How are ethical issues and boundaries addressed when using spiritually integrated interventions? How is the principle of self-determination addressed by practitioners of highly religious clients? Many other issues can fill the gap of mental health concerns where evaluations and outcomes lead to efficacy and viable solutions to mental health problems

Lastly, this study has delivered a unique understanding of a cohort of practitioners who belong to a religion that has not been previously studied. Their beliefs and values are interwoven within their practice, and their intrinsic motivation seems to reflect their boldness and confidence in utilizing spiritually integrated interventions. Such distinctive and diverse practice could add to the reservoir of skills available to mental health practitioners in the United States and the world.

As research is wide open for other multicultural practices, it would be crucial to find out what other local or global practitioners of diverse religions, such as Islam, Buddhism, Hinduism, Judaism, or non-religious practitioners like atheists, do with spiritually integrated interventions in their practice. Finally, it is hoped that this research opens the door for a more thorough investigation of both clients' and practitioners' practices in education, teaching, and instruction about the role of spirituality and religion in mental health and healing.



RELATIONAL PROCESS/THIRDNESS*

Figure 9. A proposed framework for utilizing spiritually integrated interventions in mental health practice. This framework shows on-going relational process between the practitioner and the client. This process is set in a balance to show that there are in fact several factors that contribute to the dynamic process. From the practitioner's perspective, spiritual awareness, beliefs, motivations, experiences and training may need to be considered before assessments and interventions can be fully understood as appropriate for the clients. On the other hand, the client brings in a set of religious/spiritual beliefs and practices, spiritual resources as well as the social-ecological influences that may influence the client-practitioner process.

Appendix 1A**Letter of Approval from the Institutional Review Board**

(Letter was emailed to Dr. R. Sands February 8, 2011)

University of Pennsylvania
Office of Regulatory Affairs
Yvonne Higgins, Executive Director Human Research Protections
Emma Meagher, MD, IRB Executive Chair
3624 Market St., Suite 301 S
Philadelphia, PA 19104-6006
Ph: 215-573-2540/ Fax: 215-573-9438
INSTITUTIONAL REVIEW BOARD
(Federalwide Assurance # 00004028)

08-Feb-2011

Roberta G Sands
Ssw - Caster Building
3701 Locust Wk
Philadelphia, Pa 191046214
Email: rgsands@sp2.upenn.edu
guiac@sp2.upenn.edu
PRINCIPAL INVESTIGATOR: ROBERTA G SANDS

TITLE: The Use of Spiritually Integrated Interventions Among Bahai Mental Health
Practitioners

PROTOCOL #: 813099

REVIEW BOARD: IRB #8

SPONSORING AGENCY: NO SPONSOR NUMBER

Dear Dr. Roberta Sands:

The above-reference protocol was reviewed by the Institutional Review Board (IRB) on 07-Feb-2011 and it was determined that the proposal either did not meet the definition of human subjects research or that it met the eligibility criteria for IRB review exemption, as authorized under 45 CFR 46.101 or 21 CFR 56.104(d). Previously, these proposals were granted approval

for a period of 3-7 years, after which an application for continuing review was necessary if the study was to be continued.

Consistent with the federal regulations, ongoing oversight of these proposals is not required. No future continuing reviews will be required for these proposals. All previously approved administrative and exempt proposals have been closed by the IRB. The proposals can proceed as previously approved by the IRB. This decision will not affect any funding of your proposal.

Please Note: There is no federal regulatory requirement for continuing review of exempt studies; however, you are required to report to the IRB any changes that might alter the study's exempt status or increase risk(s) to participants.

If your study is funded by an external agency, please retain this letter as documentation of the IRB's determination regarding your proposal. Please Note: You are responsible for assuring and maintaining other relevant committee approvals.

If you have any questions about the information in this letter, please contact the IRB administrative staff. Contact information is available at our website:

<http://www.upenn.edu/regulatoryaffairs>.

Thank you for your cooperation.

Sincerely,

IRB Administrator

Appendix 1B

Consent Form

Research Title: **THE USE OF SPIRITUALLY INTEGRATED INTERVENTIONS AMONG BAHAI MENTAL HEALTH PRACTITIONERS**

Introduction and Purpose of Study:

I am a graduate student in the Doctorate in Clinical Social Work (DSW) program at the University of Pennsylvania School of Social Policy and Practice. The survey that I am conducting is about Bahá'í mental health practitioners and their use of spiritually integrated interventions in their practice with clients who seek spiritual interventions in their recovery process. My proposal is under the supervision of a committee composed of two Penn faculty, and two outside experts, one of whom is a Bahá'í professor and member of the Bahá'í Association of Mental Health.

