STUDENT PERCEPTIONS OF
THERAPIST CREDIBILITY BASED ON ATTENTION TO
CLIENT RELIGIOUS AND SPIRITUAL FUNCTIONING AT INTAKE

A Dissertation
Presented to
The Graduate Faculty of The University of Akron

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy

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August, 2012
ABSTRACT

This investigation tested empirically whether college student participants (N = 176) would perceive a counselor during an intake interview as more credible when she asked questions of a religious and spiritual nature versus when she did not. Additionally, because research has suggested clients prefer to discuss religion and spirituality in counseling (Rose, Westefeld, & Ansley, 2001), and that level of religiosity influences perceptions of the counselor in this situation (Guinee & Tracey, 1997), the current study investigated whether preference for discussion of religious and spiritual issues and level of participant religiosity would influence counselor ratings. Results of the current study indicated students did not find the intake counselor who included religious and spiritual items in the intake session more credible than the intake counselor who did not include religious and spiritual items in the intake. Results also demonstrated preferences for discussing religious and spiritual issues in counseling and participant level of religiosity did not moderate the relationship between group assignment (religious and spiritual experimental condition versus non-religious and spiritual experimental condition) and counselor ratings on the CRF-S (Corrigan & Schmidt, 1983).

Analyses comparing participants who had never received counseling before (n = 115) and participants who had previous counseling experience (n = 61), suggested the participants who had no previous counseling experience rated the counselor in both role plays significantly higher overall. Exploratory analyses with a short-answer open-ended
opinion question suggested some students (31%) want to discuss religious and spiritual issues in counseling; some students (23%) stated their preference to discuss religious and spiritual issues in counseling depended on other factors; and some students (41%) did not want to discuss religious or spiritual issues in counseling. The fact that student participants rated the counselor who introduced religious and spiritual issues in this brief section of an intake interview similar to when she did not is noteworthy and is discussed in terms of implications for research, training, supervision, and clinical work.
ACKNOWLEDGMENTS

I would like to thank my advisor, Dr. Charles A. Waehler, my committee members, Dr. Linda M. Subich, Dr. Suzette L. Speight, Dr. John E. Queener and Dr. Linda M. Perosa, for their assistance, feedback, and encouragement during this process.

I would also like to thank graduate students Shannon Schmidt and Nicole Johnson, who agreed to assist in the role play for the current study; Bryan Batien, Nadia Hasan, Ben Keizer, Erin MacDougall, Melissa Plaufcan, and Christine Williams (graduate student raters for the open-ended question portion of the study); and Dr. Ryan Robinson, for his statistical analyses assistance during the data analyzing phase of the current study.

Next, I would like to thank my husband Daniel who has never wavered in his love and support, nor complained in the whole of this journey together. I would also like to thank my children, Abigail, Samuel, Tabitha, and Rebekah, who have lived the majority of their childhood and adolescence with a mother in college. They are all the dearest people in my life! I love you so far I can’t reach that far!

Finally, I owe my life and hope eternal to the Lord Jesus Christ, without whom my life would have turned out very differently. Thank you for the joy of living to serve you all the days of my life.
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CHAPTER I
INTRODUCTION

American society is a multicultural landscape with a diverse blend of citizens from all parts of the globe (Longo & Peterson, 2002). The American Psychological Association (APA) currently encourages psychologists to be cognizant of gender, age, race, ethnicity, language, sexual orientation, disability, education, class status, and religious/spiritual orientation as dimensions of multiculturalism (American Psychological Association, 2003). Standard 201.b of the Ethical Principles of Psychologists and Code of Conduct requires psychologists to obtain competency in areas of diversity through training, experience, consultation, or supervision; and when competence is lacking, psychologists are required to make appropriate referrals (APA, 2002).

As multicultural sensitivity becomes a focus in research, training, and practice, one area that has gained increased attention in the literature is the issue of religion and spirituality as a cultural variable that needs to be recognized, assessed, and in some instances, integrated into a client’s therapy as one aspect of his/her identity (Constantine, Lewis, Conner, & Sanchez, 2000; Eck, 2002; Hathaway, Scott, & Garver, 2004; Hill & Pargament, 2003; Kelly, 1997; Longo & Peterson, 2002; Miller & Thoresen, 2003; Pate & Bondi, 1992; Richards & Bergin, 2000; Worthington, Wade, Hight, et al., 2003). At the same time, Wulff, in Richards and Bergin (2000), acknowledged that:
No other human preoccupation challenges psychologists as profoundly as religion. Whether or not they profess to be religious themselves—and many do not—psychologists must take religion into account if they are to understand and help their fellow human beings (p. 3).

Indeed, for the majority of Americans, spirituality and religion are an important part of their cultural identity (Hage, 2006; Richards & Bergin, 2000). Moreover, research suggests highly religious Americans have a preference for discussing religious and spiritual issues in psychotherapy (Rose, et al., 2001). Making these matters even more cogent, starting in 1994, spiritual and religious problems were officially recognized by the American Psychiatric Association as a normal developmental issue when a diagnostic category of “Religious or Spiritual Problem” was added as a V-Code in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (4th Ed.),* (APA, 1994).

The current chapter introduces the important questions investigated in this study regarding assessing client religious and spiritual functioning. Specifically, this chapter provides a rationale for the present study which examined perceptions of therapist credibility as a function of assessment of religious and spiritual functioning during intake. The chapter begins by clarifying the domain of religion and spirituality in human functioning as it is represented in this study. Religion and spirituality are then discussed as an important domain in client functioning related to mental health. Next, the chapter addresses religion and spirituality as salient to client experience by exploring research that suggests religion and spirituality are appropriate for discussion in therapy. Additionally, this section addresses the influence of clients’ level of religiosity on counselor ratings because level of religiosity has been found to influence counselor ratings and attitudes toward seeking help (Guinee & Tracey, 1997).
The chapter then presents several theorists who recommended assessing client religion and spirituality at intake for the purpose of establishing its role in client experience, and as an important component of the clinical environment. Next, a recommendation to address religion and spirituality in therapeutic activity is introduced. Finally, the chapter concludes with a statement of the empirical questions asked in this research.

Religion and Spirituality

Clarifying what is meant by religion and spirituality is necessary to begin an investigation in this area. The majority of the evidence points toward the overlapping and related usage of these terms in the research literature (Boyd-Franklin, 2010; Hage, 2006; Hathaway et al., 2004; Hill & Pargament, 2003; Mattis & Watson, 2009; Pargament, 2007). Hill and Pargament (2003) suggested that most individuals experience spirituality within organized religion and do not see the two terms as distinct constructs. Pargament (2007) reported the majority (74%) of people see themselves as both religious and spiritual and do not see a conflict between the two. Mattis and Watson (2009) stated that due to their experiential overlap, historically, religiosity and spirituality have been used interchangeably.

Consistent with Pargament, and Mattis and Watson, Boyd-Franklin (2010) reported that a large percentage of African Americans (81%) characterized themselves as both religious and spiritual. She went on to report that, for some, spirituality and going to worship services are intertwined. She referred to religion as “a core set of beliefs and the formal practice of those beliefs through membership in a church or other faith-based
Spirituality, according to Boyd-Franklin, “refers to belief in God, the Creator, or a Higher Power and the power of spiritual beliefs in one’s life” (p. 978).

Worthington et al. (2003) defined spirituality as “a feeling, thought, experience, and behavior that arises from a search for the sacred” (p. 84). Hage (2006) described spirituality as meaning and purpose, a search for wholeness, and a relationship with a transcendent being. Hage pointed out that the terms religion and spirituality are sometimes used interchangeably with overlapping meanings. And in much of the research, the terms are used side by side as related or interchangeable (Duffy & Blustein, 2004; Hage, 2006; Hathaway, Scott, & Garver, 2004; Hill & Pargament, 2003; Knox, Catlin, Casper, & Schlosser, 2005; Rose et al., 2001; Worthington et al., 2003). For example, Hathaway et al. (2004), grouped the terms together in an examination of “religious/spiritual” functioning as a neglected domain in clinical practice, and described religious/spiritual functioning as a clinically relevant functional domain that is significantly related to facets of adaptive functioning. Additionally, Hathaway et al. described a significant relationship between religious/spiritual functioning and dealing with one’s mortality, finding purpose and meaning in life, coping with life’s problems, and having a sense of hope and optimism. Miller and Thoresen (2003) described religion or religiousness as both a social phenomenon and an individual experience, and spirituality, according to Miller and Thoresen, is generally thought to be experienced at the individual level which is usually, but not always, experienced within a religious context. Miller and Thoresen reported “almost all empirical studies to date have not
recognized the distinctions made above but instead have treated religiousness, religion, and spirituality as the same general concept” (p. 29).

Based on their prior observations, in this study the terms “religion and spirituality” and “religious and spiritual,” were treated as a single domain of functioning important to client experience and therefore important for clinical consideration. This domain of religious and spiritual functioning includes any expression of a search for the sacred, purpose, and meaning of life, a set of beliefs, practices, and values that give meaning to life and provide support for life’s struggles either within organized religious institutions or independent from an organized religion (Boyd-Franklin, 2010; Hage, 2006; Hill & Pargament, 2003; Miller & Thoresen, 2003; Worthington et al., 2003).

Religion and Spirituality and Mental Health

Hathaway et al. (2004) reported that religious community plays an important role in the lives of most Americans. Hathaway et al. cited numerous studies where religion and spirituality were found to be related to hope and optimism, the ability to cope with life stressors, and with achieving a sense of meaning in life. Additionally, a person’s level of religiousness has been found to lead to reduced rates of suicide and substance abuse. Despite these findings, according to Hathaway et al. the majority of clinicians don’t consider religion and spirituality an important domain of functioning and subsequently they do not routinely evaluate religious and spiritual functioning. Hathaway et al. stated that psychotherapists need to:

Consider this finding in the context of religion as an area of client diversity. Imagine that a sizable group of clinicians denied that race or sexual orientation is an important client domain. At a minimum, such a clinician attitude would appear
discordant with a serious appreciation of religion and spirituality as an area of diversity (p. 102).

Further illustrating this point, Pargament (2007) wrote of a 35-year old client named Rachel he was seeing for long-term depression. As therapy progressed, according to Pargament, they were getting nowhere. One day during a session Rachel mentioned almost in passing, that she had been gang-raped 10 years prior. Other than to the hospital emergency staff, Rachel did not talk about it again. Pargament asked Rachel how she thought the rapes affected her. At the time she reported “there are no words” (p. 95). Then one day when Rachel came in for a session and she reported that she felt “contaminated” by the rapes. She described feeling dirty without being able to get clean again and polluted to the core of her being. According to Pargament, this is the language of “desecration.” Rachel’s body and mind had been violated, and she had also experienced a deep spiritual violation of her soul. Pargament reported that recognizing the spiritual violation that had taken place was the turning point of her recovery from depression in therapy.

Longo and Peterson (2002) also reported that for many individuals, spirituality has played an important role in coping with mental illness. Longo and Peterson suggested that there is a positive relationship between spirituality and higher self-esteem, physical health, and lower levels of neuroticism and anti-social behavior when an individual has a deep religious or spiritual orientation. Additionally, in a report on the ethical challenges and opportunities for incorporating spirituality and religion into psychotherapy, Gonsiorek, Richards, Pargament, and McMinn (2009) stated, “Religion and spirituality are important aspects of human diversity; these concerns are important to our clients; and
these concerns are interesting, important, and legitimate subjects of psychological research” (p. 388). Pargament (2009), in a response to Gonsiorek et al., stated that psychotherapists attend to clients’ social and physical functioning during the assessment process, so why should religion and spirituality be any different. Pargament (2009) also stated, “We cannot and should not disconnect religion and spirituality from the evaluative process in psychotherapy” (p. 392).

Discussing Religion and Spirituality in Psychotherapy

The salience of religious and spiritual functioning for people living in the United States makes it an important cultural component worthy of evaluation in a way similar to other personal undertakings reviewed in psychotherapy (Boyd-Franklin, 2010; Brawer, Handal, Fabricatore, Roberts, & Wadja-Johnston, 2002; Eck, 2002; Hage, 2006; Hathaway, Scott & Garver, 2004; Russell & Yarhouse, 2006). To this end, most clients indicate a preference for discussions of religious and spiritual issues in therapy (Eck, 2002; Hage, 2006; Rose et al., 2001).

In 2001, Rose et al. assessed clients’ beliefs about the appropriateness of discussing religious and spiritual concerns in counseling, and clients’ preferences to discuss spiritual issues in counseling. Rose et al. recruited client participants (N=74) from a university counseling center, a psychology training clinic, a women’s center, two community mental health centers, one private psychology practice and a Lutheran Social Service Center for their study. Sixty percent of the clients participating reported a current religious affiliation and 40% reported no current religious affiliation. Client participants were asked by their counselor if they wanted to participate in the study and if they did,
they were given a packet of questionnaires assessing client attitudes, experiences, and concerns about religion and spirituality. Additionally, participants completed a questionnaire related to their expectations about counseling. Results indicated that clients believed religious and spiritual concerns are appropriate for discussing in counseling and that clients preferred to discuss religious and spiritual concerns in therapy. Clients who had higher levels of past spiritual experiences (higher religiosity) were more likely to believe that it was more appropriate to discuss religious concerns in counseling and to have a preference for those discussions in counseling than those who had lower levels of past spiritual experiences (lower religiosity). Expectations about counselors, previous counseling experience, and religious problems were not found to be related to beliefs about appropriateness or preference for discussing religious and spiritual issues.

Within the Rose et al. (2001) study, when asked why a person would or would not want to discuss spiritual or religious issues in counseling, some of the reasons indicated were religion and spirituality’s importance to healing, growth, behavior, worldview, and religion and spirituality’s relevance to problems. Some participants indicated that their preference for bringing religion and spirituality into therapy would depend on therapist characteristics. Participants were concerned about how their therapist might view their spirituality and whether their therapist would understand their religion. Also, some participants believed that religious and spiritual issues should be discussed with a member of the clergy. Based on the findings of this research, Rose et al. recommended that psychotherapists be sensitive to clients’ religious and spiritual issues. Rose et al. also suggested that training for future counseling psychologists is needed to prepare students
for their inevitable encounter with client religion and spirituality, and recommended that future research in this area identify how religion and spirituality may be used effectively in therapy.

Eck (2002) explored the use of spiritual interventions in clinical practice, and identified the ethical, cultural, and professional practice contexts for its therapeutic use. Eck reported that research demonstrates clients prefer to discuss religion and spirituality in therapy. According to Eck, therapists routinely ask clients to talk about their family history, ethnicity, sexual behavior, substance use, abuse suffered, and other issues, so why not incorporate religious and spiritual experience into therapy. Eck stated that according to APA ethical codes (APA, 1992; APA, 1993), psychologists are required to recognize the centrality of religion in clients’ lives and to demonstrate awareness, sensitivity, and respect for those beliefs by addressing religious and spiritual functioning with clients in clinical practice where appropriate.

Hage (2006) explored the role of spirituality in psychology training programs. She reported that, traditionally, marriage and family therapists give the greatest attention to issues of diversity regarding religion and spirituality in their clinical training. Counseling psychology and clinical psychology students often do not receive training in religious and spiritual issues. This, according to Hage, is in spite of the fact that two out of three Americans report that religion is an important part of their lives. Moreover, when faced with a serious problem, most prefer to see a therapist with similar beliefs and values and prefer a therapist who will integrate their beliefs and values into the counseling situation.
The current investigation extended the work of Rose et al. (2001), Eck (2002), and Hage (2006). These researchers suggested clients believe religion and spirituality are an appropriate area of discussion for counseling, and that clients indicate a preference for discussing religious and spiritual beliefs in counseling. Within the current investigation, preference for discussing religious and spiritual issues and participants’ level of religiosity were assessed for possible influence on counselor credibility ratings.