What is involved?

The survey will last for about 15 to 30 minutes. It will include 2 indexes and 4 open-ended questions. Demographic data will also be asked to establish a profile of practitioners.

Confidentiality:

The information you share will be kept strictly confidential. I will not share information about whether or not you participate in this project with anyone. I will only be interested in collective information in my write-up of the survey.

Nothing with your name or other identifying information (names and places mentioned in your example) will be cited in the results. Once I have analyzed the survey and written the final results for this project, I will keep the survey results in a secured/locked file for one year and destroy them by the end of 2011. I will remove anything that might serve to identify you, including geographic locations and names of particular individuals you might mention in the survey.

Risks of participating:

The risks of participating in this research are unlikely. The ways that confidentiality will be protected have already been described. In the unlikely event that you find that what you wrote is upsetting to you after the survey is over, please be in touch with me. I will provide you with some names and numbers of individuals or agencies that can provide further assistance.

Benefits of participating:

This is one unique opportunity to incorporate your insights among a cohort of Bahá'í mental health practitioners. As such, sharing your views regarding your own practice will advance the literature in mental health profession where religion, particularly the Bahá'í Faith, has long been neglected in the arena of client recovery.

Compensation: Instead of a personal compensation for each respondent, the researcher will contribute to the Bahá'í Association of Mental Health (\$300), offering that this small contribution will be used to assist future Bahá'í mental health conference presenters, researchers or other projects that will advance the knowledge and practice of mental health among Bahá'í.

If you have questions about the project after the survey is over, please feel free to contact me:

Guia Calicdan-Apostle

Doctoral Candidate

School of Social Policy and Practice

University of Pennsylvania

guiac@sp2.upenn.edu

(856) 981-9655

If after talking with me you have other concerns, you can contact my Dissertation Chair who is supervising this work:

Dr. Lani Nelson Zlupko

Assistant Professor

School of Social Policy and Practice

University of Pennsylvania

laninz@sp2.upenn.edu

Your participation is voluntary:

You do not have to participate in this project. There will be no negative consequences if you decide not to participate. Any program or agency that you work with will not know whether you participate or not. If you do not participate, it will not affect your job or anything else. If you do decide to fill out the survey today, you can stop the survey at any time. You can also refuse to answer any questions that you do not want to answer.

SIGNATURE OF THE CONSENT FORM (NOT SIGNING THE CONSENT FORM WILL INVALIDATE YOUR ANSWERS TO THIS SURVEY)

By signing this consent form, I am indicating that I have had all of my questions about the survey answered to my satisfaction and that I understood the agreement of this consent form.

Participant signature: _____

Participant printed name: _____

Date: _____

Appendix 1.C

Questionnaire

Instructions: Please answer all questions as frankly as possible. The purpose of this study is to find out how Bahá'í mental health practitioners utilize spiritually integrated interventions in their professional practice. This questionnaire is divided into three sections. Space is provided at the end for your comments.

Section I: Please provide the following demographic information.

1. Age: ____
2. Gender: ____ M ____ F
3. Racial Identity or Affiliation: __ Caucasian __ African-American __Asian __Hispanic
____Native American __Biracial __ (Please specify) ____ Other _____
4. What is your profession? (Please circle your answer).
 - a. Social Work
 - b. Psychology
 - c. Psychiatry
 - d. Counseling
 - e. Mental Health/ Psychiatric Nursing
 - f. Family Therapy
 - g. Other (Please specify) _____
5. Highest Level of Professional Education:
 - a. MS/MA/MS
 - b. Ph.D./DSW

- c. EdD
- d. Doctorate in Ministry or its equivalent
- d. MD
- e. Other

6. Do you have a license to practice your profession in the USA? (Please circle your answer)

- a. Yes
- b. No

7. What is your current practice setting?

- a. Public nonprofit
- b. Public for profit
- c. Private nonprofit
- d. Private for Profit
- e. Other (Please specify) _____

8. What field of practice are you currently involved in? (Please circle your answer/answers that apply to your practice)

- a. Mental Health
- b. Health Care
- c. Family Services
- d. Child Services
- e. Gerontology
- e. Substance Abuse
- f. Correction
- g. Private Practice
- h. Other _____

9. Years of Clinical or Direct Service Experience with Clients. (Please circle your answer).

- a. Less than 1 Year
- b. Between 2-4 Years
- c. Between 5-7 Years
- d. Between 8-10 years\
- e. Between 11-13 Years
- f. Over 13 Years

10. Was spirituality or religion given attention in your professional education (course or fieldwork) with clients?

Very Often	Often	Sometimes	Rarely	Never
5	4	3	2	1

11. Have you attended any continuing education workshops/conferences that deal with spirituality in mental health?

Very Often	Often	Sometimes	Rarely	Never
5	4	3	2	1

12. Have you read professional journal articles or scholarly writings that deal with spirituality and mental health practice?

Very Often	Often	Sometimes	Rarely	Never
5	4	3	2	1

12. What type of graduate school did you attend?

a. Religious _____ b. Secular _____ c. Don't Know _____

13. Were you born in a Bahá'í household?

a. Yes _____ b. No _____

14. Did you convert from another religion?

a. Yes _____ b. No _____

16. What religion did you convert from? Please specify. _____

Section II: Please use the following scale to indicate your response to each statement listed below:

1 = strongly disagree

3 = moderately agree

2 = moderately disagree

4 = strongly agree

	Strongly Disagree	1	2	3	Strongly Agree
1. My faith involves all of my life.		1	2	3	4
10. One should seek God's guidance when making every important decision.		1	2	3	4

2. In my life I experience the presence
of the Divine. 1 2 3 4

3. My faith sometimes restricts my
actions. 1 2 3 4

4. Nothing is as important to me as
serving God as best I know how. 1 2 3 4

5. I try hard to carry my religion over
all my other dealing in life. 1 2 3 4

6. My religious beliefs are what really
lie behind my whole approach in life. 1 2 3 4

7. It doesn't matter so much what I believe
as long as I lead a moral life. 1 2 3 4

8. Although I am a religious person, I
refuse to let religious considerations
influence my everyday affairs. 1 2 3 4

9. Although I believe in my religion,

I feel there are many more important
things in life.

1 2 3 4

THIS IS THE LAST SECTION. PLEASE CONTINUE TO ANSWER.

Section III. The following questions ask about how often you use the stated religious or spiritual interventions/behaviors with mental health clients who seek or prefer spiritually integrated interventions. Next, you are provided with two sets of letters- *A, which stands for Appropriate* and *I, which stands for inappropriate*. The following scale indicates your response to each statement listed below:

Very Often Often Sometimes Rarely Never Appropriate Inappropriate

5 4 3 2 1 A I

1. Actively communicate respect for
clients' religious/spiritual beliefs.

5 4 3 2 1 A I

2. Actively seek client feedback about
psychotherapy provided.

5 4 3 2 1 A I

3. Evaluate when one's religious/spiritual
values and biases negatively impact
treatment.

	5	4	3	2	1	A	I
4. Self-assess one's competence to counsel clients regarding religious/ spiritual issues							
	5	4	3	2	1	A	I
5. Promote autonomy and self-determination of highly religious clients, even when their values differ from one's own							
	5	4	3	2	1	A	I
6. Use clients' religious/spiritual strengths in treatment.							
	5	4	3	2	1	A	I
7. Modify treatment plan to account for clients' religious/spiritual concerns.							
	5	4	3	2	1	A	I
8. Ask religious/spiritual questions to assess clients' religious/spiritual involvement.							
	5	4	3	2	1	A	I
9. Use clients' religious/spiritual beliefs							

to help inform their decisions.

5 4 3 2 1 A I

10. Use extra-therapy resources to inform oneself about a client's specific religious/spiritual beliefs.

5 4 3 2 1 A I

11. Accurately determine when religious/spiritual beliefs are adversely affecting the client's well-being.

5 4 3 2 1 A I

12. Refer to local community resources (church, synagogue, religious professionals, etc.).

5 4 3 2 1 A I

13. Refer a client to a more religiously/spiritually qualified provider.

5 4 3 2 1 A I

14. Include religious/spiritual dimensions in case conceptualization.

5 4 3 2 1 A I

15. Use interventions that have been shown to be effective for individuals

with specific religious/spiritual beliefs.

5 4 3 2 1 A I

16. Help clients explore their religious/
spiritual questions in therapy.

5 4 3 2 1 A I

17. Strive to repair religious/spiritually
based mistakes in treatment.

5 4 3 2 1 A I

18. Use prayer as a psychotherapy intervention

5 4 3 2 1 A I

19. Help clients deepen their religious/
spiritual beliefs in treatment.

5 4 3 2 1 A I

20. Seek out religious/spiritual informed
case consultation.

5 4 3 2 1 A I

21. Seek out religiously/spiritually
informed continuing professional
education.

	5	4	3	2	1	A	I
22. Actively seek feedback on one's religious/spiritual psychotherapy competence from colleagues.							
	5	4	3	2	1	A	I
23. Develop and implement a professional development plan to improve one's religious/spiritual psychotherapy competence.							
	5	4	3	2	1	A	I
24. Initiate and explore religious/spiritual differences between therapist and client.							
	5	4	3	2	1	A	I
25. Self-disclose one's own religious/spiritual beliefs.							
	5	4	3	2	1	A	I
26. Use religious metaphors in treatment.							
	5	4	3	2	1	A	I
27. Make <i>DSM-IV-TR</i> (2000) diagnosis for religious/spiritual problem (V62.80).							
	5	4	3	2	1	A	I

28. Integrate religious/spiritual resources

into treatment

5 4 3 2 1 A I

29. Cite religious texts (i.e., scripture) in

treatment.