Religious and Spiritual Assessment Strategies

A number of established theorists have suggested the intake interview is the optimal place to broach the topic of religion and spirituality with a client (Aten & Hernandez, 2004; Gorsuch & Miller, 1999; Leach, Aten, Wade, & Hernandez, 2009; Pargament, 2007; Plante, 2009). For example, according to Pargament (2007), religion and spirituality is one more dimension of which to attend in the assessment process. In this regard Pargament stated that every clinical intake “should include an initial spiritual assessment” (p. 211). He suggested a few simple questions at intake to assess the salience of spirituality (whether a client sees their lives through a spiritual lens), the salience of religious affiliation or community (the client’s particular religious/spiritual affiliation), the salience of spirituality to the presenting problem (the client’s conceptualization/or not, of the problem in spiritual terms), and the salience of spirituality to the solution (whether spirituality is a potential resource during treatment).

When inquiring about the salience of spirituality to the client, Pargament (2007) recommended asking, “Do you see yourself as a religious or spiritual person? If so, in what way?” (p. 211). Pargament suggested that these sets of questions be integrated into
the conversation during intake instead of being set apart as a separate line of questioning.
He recommended asking the first and second pair of questions regarding salience of
spirituality and affiliation or community during the portion of the intake when other
questions about client roles and identity (i.e., family role and work role) are discussed.
The third pair of questions about the salience of spirituality to the solution can be inserted
in the broader question about the impact of the client’s problems psychologically,
socially, and physically. And, the fourth pair of questions regarding salience of
spirituality to the solution can be broached in the context of other questions about how
the client has tried to deal with his or her problems in the past.

Gorsuch and Miller (1999) stated that, “As a starting point, think of clients’
spirituality as one of several broad areas about which you will want to learn in initial
clinical interviews” (p. 52). They suggested that it is important to understand the role of
religious and spiritual processes in prognosis, context, outcome, and intervention. For
example, regarding prognosis purposes, Gorsuch and Miller reported that religious and
spiritual involvement has been shown to be predictive of health outcomes. Regarding
context, religion and spirituality are central components of worldview for many people.
Additionally, in regards to outcome, Gorsuch and Miller stated that clinicians need to
keep in mind sensitivity to and understanding of a client’s religion and spirituality for use
as a resource in working with the client on changing coping styles toward more adaptive
patterns. Gorsuch and Miller also suggested that for treatment, “Involving the client in
the positive elements of his or her spirituality may enhance hope, forgiveness, restoration
of community, and a renewed sense of self-worth” (p. 51).
Leach, Aten, Wade, and Hernandez (2009) recommended that religion and spirituality be addressed in the informed consent portion of the intake interview both in written form and verbally. These theorists suggested that the initial intake may be the client’s first exposure to the counseling process and this exposure often determines whether a client will return for further sessions. Therefore, according to Leach et al. the initial interview would be an ideal place to broach the subject of religion and spirituality so that the client would be informed of what is appropriate for discussion and valued in therapy.

Aten and Hernandez (2004) developed a set of eight conceptual guidelines for use by supervisors with supervisees for promoting competence when working with religious clients. Using Stoltenberg and Delworth’s (1987) integrative developmental model (IDM) as a template, the eight domains of the IDM are as follows: (a) intervention skills competence, (b) assessment, (c) interpersonal assessment, (d) client conceptualization, (e) individual and cultural differences, (f) theoretical orientation, (g) treatment goals and plans, and (h) professional ethics. In each of the eight domains Aten and Hernandez offered guidelines for introducing supervisees to religious and spiritual interventions. In the domain of assessment, these theorists recommended supervisees assess religion at the onset of treatment because doing so helps determine (a) salience of a client’s religious experience, (b) whether religion is a help or hindrance to the client, and (c) how supervisees might use a client’s religion as a source of therapeutic gain.

Plante (2009) recommended that therapists include several basic questions that assess religious and spiritual factors as part of an intake form or brief demographic
questionnaire. Plante stated, “At least some minimal assessment can help the clinician to
determine how (if at all) religious-spiritual factors might be used in better understanding
and treating clients” (p. 64). According to Plante, by including religious and spiritual
elements at intake, the therapist can determine if religion and spirituality are relevant to
the client, and if religion and spirituality are relevant, they may be valuable resources for
healthy behavioral change in the client. Also, including religious and spiritual questions
at intake can inform the clinician if religion and spirituality are components of the
problem (Plante). Finally, Gonsiorek et al. (2009) suggested that religious and spiritual
questions are appropriate and important to ask about, whether a client’s religious and
spiritual beliefs are part of the solution or whether a client’s religious and spiritual beliefs
are part of the problem.

Despite these numerous recommendations to include an assessment of client
religion and spirituality at intake (Aten & Hernandez, 2004; Gorsuch & Miller, 1999;
Leach, Aten, Wade, & Hernandez, 2009; Pargament, 2007; Plante, 2009), we know little
about the effects of such an inclusion. The specific question of whether addressing client
religious and spiritual functioning during the initial intake interview actually alters
clients’ perception of therapist credibility has yet to be assessed empirically. The current
study attempted to rectify this shortcoming. This study’s primary purpose was to assess
empirically, whether perceptions of therapist credibility would increase if counselors
assessed client religious and spiritual functioning at intake.
Statement of the Question

What can be seen from the initial review of the literature is that religious and spiritual practice have been shown to be related to positive mental health outcomes (Hathaway et al., 2004; Longo & Peterson, 2002; Pargament, 2007). The majority of Americans report religion and spirituality are very important in their everyday lives (Boyd-Franklin, 2010; Brawer et al., Eck, 2002; Hage, 2006; Hathaway et al., 2004; Rose et al., 2001), and a significant number of clients and Americans in general prefer to have discussions of religion and spirituality in counseling (Eck, 2002; Guinee & Tracey, 1997; Hage, 2006; Rose et al., 2001). Assessment of religious and spiritual functioning at intake is a legitimate area of study as demonstrated by the reported recommendations and investigations. Of particular note, several prominent theorists and researchers have recommended religion and spirituality be assessed during the initial clinical intake (Gorsuch & Miller, 1999; Leach et al., 2009; Pargament, 2007; Plante, 2009).

What had not been investigated at this juncture was how assessing religious and spiritual functioning of the client at intake affects perception of the counselor’s credibility. Research has demonstrated that perceptions of counselor credibility and competence are important for retention in, and satisfaction with, counseling (Constantine, 2002; Fuertes & Brobst, 2002; Kokotovic & Tracey, 1987; McNeill et al., 1987; Ramos-Sánchez et al., 1999; Wade & Bernstein, 1991). Research at this time in the domain of religion and spirituality and perceptions of counselor credibility would address recommendations for psychologists to consider the domain of religion and spirituality as another dimension of human functioning in psychotherapy (Aten & Hernandez, 2004;
Gonsiorek et al., 2009; Gorsuch & Miller, 1999; Leach et al., 2009; Pargament, 2007; Plante, 2009).

In summary, because theorists have suggested that attention to clients’ religion and spirituality at intake is important (Aten & Hernandez, 2004; Gorsuch & Miller, 1999; Pargament, 2007; Plante, 2009), this study examined with an analogue design a counseling situation in which the client’s religious and spiritual functioning was addressed at intake by a counselor in order to evaluate participants’ perceptions of the counselor’s credibility. This study sought to offer empirical evidence regarding the effect on perceptions of psychotherapist credibility when psychotherapists conduct an intake evaluation that includes items of a religious and spiritual nature.