5 4 3 2 1 A I

Section III. Please answer the following questions as briefly as you can.

A. Did your religious beliefs influence your decision to practice as a mental health practitioner? Yes _____ No _____

B. If yes, how if at all, does your religion influence you in your mental health work?

C. What other spiritually integrated interventions, if any, did you use in your practice?

How would you rate this intervention using the same scale as above?

Very Often Often Sometimes Rarely Never Appropriate Inappropriate

5 4 3 2 1 A I

1.

2.

3.

D. Can you think of a situation where you utilized a spiritually integrated intervention with your client who has a spiritual/religious concern? What was the outcome of this intervention? Please describe your experience.

Comments:

Thank you for participating in this survey.

Appendix 1.D

Copy of Permission from Dr. Frazier, Author of Religious and Spiritual Belief and Practice

Questionnaire

----- Forwarded Message -----

From: "Royce Frazier" <royce.frazier@barclaycollege.edu>
 To: "Guia Calicdan-Apostle" <guiac@sp2.upenn.edu>
 Sent: Friday, August 6, 2010 3:02:06 PM GMT -05:00 US/Canada Eastern
 Subject: RE: RSBPQ

Hi,

Yes, you may use my scale for your study. Congratulations on your efforts.

Blessings,
 Royce

Royce E. Frazier, PhD.
 President
 Barclay College
 607 N Kingman
 Haviland, KS. 67059
[1-800-862-0226](tel:1-800-862-0226) ext. 53
[1-620-862-5252](tel:1-620-862-5252) ext. 53
[1-620-482-2887](tel:1-620-482-2887) cell
[1-620-862-5403](tel:1-620-862-5403) FAX

-----Original Message-----

From: Guia Calicdan-Apostle [mailto:guiac@sp2.upenn.edu]
 Sent: Thursday, August 05, 2010 10:10 PM
 To: Frazier, Royce
 Subject: RSBPQ

Dr. Frazier,

I am a Penn Clinical Social Work doctoral student who is very interested in looking at your scale as a research instrument for my proposal. This scale will be used to survey mental health practitioners.

I would like to request for your approval to use your scale for my study. Rest assured, your name and work will be acknowledged appropriately if approved by the committee. If there are other specific descriptions of this measure that were not mentioned in your publicized article,

please let me know.

I look forward to your response. Thank you very much for your kind attention.

Sincerely,

Guia Calicdan-Apostle
DSW Doctoral Candidate
School of Social Policy and Practice
University of Pennsylvania
guiac@sp2.upenn.edu

Appendix 2.A

Spiritually Integrated Interventions: Additional Compilation

The following are some anecdotal experiences of Bahá'í mental health practitioners on their use of spiritually integrated interventions.

“Have explored belief in God as source of strength when seeking solutions, guidance, power outside oneself, clients appear to find such questions helpful.” [*Exploring beliefs in God*]

“Yes, I have used interventions that invited clients to reflect upon the incongruence between their behavior and their professed beliefs. This intervention tends to nurture in clients a greater desire to bring their behavior into harmony with their beliefs, and this effort generally helps clients feel more authentic and in greater harmony with themselves. It also tends to reduce moral anxiety and worry.” [*Client self-reflection to achieve authenticity*]

“Sadly, few, if any, of my clients in the public agency where I work come with spiritual concerns. In my young private practice, I have encouraged a client to revive his connection with God, in accordance with his own wish.” [*Encourage the client to revive spiritual connection*]

“I have a client who recently felt that her contribution to the world outside of work was too small. I suggested that perhaps she needed some activity or volunteer commitment that felt like service. We talked about service a lot, and I told her some things about the Bahá'í notion of service. She has been religious in the past but is not currently. She found a place to volunteer in her community, and it has completely changed her outlook on life.” [*Belief in God by encouraging acts of service*]

“Even just using the Golden Rule in dealing with couples can have an impressive effect on assisting them to see both sides of their situation.” [*Impact of the Golden Rule*]

“I had a young client dealing with anger and aggression. The mother reported that she often prayed with her son and the family identified themselves as Muslim. I encouraged the mother to pray prayers that dealt with anger and aggression as she and her son prayed. Her young son also was deeply religious. I do believe that this was a helpful intervention for this client and his mother.” [*Role of faith and prayers*]

“Have explored belief in God as source of strength when seeking solutions, guidance, power outside oneself[;] clients appear to find such questions helpful.” [*Exploring beliefs in God*]

“Often, people will complain that they feel disconnected from God and prayer, and ultimately from themselves. I will help them practice mindful slowing down and presence to their inner space in the moment, letting go of internally held judgments and pre-conceived ideas. The outcome will typically be a growing sense of centeredness, spiritual connection, and assurance. Sometimes, that may take some time to achieve but it does consistently happen.” [*Teach mindful slowing down to maintain spiritual connection*]

“I sometimes quote the Bible to Christians, e.g., saying to those who have self-hatred, the Bible says[, ‘] Do unto others, as you would have others do unto you.[’] I ask them to reverse it, do to yourself, as you do to others, if you are kind to others but not to yourself. I say this one at least once a year or more. Otherwise, I keep in mind general virtues like justice, or love, and especially truthfulness to guide my work overall. I might also refer to a Bahá’í quote such as, ‘Did you think yourself a puny form when the whole universe is folded up within you?’ On the other hand, a Bible story such as the story of Solomon in the temple is useful to make a point about concepts.” [*Use of quotations from the Holy Books*]

“Two situations: One couple had to do with a year of patience, one was a Bahá’í and the other was not. The other: two individuals became Bahá’í, but one later left the faith. Clarification of misconceptions of Bahá’í year of patience pushes the clients to be honest about themselves and their relationship with other people. Using the book *Divine Lights of Guidance* also guides those who are sincerely looking for guidance that is beyond their own way of thinking.” [*Using a Bahá’í Guide as a tool to clarify religious laws*]

“It was the Family Virtues guide that influenced me to work with families every week, which in the Bahá’í sense, pushes my clients to be honest and look at issues in a frank way.”

“A young boy, about 9 years old[,] was being removed from one parent's home to be put in the other parent's home. His parents kidnapped him and involved Child Protective Services to move him back and forth a few times, and he experienced neglect from his substance abusing, mentally ill parents. I knew his parents and foster parents had consistently kept him involved in a Christian church and that he believed in God. I asked him why he thought God allows this to happen to him. He did not know. I asked him what he does when he is angry, sad, or hurt, and he said he prays. I asked what he does when the anger, sadness, and hurt continue, and he said he prays more. I was silent. He said that maybe God allows this so he will pray more ... we moved to discussing how prayer brings him closer to God. He was grateful.” [*The role of prayer in a dysfunctional setting*]

“I was working with a Vietnam vet who had guilt from causing the death of a Vietnamese woman. He said he prayed for her every day. I asked him how many

people have someone in addition to their parents pray for them every day after their death. He thought about that, how fortunate the girl was that he was involved in her death. He, then, let go of the guilt and understood that war does not make sense. He was grateful.” [*The role of prayer in forgiveness*]

“Many people have the idea of a punishing God who has judged them. I provide a variety of attributes of God to help establish a contrasting image of the Divine. Many people form a God image in childhood, which replicates their paternal relationship, and benefit from a more adult concept of God. My client had an abusive father, and believed that God thought he himself was lower than dirt and therefore deserved the punishment, and that his father was therefore correct in giving him the abuse. We developed a contrasting God using the many ‘names of God,’ which changed this man's concept of himself as well.” [*Clarifying God image and attributes*]

Appendix 2.B

Table 8

The Use of Spiritually Integrated Interventions among Bahá'í Mental Health Practitioners

VARIABLE	1	2	3	4	5	Mean	SD	Missing Values (in %)
	Never	Rarely	Some- times	Often	Very Often			
1. Actively communicate respect for clients' religious/spiritual beliefs.	0	2.6	5.3	28.9	60.5	4.51	.731	2.6
2. Actively seek client feedback about psychotherapy provided.	2.6	0	7.9	39.5	42.1	4.29	.860	7.9
3. Accurately determine when religious/ spiritual beliefs are adversely affecting the client's well-being.	5.3	2.6	13.2	36.8	31.6	3.97	1.07	10.5

4. Ask	18.4	0	2.6	21.1	50.0	3.91	1.50	7.9
religious/spiritual								
question to assess								
clients'								
religious/spiritual								
involvement.								
5. Help clients explore	10.5	5.3	7.9	31.6	28.9	3.75	1.34	15.8
their religious/spiritual								
questions in therapy.								
6. Use religious	5.3	7.9	18.4	36.8	26.3	3.75	1.34	5.3
metaphors in								
treatment.								
7. Integrate	5.3	5.3	21.1	36.8	23.7	3.74	1.04	7.9
religious/spiritual								
resources into								
treatment.								
8. Seek out	2.6	13.2	23.7	26.3	26.3	3.66	1.16	7.9
religiously/spiritually								
informed continuing								
professional education.								