Since preference for discussion of religious and spiritual issues and level of religiosity of study participants have been found to affect the counseling process, they also warranted further investigation. Therefore, the current investigation explored the influence of preference for discussing religious and spiritual issues in counseling and level of religiosity of participant on ratings of counselor credibility when the counselor did or did not include religious and spiritual questions in the intake session.
CHAPTER II
LITERATURE REVIEW

“When people walk into the therapist’s office, they don’t leave their spirituality behind in the waiting room” (Pargament, 2007, p. 4).

This chapter begins with a review of the literature establishing religion and spirituality’s historical role in the field of psychology and the current role religion and spirituality occupy in psychology. It is important to present the changing landscape of the relationship between psychology and religion and spirituality from the early 1900s to the present time to lay a foundation for the current research questions. Just in the last decade, religion and spirituality have emerged as dimensions of client functioning that are enjoying increased attention in research. During this time period, religion and spirituality have also been the topic of numerous important texts designed to assist clinicians in sensitively and accurately attending to client religious and spiritual issues. This chapter next introduces a rationale for assessing religious and spiritual functioning at intake, which was the main focus of this research. A focus on religion and spirituality in the treatment process is important because religion and spirituality are integral to the lives of many clients, and whether addressed openly or not, a client’s life experience has, in most cases, involved religion and spirituality. A third section focuses on studies that are similar to the current project in that client perceptions of counselor credibility based on other variables of interest (e.g., termination process, outcome in counseling, satisfaction with
counseling) were investigated empirically. Then the chapter turns to research exploring preference for discussion of religious and spiritual issues in therapy and religiosity of clients. The chapter concludes with a brief summary of the empirical questions this study addressed and the need for further scientific inquiry in this area of human functioning. Finally, the hypotheses for the current study are stated.

Historic Relationship Between Psychology and Religion in the United States

In order to fully understand the contemporary context for conducting the current research project, it is important to understand the historical underpinnings of the relationship between psychology and religion and spirituality in this country. Traditionally, the topic of religion was avoided by professionals in the field of mental health in general, and in psychology specifically (Brawer, Handal, Fabricatore, Roberts, & Wadja-Johnston, 2002; Hill & Pargament, 2003; Longo & Peterson, 2002; Miller & Thoresen, 2003; Russell & Yarhouse, 2006; Zinnbauer & Pargament, 2000). Quackenbos, Privette, and Klentz (1986) noted that “Religion is a pervasive force in our society, and yet it is excluded from most psychotherapy” (p. 84). According to Hill and Pargament (2003), some of the reasons social scientists, including psychologists, have kept their distance from religious and spiritual issues, are that religion and spirituality fall outside the scope of scientific study, are thought to be of less importance to psychologists and the public as a whole, and the belief that religion and spirituality have receded in an age of science and rational enlightenment. The spiritual side of human nature has also been considered by some psychologists to lack relevance and thus to be improper for scientific investigation (Miller & Thoresen, 2003).
The context that may help explain why psychology has distanced itself from the study of religion lies in the historical factors in psychology’s quest to become a respected science. In the early part of the 20th century, psychologists attempted to establish themselves as a mainstream science and focused on the field becoming a methodologically improved, measurement-oriented science (Brawer et al., 2002; Richards & Bergin, 2005). As such, the field sought to separate and distance itself from philosophical and spiritual concerns that were not considered empirical and worthy of study (Brawer et al., 2002; Pargament, 2007; Plante, 2009). Richards and Bergin (2005) stated that “Many scientists believed that humanity was … a part of the all-encompassing world machine, whose operation could be explained without reference to God” (p. 37).

Around the same time, Sigmund Freud introduced the United States to psychoanalysis (Aten & Leach, 2009). As Freud’s prominence and popularity grew, his teaching about the harmful effects of religion and spirituality also gained attention and popularity. In The Future of an Illusion, Freud suggested that religion is “the universal obsessional neurosis of humanity” (Freud, 1927/1957, p.77). He also stated “If after this survey we turn again to religious doctrines, we may reiterate that they are all illusions, they do not admit of proof, and no one can be compelled to consider them as true or to believe in them” (Freud, p. 54). This led his followers and others in the mental health profession to begin to see religious and spiritual beliefs and practices in their patients as harmful (Aten & Leach, 2009; Brawer et al., 2002; Richards & Bergin, 2005). Research conducted at that time regarding religion tended to focus on the negative aspects of religion, such as emotional and mental disturbance being caused by religious beliefs, and
low intelligence was associated with those who were religious (Brawer et al., 2002; Richards & Bergin, 2005). This research base effectively undergirded the prevalent hostile attitude toward religion and spirituality in general.

Additionally, leading theorists of other psychological persuasions during the 20th century such as J. B. Watson, B. F. Skinner, and Albert Ellis (Longo & Peterson, 2002), suggested that religion and spirituality were negative influences in patients’ lives. For example, Ellis (1980) stated “Devout, orthodox, or dogmatic religion (or what might be called religiosity) is significantly correlated with emotional disturbance,” and, “Religiosity, therefore, is in many respects equivalent to irrational thinking and emotional disturbance” (p. 637). According to Longo and Peterson (2002), Ellis equated good mental health as being absent of any religious yearnings; which ultimately labeled religious beliefs as pathological in nature. Longo and Peterson also suggested that these leading theorists’ negative views of religion and spirituality led to an enduring stereotype within psychology and the mental health field that religiously-identified people have a mental illness. Pargament (2007) reported that B.F. Skinner suggested that “God” is fiction, and that religious institutions maintain that fiction by controlling individual behavior in setting up religious practices and laws designed to reduce sinful behavior. Skinner (1948/1976) wrote that religious faith “becomes irrelevant when the fears which nourish it are allayed and the hopes fulfilled—here on earth” (p. 185). In Psychology from the Standpoint of a Behaviorist, Watson (1924) stated that “spiritualism” could not be verified objectively and so therefore spiritualism could never be a study for science. Watson also stated “Psychology, up to very recent times, has been held so rigidly under
the dominance both of traditional religion and philosophy-the two great bulwarks of medievalism-that it has never been able to free itself and become a natural science,” and “States of consciousness, like the so-called phenomena of spiritualism, are not objectively verifiable and for that reason can never become data for science” (p. 1).

Karier (1986) stated that Watson “….proceeded to deny soul, mind, consciousness, or any unique status for man or his mental or spiritual experiences” (p. 129).

There were some theorists in psychology’s history, however, who said that psychology went too far in distancing itself from religion and spirituality. William James, Carl Jung, Rollo May, Gordon Allport and Viktor Frankl espoused the positive nature of religion and spirituality (Aten & Leach, 2009; Richards & Bergin, 2005). For instance, James remarked “Religion is the great interest of my life” (Karier, 1986, p. 26). Frankl, a Jewish psychiatrist, believed the human psyche was religious by nature (Quackenbos, Privette, & Klentz, 1986). Jung (1938) stated:

Since religion is incontestably one of the earliest and most universal activities of the human mind, it is self-evident that any kind of psychology which touches upon the psychological structure of human personality cannot avoid at least observing the fact that religion is not only a sociological or historical phenomenon, but also something of considerable personal concern to a great number of individuals (p. 1).

Rollo May (1953) stated “religion is constructive as it strengthens the person in his sense of his own dignity and worth, aids him in his confidence that he can affirm values in life, and helps him in the use and development of his own ethical awareness, freedom and personality (p. 205). Rollo May also suggested that the main issue with regard to a patient’s religion is “how much the belief or practice is, for the given person,
an escape from his freedom, a way of becoming ‘less’ of a person; or how much it is a way of strengthening him in the exercise of his own responsibility and ethical power” (p. 205-206).