9. Use clients' religious/spiritual belief to help inform their decisions.	18.4	0	7.9	28.9	31.6	3.64	1.57	13.2
10. Use extra-therapy resources to inform oneself about a client's specific religious/spiritual beliefs.	10.5	2.6	21.1	47.4	15.8	3.57	1.14	2.6
11. Use interventions that have been shown to be effective for individuals with specific religious/spiritual beliefs.	5.3	15.8	21.1	31.6	18.4	3.46	1.12	7.9
12. Refer to local community resources (church, synagogue, religious professionals, etc.).	13.2	2.6	26.3	28.9	21.1	3.46	1.21	7.9

13. Modify treatment plan to account for clients' religious/spiritual concerns.	21.1	2.6	7.9	36.8	23.7	3.43	1.51	7.9
14. Use prayer as a psychotherapy intervention.	2.6	13.2	31.6	28.9	13.2	3.41	1.09	10.5
15. Self-disclose one's own religious/spiritual beliefs.	7.9	7.9	34.2	26.3	15.8	3.37	1.10	7.9
16. Include religious/spiritual dimensions in case conceptualization.	21.1	0	13.2	23.7	23.7	3.35	1.51	18.4
17. Cite religious texts (i.e., scripture) in treatment.	5.3	13.2	26.3	44.7	2.6	3.29	.957	7.9
18. Strive to repair religious/spiritually based mistakes in treatment.	5.3	18.4	21.1	36.8	5.3	3.21	1.03	13.2

19. Help clients deepen their religious/spiritual beliefs in treatment.	15.8	13.2	10.5	34.2	13.2	3.18	1.30	13.2
20. Use clients' religious/spiritual strengths in treatment.	34.2	2.6	0	5.3	39.5	3.16	1.91	18.4
21. Seek out religious/spiritual informed case consultation.	7.9	18.4	26.3	39.5	2.6	3.11	1.06	5.3
22. Actively seek feedback on one's religious/spiritual psychotherapy competence from colleagues.	5.3	23.7	26.3	31.6	5.3	3.09	1.00	7.9
23. Self-assess one's competence to counsel clients regarding religious/spiritual issues.	23.7	7.9	10.5	31.6	13.2	3.03	1.49	13.2

24. Evaluate when one's religious/spiritual values and biases negatively impact treatment.	26.3	5.3	7.9	31.6	13.2	3.00	1.55	15.8
25. Refer a client to a more religiously spiritually qualified provider.	7.9	26.3	23.7	36.8	2.6	3.00	1.04	2.6
26. Initiate and explore religious/spiritual differences between therapist and client.	0	42.1	18.4	26.3	5.3	2.94	.998	7.9
27. Promote autonomy and self-determination of highly religious clients, even when their values differ from one's own.	36.8	0	2.6	5.3	26.3	2.78	1.98	28.9
28. Develop and implement a professional	5.3	47.4	13.2	21.1	7.9	2.78	1.14	5.3

development plan to

improve one's

religious/spiritual

psychotherapy co

competence.

29. Make *DSM-IV-TR* 5.3 55.3 28.9 5.3 0 2.36 .683 5.3

(2000) diagnosis for

religious/spiritual

problem (V62.80).

* Correlation is significant at the 0.05 level (1-tailed & 2-tailed).

** Correlation is significant at the 0.01 level (1-tailed & 2-tailed).

Appendix 2.C

Table 8

Appropriate & Inappropriate Use of Spiritually Integrated Interventions

VARIABLE	Appropriate Use		Inappropriate Use	
	Frequency	%	Frequency	%
1. Actively communicate respect for clients' religious/spiritual beliefs.	24	63.2	14	36.8
2. Actively seek client feedback about psychotherapy provided.	23	60.5	15	39.5
3. Accurately determine when religious/ spiritual beliefs are adversely affecting the client's well-being.	36	94.7	2	5.3
4. Ask religious/spiritual question to assess clients' religious/spiritual involvement.	37	97.4	1	2.6
5. Help clients explore their religious/spiritual questions in therapy.	38	100	0	0
6. Use religious metaphors in treatment.	36	94.7	2	5.3
7. Integrate religious/spiritual resources into treatment.	35	92.1	3	7.9