Further, although mainstream psychology distanced itself from religion and philosophy, African American psychologists recognized that religion and spirituality were integral to the identity of African Americans and therefore including these areas into the therapeutic process was expected (Boyd-Franklin, 1989). In 1938 the first conference of Black psychologists convened at Tuskegee Institute in Alabama where they discussed topics relevant to the black community such as church, home, community, and cultural awareness (Guthrie, 1991). In 1972, Black Psychology, edited by Reginald Jones, described the need to be sensitive to and integrate cultural worldviews of African Americans, including religion and spirituality, into counseling and psychotherapy (Richards & Bergin, 2000).

Although these theorists espoused a more positive view of religion and spirituality, their voices were not embraced within the scientific society of the time. In fact, Richards and Bergin (2005) noted that many scientists of that time thought religious and spiritual views of the universe would become extinct. On the contrary, however, according to Richards and Bergin, religious and spiritual views of the universe are now being espoused among physicists and scientists.

In his 1975 presidential address, APA President Donald T. Campbell stated “present-day psychology and psychiatry in all their major forms are more hostile to inhibitory messages of traditional religious moralizing than is scientifically justified”
(Brawer et al., 2002, p. 203). Citing Sarason’s 1992 centennial address to the APA,

Brawer et al. (2002) reported that this attitude had not changed almost two decades later:

I think I am safe in assuming that the bulk of the membership of the APA would, if asked, describe themselves as agnostic or atheistic. I am also safe in assuming that any one or all of the ingredients of religious worldview are of neither personal nor professional interest to most psychologists….Indeed, if we learn that someone is devoutly religious, or even tends in that direction, we look upon that person with puzzlement, often concluding the psychologist obviously had personal problems (p. 203).

Psychology and Religion and Spirituality: A Renewed Relationship

Despite this antagonistic beginning, a constructive dialogue between mainstream science and religion began again in the 1990s according to Richards and Bergin (2005). Richards and Bergin suggested that despite the historic schism between psychology and religion and spirituality during most of the 20th century, new evidence suggested psychology was shedding previously held negative views of the role of religion and spirituality in people’s lives and exchanging these views for a more positive perception of how psychology and religion and spirituality interface to bring about mental health. New forms of psychotherapy such as humanistic-existential, multicultural counseling, and spiritually oriented treatment approaches challenged deterministic, relativistic, naturalistic, and hedonistic views of human nature and what brings about therapeutic change.

As part of this shift, Richards and Bergin (2005) reported on research supporting the positive associations between religion and spirituality on mental health. Similarly, Guine and Tracey (1997) cited numerous studies between 1983 and 1995 regarding the influence of religious values on counseling, the relationship between religiousness and mental problems, and the relationship between personality, mental health, and religious
values and belief systems. This evolution came about, according to Guinee and Tracey, in part because psychologists realized religious and spiritual issues could be examined scientifically. This gave rise to new research in religion and spirituality, an increase of religious and spiritual issues discussed in clinical practice, and measurement development with a focus on religious and spiritual variables of interest.

In 1997, when M. E. P. Seligman became president of the American Psychological Association he stated that he “shifted his focus from studying mental illness to understanding human strengths and virtues” (Richards & Bergin, 2005, p. 60). Coining the term “positive psychology,” Seligman called on psychologists to change their focus from repairing what was wrong in the life of their client to building on the client’s best qualities. According to Seligman (2002), psychologists’ best work in therapy consists of amplifying strengths that clients already possess. Seligman (2002) stated “We have discovered that there are human strengths that act as buffers against mental illness: courage, future-mindedness, optimism, interpersonal skill, faith, work ethic, hope, honesty, perseverance, the capacity for flow and insight, to name several” (p. 5).

Consistent with this view, Richards and Bergin (2005) reported that the previous belief that being “religious” was synonymous with “emotional disturbance” has not been supported in the research. On the contrary, numerous studies have demonstrated the positive influence of religion and spirituality on mental health (Gorsuch & Miller, 1999; Koenig & Larson, 2001; Richards & Bergin, 2005). Pargament (2007) reported that the deeply held assumption that spirituality is a side issue in psychotherapy led psychotherapists to either avoid the topic of spirituality altogether, or to downplay a
client’s spirituality, and attempt to lead the client away from what the therapist viewed as an unrealistic worldview within the context of the client’s presenting problem. According to Pargament “this assumption is just plain wrong” (p. 9). Pargament further suggested that the training and education of contemporary practitioners often leaves them very different from the clients coming into their practices, and that these professionals are in many ways unprepared to fully meet their clients’ needs.

According to Sperry and Shafranske (2005) “Religiosity or spirituality plays a role in the orienting systems of most individuals and therefore requires deliberate and thoughtful assessment in respect to its contributions to mental health and well-being” (p. 18). Sperry and Shafranske suggested that the reemergence of religion and spirituality as variables of interest in psychology are due, in part, to the increase of positive psychology’s approach to psychological health which espouses strengths and virtues. These strengths and virtues come in the form of our values that guide us throughout our lives and influence our well-being. Sperry and Shafranske suggested that, due to positive psychology, there has been a paradigm shift within psychology where religion and spirituality are welcome.

More recently, Plante (2009) also suggested that people do not check their religion and spirituality at the door of the therapist’s office. Although clients may not bring up their religion and spirituality in therapy, they likely use their religious and spiritual beliefs and practices to help them manage their lives. According to Plante, most people’s religious and spiritual beliefs provide meaning and purpose in life and people use their religion and spirituality to help them cope with life’s stressful experiences.
Plante’s *Spiritual Practices in Psychotherapy* provides religious and spiritual tools for clinicians to use when conducting psychotherapy with clients who desire to discuss their religion and spirituality during the course of therapy as a relevant component of their presenting concern. For example, along with encouraging a client to follow a prescribed recommendation for problems with sleep, a clinician can also encourage an identified religious and spiritual client to pray when she can’t sleep or when she wakes in the night and has trouble falling asleep. Another tool the clinician can incorporate into therapy is encouraging altruism in the form of volunteerism and charity with a client who might be retired and presents with depression because of boredom or loss of meaning with everyday life. Plante suggested that psychologists have an obligation to respect and integrate religious and spiritual concerns of their clients into psychotherapy when appropriate.

Also giving evidence of the reemerging nature of religion and spirituality in psychology, are a number of peer-reviewed psychological journals devoted to research on religious and spiritual topics. These journals include “*Counseling and Values; International Journal for the Psychology of Religion; Journal of Psychology and Christianity; Journal of Psychology and Theology; Journal of the Scientific Study of Religion; Mental Health, Religion, and Culture; and Research in the Social Scientific Study of Religion*” (Aten & Leach, 2009, p. 15).

Additionally, in the last two decades, a number of books have been written for use by clinicians as essential resources for working with religious and spiritual clients to increase their level of expertise with this population. These include Richards and

What contemporary books have addressed is the legitimacy of client religious and spiritual experience and its appropriate role in the therapeutic process. For example, in *Spiritually Integrated Psychotherapy*, Pargament (2007) presented a spiritually integrated psychotherapy model that can be applied to clients from diverse traditions. Spiritually integrated psychotherapy, according to Pargament, can be woven into any treatment modality by attending to and being sensitive to the spiritual domain in the process of psychotherapy.

In *A Spiritual Strategy for Counseling Psychotherapy*, Richards and Bergin (2005) presented a theoretically grounded theistic spiritual strategy for mainstream psychology. Richards and Bergin suggested that because religion and spirituality are so important to so many Americans, there is a cultural demand for psychotherapists to become acquainted with and be sensitive to religious and spiritual values of their clients. In this important text, Richards and Bergin focused on educating and encouraging the mental health profession to address religious and spiritually oriented clients in a culturally sensitive way.
Moreover, Measures of Religiosity (Hill & Hood, Jr., 1999) was written to provide a clinical resource of religious and spiritual measures for assessing client religious and spiritual experience. Hill and Hood, Jr., recognized a need for such a resource for clinicians in order to prevent unnecessary duplication of scales already in existence measuring religious and spiritual constructs. According to Hill and Hood Jr., researchers can use their text to determine if an adequate measure has been developed for a theorized construct, and whether a particular measure is adequate for their therapeutic purpose. In that regard, an empirically robust research base in the measurement of religion and spirituality could be established.

Rationale for Assessing Religion and Spirituality

Numerous theorists have presented a theoretical basis for the inclusion of client religious and spiritual dimensions into psychotherapy, and have recommended assessing religious and spiritual functioning at intake (e.g., Aten & Hernandez, 2004; Gorsuch & Miller, 1999; Leach et al., 2009; Pargament, 2007; Plante, 2009). These theorists suggested that attending to a client’s religion and spirituality should be the same as attending to a client’s other important domains of functioning (i.e., family role and work role). What is needed is an empirical investigation of their claims to add to the research regarding the interface of client religious and spiritual functioning and psychotherapy. The following review of these theorists’ conjecture provides a foundation for the specific research questions in the current study.

In Spiritually Integrated Psychotherapy, Pargament (2007) stated four rationales for a spiritually integrated psychotherapy: (1) spirituality can be part of the solution, (2)
spirituality can be part of the problem, (3) spirituality cannot be separated from
psychotherapy, and (4) people want spiritually sensitive help. According to Pargament,
humans are spiritual beings and one’s spirituality is woven into every aspect of one’s life.
Spiritually integrated psychotherapy is an approach to therapy that can be incorporated
into existing psychotherapeutic traditions by sensitively attending to the spiritual
dimension of the client in the same way as a clinician would attend to the client’s other
important domains of functioning.

According to Pargament (2007), sometimes spirituality is the basis for the
presenting concern and sometimes spirituality can be a resource in alleviating
psychological problems. Pargament suggested sensitively attending to the religious and
spiritual dimension of the client during intake by briefly asking a few simple questions
regarding the client’s religious and spiritual experience. Examples of questions that might
be asked are “Do you see yourself as a religious or spiritual person? If so, in what way?”
and, “Are you affiliated with a religious or spiritual denomination or community? If so,
which one?” (p. 211). Pargament suggested empirical research into religious and spiritual
functioning is needed at this time to investigate whether or not clients want therapists to
attend to and integrate their religion and spirituality into the therapy setting.

According to Plante (2009), the purpose of assessing religious and spiritual
functioning in a client’s life is to gain an understanding of the role of religion and
spirituality in the client’s existential experience, and to gain knowledge of how religious
and spiritual tools may or may not be useful for therapy with the client. At minimum,
according to Plante, a clinician should ask the client about a particular religious and
spiritual affiliation and whether the client would like to have religious and spiritual beliefs considered during the course of therapy. Plante offered the acronym FICA from Puchalski and Romer (2000), as an easy way to remember to assess specific domains (e.g., faith, importance, church, address) of a client’s religious and spiritual influences during assessment. A faith question might be “What is your faith tradition, if any?” for importance it might be “How important is your faith to you?”, for church it might be “What is your church or faith community, if any?”, and, for address it might be “How would you like me to address these issues in your care?” (Plante, 2009, p. 58). By asking these questions Plante suggested that the clinician will be better informed regarding both positive and negative religious and spiritual experiences in the client’s life and what kind of role religion and spirituality may play in therapy with this client.

Aten and Hernandez (2004) also suggested that if the client’s religion and spirituality are important to him or her, it should be discussed in treatment. Aten and Hernandez developed a model for supervision that could provide tools to guide supervisees’ work with religious and spiritual clients. Their model’s template was Stoltenberg and Delworth’s (1987) integrative developmental model (IDM). Aten and Hernandez described specific intervention strategies in each of Stoltenberg and Delworth’s eight domains for supervisees’ work with religious and spiritual clients. In the Assessment Approach and Techniques domain of their model for supervisee training, Aten and Hernandez suggested that assessing religion and spirituality should begin at intake because it would help supervisees determine the salience of religion and spirituality to their client’s issue, whether religion and spirituality in the client’s life is
harmful or helpful to client growth, and give suggestions for the use of religious and spiritual practices as a resource for therapeutic gain. Additionally, Aten and Hernandez suggested that a simple open-ended question like “Do you consider yourself a religious person?” (p. 155) could yield useful information, and could then be followed up with more specific questions about religious beliefs and practices if the first question provided information indicating religion and spirituality are important to the client.

Indeed, Gorsuch and Miller (1999) suggested that research has demonstrated a positive relationship between religion and spirituality and health outcomes. Similarly, according to Miller and Thoresen (1999), and Mattis and Watson (2009), religious and spiritual involvement has consistently been linked to positive gains in health and has been found to be inversely related to disorders. Miller and Thoresen reported this to be true in correlational and longitudinal studies, and across physical, mental, and substance use disorders. Therefore, according to Gorsuch and Miller, it is important to assess a client’s spirituality, along with a family history, social support, and stress issues as potential risk or protective factors at intake. “Understanding clients’ spirituality can promote clearer communication, offering contextual information that is important to the process of treatment” (Gorsuch & Miller, p. 49).

As a starting point, Gorsuch and Miller (1999) suggested including a question such as, “How important is spirituality or religion in your daily life?” (p. 52), during the clinical interview. This question is designed to open up the discussion for exploration of spiritual issues. The next statement should be one of reflective listening such as, “Tell me in what ways spirituality (or religion) has been important to you.” (p. 52). Gorsuch and
Miller also suggested that these questions can be asked in another way, such as, “What things are most important to you?” and “What gives your life purpose or meaning?” (p. 52).

Leach et al. (2009) suggested that addressing the issue of spirituality in treatment is important because clients are spiritual, clients want to discuss spirituality, and in some cases spirituality is relevant to the therapeutic issue. Leach et al. suggested addressing spirituality initially during the informed consent portion of the clinical intake for the purpose of ensuring the client makes an informed choice about treatment. Leach et al. suggested either an explicit (i.e., an inclusion statement regarding a specific belief about the place of religion and spirituality in client experience) or implicit (i.e., a general statement regarding the availability of addressing client religious and spiritual experience) approach be used for addressing spirituality during informed consent depending on the setting for therapy. For example, in a religiously oriented therapy setting spirituality should be mentioned explicitly in the informed consent. An informed consent form at a religiously oriented mental health facility might have an explicit religious and spiritual statement such as, “It is our belief that spirituality and/or religion are important elements of many people’s lives” (Leach, et al., 2009, p. 80). In a secular setting a more implicit approach to spirituality could be utilized in the informed consent as one of a number of other cultural variables (e.g., gender, race, sexual orientation). An informed consent form at a secular mental health facility might have an implicit religious and spiritual statement such as, “Your therapist may ask if you would like to integrate specific spiritual or religious practices into your treatment” (Leach, et al., 2009, p. 81).
Additionally, Leach et al. (2009) offered the following questions that can be asked during an intake session depending on the setting, “Do you have any spiritual or cultural beliefs that may influence your treatment?” (p. 81). A more explicit question might be “Is spirituality an important part of your life?” or “Do you have any religious or spiritual beliefs that may be important to discuss in counseling?” (p. 83). Implicit questions such as “What gives your life purpose?” or “How do you cope with the stress in your life?” (p. 85) could also be used without necessarily mentioning spirituality. Leach et al. provided options for clinicians when approaching the topic of a client’s religion and spirituality, either during the informed consent (explicitly or implicitly) or during the initial intake session (explicitly or implicitly) with the client.