8. Seek out religiously/spiritually informed continuing professional education.	38	100	0	0
9. Use clients' religious/spiritual belief to help inform their decisions.	37	97.4	1	2.6
10. Use extra-therapy resources to inform oneself about a client's specific religious/spiritual beliefs.	38	100	0	0
11. Use interventions that have been shown to be effective for individuals with specific religious/spiritual beliefs.	37	97.4	1	2.6
12. Refer to local community resources (church, synagogue, religious professionals, etc.).	38	100	0	0
13. Modify treatment plan to account for clients' religious/spiritual concerns.	38	100	0	0
14. Use prayer as a psychotherapy intervention.	31	81.6	7	18.4
15. Self-disclose one's own religious/spiritual beliefs.	31	81.6	7	18.4
16. Include religious/spiritual	38	100	0	0

dimensions in case conceptualization.				
17. Cite religious texts (i.e., scripture) in treatment.	33	86.8	5	13.2
18. Strive to repair religious/spiritually based mistakes in treatment.	34	89.5	4	10.5
19. Help clients deepen their religious/spiritual beliefs in treatment.	31	81.6	7	18.4
20. Use clients' religious/spiritual strengths in treatment.	37	97.4	1	2.6
21. Seek out religious/spiritual informed case consultation.	37	97.4	1	2.6
22. Actively seek feedback on one's religious/spiritual psychotherapy competence from colleagues.	36	94.7	2	5.3
23. Self-assess one's competence to counsel clients regarding religious/spiritual issues.	36	94.7	2	5.3
24. Evaluate when one's religious/spiritual values and biases negatively impact treatment.	37	97.4	1	2.6
25. Refer a client to a more religiously spiritually qualified provider.	38	100	0	0
26. Initiate and explore	25	65.8	13	34.2

religious/spiritual differences between therapist and client.				
27. Promote autonomy and self-determination of highly religious clients, even when their values differ from one's own.	38	100	0	0
28. Develop and implement a professional development plan to improve one's religious/spiritual psychotherapy co competence.	35	92.1	3	7.9
29. Make <i>DSM-IV-TR</i> (2000) diagnosis for religious/spiritual problem (V62.80).	35	92.1	3	7.9

* Correlation is significant at the 0.05 level (1-tailed & 2-tailed).

** Correlation is significant at the 0.01 level (1-tailed & 2-tailed).

+ No missing values for appropriate/inappropriate use.

N=38

Appendix 3

Facts About The Bahá'í Faith

Although there are presently an estimated 500,000 Bahá'ís in the United States (U.S. Bahá'í Statistics, 2009), no social work research with regard to this important subset of the population has been done. The connection between spirituality and social work practice is universal, and social work practice may benefit from examining this link through a more diverse lens. In an effort to expand the parameters of this essential connection, the preceding discussion will address spirituality, principles, values, and beliefs of the Bahá'í Faith.

The Bahá'í Faith: Its Mission and History

The Bahá'í Faith is one of the world's nine major religions and the youngest independent monotheistic religion. Bahá'í membership has grown from 18 believers in 1844 to more than five million in 236 countries and territories, currently. Bahá'ís come from nearly every ethnic, national, and religious background, residing in more than 100,000 localities around the world (Momen,1996). This expansion reflects the followers' dedication to the ideal of world citizenship.

The Bahá'í Faith originated in Iran in the middle of the 19th century when, in 1844, the Bab, whose name means "Gate" or "Door," foretold the coming of a new messenger or prophet of God (Esslemont,1980). The Bab's prediction was likened to John the Baptist's foretelling of the coming of Jesus Christ. A distinguished Persian nobleman, Bahauallah (1817-1892), whose name was Mirza Husayn Ali, announced that he was the Promised One of all the world's religions. He fulfilled the prophecies of the previous messengers' sacred scriptures and is recognized as the most recent in a line of Divine Messengers or Teachers, including Abraham, Moses, Christ, Buddha, Krishna, Zoroaster, Muhammad, and the Bab. While the traditions of

Judaism, Christianity, and Islam are viewed as “religions of ascetism and the doctrine of the transcendence of God,” and Hinduism and Buddhism are considered “religions of mysticism and the doctrine of the imminence of God in nature” (Lample, 2009), the Bahá’í Faith provides a unique synthesis of these traditions. It is viewed as a religion from the position of sacred and profane to harmony and unity (Weber, 1963). Thus, when an individual from a different religious background (e.g., Christian, Muslim, Jewish, Zoroastrian, Babi, Hindu, Buddhist, or Sabeian) joins the Bahá’í community, it is not a rejection of personal previous beliefs but a fulfillment of the spirit and message of a previous religion (Shoghi Effendi, 1963).