In summary, despite years of attempts to distance religion and spirituality from mainstream psychology, the current study’s particular focus on religious and spiritual assessment by the counselor during the initial intake session was based on the recommendations of several theorists. According to Pargament (2009), spiritual assessment is essential to the clinician in beginning the process of getting to know the client’s spiritual dimension and its possible relevance in therapy. This view is shared by Gorsuch and Miller (1999) who stated that client spirituality is one of several broad areas that should be assessed in an initial clinical interview.

The recommendation by Leach et al. (2009) that religion and spirituality be addressed in the informed consent portion of the intake interview in both written and verbal form is consistent with others’ recommendations to assess religion at the onset of treatment (Aten & Hernandez, 2004; Plante, 2009; Sperry & Shafranske, 2005). Further,
Constantine et al. (2000), Hage (2006), Prest et al. (1999), and Richards and Bergin (2000) suggested that assessing for religion and spirituality may increase therapists’ competence ratings from the perspective of their clients.

To date, however, there has not been an empirical study that confirms or refutes the claim that asking clients about religious and spiritual functioning during the initial intake interview would increase therapist competence ratings. Rose et al. (2001) found that clients prefer to discuss religion and spirituality, and believe religion and spirituality are appropriate for discussion in psychotherapy, but her examination was not conducted at intake and her investigation did not evaluate counselors. Therefore, the current investigation was needed in order to provide initial empirical evidence regarding whether stated questions of a religious and spiritual nature during an initial intake interview influence perceptions of a counselor’s credibility. The current study, thus, investigated the above recommendations empirically. The primary question addressed was whether a participant’s perception of counselor credibility is enhanced when the counselor assesses religious and spiritual functioning at intake. Investigations of perception of counselor credibility during the initial intake interview are important because studies have demonstrated that client/participant perception of counselor credibility influences client rate of return for more sessions (McNeill, May, & Lee, 1987; Wade & Bernstein, 1991) and satisfaction with counseling (Constantine, 2002; Fuertes & Brobst, 2002).

Client Perceptions of Therapist Credibility

The current study examined perceptions of therapist credibility based on assessing religious and spiritual functioning at intake. Numerous other studies have examined client
perceptions of therapist credibility at various stages of the counseling process or as a
function of other behaviors. What follows are summaries of a few studies examining
perceptions of counselor credibility or competence for the purpose of providing a
foundation for the current investigation. First, however, an introduction to the
interpersonal influence process model presented by Strong (1968) is offered to provide a
theoretical foundation for investigating perception of therapist credibility in the current
study.

Strong (1968) stated that, in order to be effective in counseling, therapists must be
able to influence clients toward therapeutic change. According to Strong’s interpersonal
influence process model, in therapy the therapist is attempting to ‘influence’ the client to
attain the goals of counseling. The counselor’s perceived influence (credibility) is directly
related to the ability of the therapist to influence the client, predominantly through
communication. According to Strong, three components of the therapists’ communication
skills contribute to perceptions of therapist influence (credibility). These three
components are *expertness, trustworthiness, and attractiveness.*

In Strong’s interpersonal influence process model, expertness of a therapist is
demonstrated by the therapist’s ability to confidently communicate knowledge and skill
in the therapeutic setting. Trustworthiness, according to Strong, is evidenced through
communicating sincerity, openness, and lack of motivation for personal gain. Finally,
attractiveness is related to liking the therapist, which is achieved through communication
that displays compatibility between therapist and client, and similarities between therapist
and client in areas such as background and opinions. According to Strong (1968), by
communicating evidence for expertness, trustworthiness, and attractiveness in
counseling, a therapist conveys to the client credibility in their profession which
maximizes the probability of client change.

Barak and LaCrosse (1975) investigated Strong’s interpersonal influence process
model to determine the existence of the three dimensions of the model (expertness,
trustworthiness, and attractiveness). Through factor analysis, Barak and LaCrosse
investigated the three dimensions of Strong’s model and developed the Counselor Rating
Form (CRF) to measure expertness, trustworthiness, and attractiveness. The results of
their investigation supported Strong’s three dimensional interpersonal influence process
model of perceived counselor credibility. Moreover, Barak and LaCrosse found that the
counselor’s ability to influence the client toward therapeutic change is enhanced when the
therapist is perceived as credible (i.e., expert, trustworthy, and attractive).

Since Barak and LaCrosse (1975) developed their scale (i.e., CRF) for measuring
Strong’s interpersonal influence process model, numerous investigators have utilized the
measure to evaluate counselor credibility. The following sampling of studies utilizing the
CRF and a revision of that scale (CRF-S; Corrigan & Schmidt, 1983) were selected
because they either assessed counselor credibility early in the counseling process and/or,
their findings suggested perceptions of counselor credibility occurs early in the
counseling process. Thus, these investigations lend validity to the current examination of
counselor credibility based on the counselor’s behavior during an initial intake interview.

LaCrosse (1980) investigated Strong’s (1968) interpersonal influence model of
counseling, and hypothesized that the dimensions of Strong’s interpersonal influence
model (expertness, attractiveness, and trustworthiness) would predict outcome in counseling. In the LaCrosse investigation, 36 individual counseling clients who were being seen for drug-abuse-related problems participated in the study. Clients completed two questionnaires, the CRF (Barak & LaCrosse, 1975) and the Goal Attainment Scaling (GAS; Kiresuk & Sherman, 1968), after the first session and at the end of counseling. Findings supported Strong’s (1968) interpersonal influence process model for conceptualizing client change in counseling leading to improved outcomes. Expertness, as a component of the counselor’s ability to exert interpersonal influence at the onset of counseling, was found to be the most powerful predictor of outcomes. Although the use of actual clients is a strength in this study, the small sample size (N= 36) is a major weakness. The current investigation used a much larger sample size (N= 226) to test its stated hypotheses.

McNeill, May, and Lee (1987) examined perceptions of counselor interpersonal influence (credibility) when comparing premature terminations and successful terminations. Premature terminators were defined as clients who terminated counseling after an average of three counseling sessions and without the knowledge or recommendation of the counselor. Successful terminations were defined as clients who attended three or more sessions and terminated with their counselor by mutual agreement. Participants (N=204) were from a large Midwestern university who sought counseling at the university counseling center during the academic year. Participants filled out and returned a questionnaire packet that included the Client Satisfaction Questionnaire (Larsen, Attkisson, Hargreaves, & Nguyen, 1979), the CRF-S (Corrigan & Schmidt,
1983) which is a shortened version of the original CRF developed by Barak and LaCrosse (1975), and other miscellaneous items for assessing client satisfaction. All materials were sent out four weeks after clients had terminated from counseling.

Results demonstrated a significant relationship between perceptions of counselor expertness, trustworthiness, and attractiveness and client satisfaction with counseling. Clients who terminated prematurely perceived their counselors as possessing significantly less expertness, trustworthiness, and attractiveness than did the clients who terminated successfully. These clients were also significantly less satisfied with the counseling services they received than those who terminated successfully. These findings suggested that in terms of the interpersonal influence process model (Strong, 1968), clients who perceived low levels of expertness, trustworthiness, and attractiveness in their counselor were less influenced by the counselor to continue to seek counseling services. However, since McNeill et al. (1987) assessed client perceptions of counselor credibility after termination, the results only provided evidence for client perceptions after counseling has ended. The current investigation assessed students’ perception of counselor credibility based on their impression of a counselor at intake as a function of whether the counselor asks the client about religious and spiritual activities. If variables contributing to retention in counseling in the initial intake interview are identified, this may be helpful in preventing premature termination in counseling.