The Bahá’ís believe that all the world's major religions are interconnected. Baha'u'llah's message is one of unity—that humanity is a single race, and that the day has come for humanity to come together to form one global society (The Bahai Faith). This faith reaffirms the core foundational and ethical principles common to all religions; Baha'u'llah also revealed new laws and teachings to lay the foundations of a global civilization. He further asserts, “The fundamental purpose animating the Faith of God and His Religion is to safeguard the interests and promote the unity of the human race” (Esslemont, 1950, p. 202).

This revelation was not a static event or an absolute state but, rather, an organic and ongoing process where man defines his/her spiritual journey in relation to the divine teachings. This is an important facet in the understanding of the constructs of Bahá’í religion, spirituality, and man’s relationship with himself and others.

Belief System of the Bahá’í Faith

The Bahá’í Faith asserts that humanity’s long and turbulent stage of adolescence is drawing to a close, and humanity is now approaching a stage of maturity in which unity in a global and just society can be established. Laws of personal morality and behavior, as well as

social laws and principles, are promoted in order to establish unity. An understanding of the Bahá'í Faith's principles and laws is essential in order to consider the possible relevance of this system for the social work profession. Below are several of the most important.

The realization of universal education. For Bahá'ís, knowledge plays a pivotal role in human life and society. The Universal House of Justice, in a 1985 statement of peace addressed to the peoples of the world, asserts that ignorance and the proliferation of prejudice are indisputably the principal reasons for the decline and fall of nations. It further explains that a nation lacking in resources limits its ability to fulfill the needs of its people, and if needs are great, it must consider giving first priority to the education of women and girls, since it is through educated mothers that the benefits of knowledge can spread throughout society. In keeping with the concept of global civilization, teaching the concept of world citizenship to every child is a component of standard education.

The abandonment of all forms of prejudice. The message of the Bahá'í Faith is a call for mutual understanding and fellowship among nations, cultures, and peoples. There is only one human race, and no singular group of people is superior to the rest of humanity. Human diversity is a means of creating a world based on unity rather than uniformity. This also means that Bahá'ís are encouraged to increase their awareness of and respect for the intrinsic value of every individual and culture.

Abolishing the extremes of poverty and wealth. The Bahá'í concept of unity is based upon justice. One striking example of injustice in the world today is the grave imbalance in material and economic systems. The gap separating rich and poor continues to widen, which indicates that existing economic systems are incapable of restoring a just balance. From the Bahá'í perspective, the prevailing assumptions regarding the accumulation of wealth reflect an

error in the understanding of human nature. Whereas Bahá'ís asserts that economic injustice is morally evil, economic conditions are divine in nature and are associated with the world of the heart and spirit in altruism and love. Within this framework is an economic system based on cooperation, rather than competition.

Equality of men and women. The Bahá'í Faith asserts that, in order to achieve world unity, humanity must recognize the equality of men and women. Metaphorically, Baha'u'llah likens the synergy of the station of a man and a woman to the two wings of a bird (Abdu'l-Bahá, 1982, p. 302). With one wing representing a man and the other wing representing a woman, the bird will not soar to its highest height if women are not recognized as equal partners in the advancement of civilization. To achieve equality, a woman must receive the same education as a man. Until this equality is established, true progress will not be achieved.

The harmony of science and religion. In order to further reinforce the teaching on unity, the Bahá'í Faith espouses the harmony and unity of science and religion. These are “two inseparable reciprocal systems of knowledge impelling the advancement of civilization” (Baha'u'llah, p. 285). Abdu'l-Baha, the perfect exemplar of the Bahá'í Faith and the expounder of the teachings of the Bahá'í Faith after Baha'u'llah, explains these two systems:

Any religious belief which is not conformable with scientific proof and investigation is superstition, for true science is reason and reality, and religion is essential reality and pure reason; therefore, the two must correspond. Religious teaching is at variance with science and reason is human invention and imagination unworthy of acceptance, for the antithesis and opposite of knowledge is superstition born of the ignorance of man. If we say religion is opposed to science, we lack knowledge of either true science or true religion, for both are founded upon the premises and conclusions of reason, and both must bear its test. (The Universal House of Justice, 1987)

This Bahá'í view draws a parallel between the physical and spiritual reality of man. Where scientific or religious perspectives may clash, scientific knowledge becomes a means of

checking the interpretation of the writings of a religion or religious beliefs in order to avoid superstition and fanaticism: “True religion is not unscientific and therefore religious beliefs and practice must correlate with the understanding of reality derived from science” (Lample, p. 120). As this study unfolds the perspective of Bahá’í mental health practitioners, it brings to the forefront this strong logic that their beliefs are founded on scientific inquiry and reality, from within (inner or intrinsic) and without (external or social).

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