In related research, Wade and Bernstein (1991) examined the effects of culture sensitivity training and counselor race on perceptions of counselor credibility and client attrition with low-income, Black female clients. Wade and Bernstein predicted that
culture sensitivity training would have a significant effect beyond the role of counselor race on client perception of counselor credibility and on whether clients would return for more sessions. Four Black and 4 White female master’s level counselors agreed to participate in the investigation. Two Black and 2 White counselors were assigned to the culture sensitivity training (treatment) condition, and 2 Black and 2 White counselors were assigned to the control (no additional training) condition. Participant clients were Black women (N= 80) from a large, Midwestern metropolitan area. All had been referred or self-referred for counseling at a college counseling center. Participants were asked to rate their counselor after each of the first three sessions with their counselor by completing a packet of questionnaires which included the Revised Barrrett-Lennard Relationship Inventory (BLRI; Strong, Wambach, Lopez, & Cooper, 1979), the Counselor Effectiveness Inventory (CEI; Linden, Stone, & Shertzer, 1965), and the CRF-S (Corrigan & Schmidt, 1983).

Findings suggested that Black female clients’ perceptions of counselor credibility after the first, second, and third counseling session were significantly affected by their counselor receiving culture sensitivity training. Clients assigned to counselors in the culture sensitivity training group returned for more counseling sessions than did those assigned to counselors in the control condition. Counselor race however, did not have a significant effect on these Black female clients’ perceptions of counselor credibility after any of the counseling sessions, but counselor race did have a significant effect on client attrition in that more clients returned to see Black counselors than White counselors.
These findings suggested that Black women’s perception of counselor credibility develops early in the counseling process, suggesting the intake session may play a decisive role in retention for this population. Therefore, according to Wade and Bernstein, being culturally sensitive influences counselor ratings. However, Wade and Bernstein’s study examined perceptions of a small population (N= 80) of Black women clients from a large metropolitan area. Therefore, results of their investigation may be limited to this specific population. The current investigation’s use of a larger (N= 226) student population from a Midwestern university attempted to broaden the generalizability of Wade and Bernstein’s findings and further support the argument for increased culture sensitivity training for psychologists by examining other culturally sensitive topics that may influence clients returning for more counseling.

Harari and Waehler (1999) investigated the effects of discussing termination during the first session of psychotherapy on perceptions of counselor social influence (credibility). Participants (N=143) were undergraduate psychology students from a large, Midwestern university who received extra-credit points for their participation. Students were randomly assigned to one of four experimental groups in which an almost identical 12 minute taped counseling session was presented. After listening to the counseling session for the first 6 minutes the tape was stopped and students were given the CRF-S (Corrigan & Schmidt, 1983) for completion. For the second half of the experimental condition (the final 6 minutes), students listened to four different concluding sessions appropriate to their specified experimental condition.
The four experimental conditions were *Termination Only* where the counselor mentioned the process of termination; *Credentials Only* where the counselor stated his credentials; *Termination Plus Credentials* where the counselor mentioned both termination and his credentials; and, *Control* where the counselor ended the interview without mentioning either termination or his credentials. After listening to the second half of the counseling session, each participant completed a second CRF-S followed by a manipulation check to ensure participants knew in which experimental condition they had participated.

Results indicated that discussing termination during the first session did not significantly influence participants’ perception of counselor credibility over those who did not discuss termination at the first session. That is, counselors in the termination only or the termination plus credentials condition were not seen as more credible than counselors in the credential only and control group. These findings demonstrated the need for continued research in the area of perceptions of counselor credibility at intake. Harari and Waehler (1999) found no evidence in their research for discussing or not discussing termination at intake for enhanced perception of counselor credibility by participants. The current study used a similar procedure to Harari and Waehler; however, instead of having participants listen to a taped counseling session together in small groups, this investigation had each participant individually listen to a recorded version of a counseling session through headphones at a computer. In this way, the limitation of listening to a taped counseling session in a group where noise from other participants
may have interfered with participant ability to maintain attention to what they were listening to was addressed.

Another limitation to Harari and Waehler’s investigation may have been the absence of an assessment of participant attitudes toward counseling. Because of this omission, there is no way of knowing if attitudes toward counseling influenced participant ratings of counselor credibility. The current investigation included a measure of attitudes toward counseling in order to determine its influence, if any, on counselor ratings.

Although no studies assessed perceived counselor credibility and its relationship to religious and spiritual functioning of the client at intake directly, one study did investigate pre-counseling information, religiosity, and problem type and their effects on willingness to seek help and ratings of counselor social influence (Guinee & Tracey, 1997). Specifically, using an analogue design, Guinee and Tracey examined the interaction between pre-counseling information (counselor description: secular, spiritual-empathic, or Christian), religiosity, and problem type for their effect on counselor social influence ratings (credibility) and willingness to seek help. Participants were from a large, Midwestern state university educational psychology class and a Christian campus organization. Participants in each group were given a questionnaire packet which included the CRF-S (Corrigan & Schmidt, 1983) to assess perception of counselor credibility, the Shepherd Scale (Bassett, Saddler, Kobischen, Skiff, Merrill, Atwater, & Livermore, 1981) for determining level of religiosity, and a willingness to seek help scale (WSH; Guinee & Tracey, 1997) developed for the study. Results of a hierarchical
multiple regression analysis found a significant main effect for participant religiosity on counselor credibility ratings (i.e., social influence) and on willingness to seek help ratings, but no significant main effects were found for counselor description or problem type on counselor credibility and willingness to seek help ratings. Additionally, significant interaction effects were found for counselor description and participant religiosity on counselor credibility and willingness to seek help ratings which accounted for 6% and 12% of the variance respectively (Guinee & Tracey, 1997). There was also a significant interaction between counselor description, problem type, and religiosity for counselor credibility ratings which accounted for 4% of the variance.

The interaction of religiosity of participant with counselor description and problem type was investigated by dividing participants into “low” and “high” religiosity groups using a sample median split Shepherd Scale (Bassett et al., 1981) score of 117. Post hoc Scheffe $t$ tests indicated that the high religiosity group rated the Christian counselor description significantly higher than the low religiosity group on the counselor credibility and willingness to seek help ratings. However, the high and low religiosity groups did not rate the secular and spiritual-empathic counselor descriptions significantly different from each other on the counselor credibility and willingness to seek help ratings. No significant interaction effect was found for counselor description and problem type, or problem type and religiosity for the counselor credibility or willingness to seek help ratings.

Although Guinee and Tracey (1997) found that participant level of religiosity predicted counselor ratings and willingness to seek help, their results were based on a
description of a counselor in a study examining pre-counseling information and not counselor characteristics during a counseling intake session. Additionally, the religiosity scale (Shepherd Scale; Bassett et al., 1981) Guinee and Tracey utilized to measure level of religiosity, was specifically designed to differentiate Christians from non-Christians which limits the generalizability of their findings. Still, their findings support religiosity as a variable of influence in counselor ratings. What are needed are further investigations of these variables in relation to counselor behavior in the therapeutic context. Thus, the current investigation which assessed counselor behavior during an initial intake interview was warranted.

In summary, what can be understood from these various findings is that perceived counselor credibility is important to the therapeutic process. Perception of counselor credibility affected counseling outcome (LaCrosse, 1980), retention (Wade & Bernstein, 1991), and satisfaction with counseling (McNeill et al., 1987). Guinee and Tracey’s findings further suggested counselor ratings can be influenced by the level of religiosity of participants, and that the influence of client religiosity on these ratings may vary as a function of the counselor’s description as religious. This suggests a need for continued examination of variables, including religion and spirituality that influence clients and potential clients to be satisfied with their counselor and to return for additional sessions after the initial intake interview. The primary question being assessed in the current investigation was whether participant perception of counselor credibility is enhanced when the counselor assesses religion and spirituality at intake.
On a related note, research indicated that general attitudes toward seeking psychological help are related to counselor ratings of competence and credibility (Constantine, 2002; Guinee & Tracey, 1997; Lewis & Epperson, 1991). Furthermore, Cepeda-Benito and Short (1998) found that favorable attitudes toward seeking professional psychological help predicted likelihood of seeking counseling regardless of presenting concern. Of note, apart from Guinee and Tracey, the previous studies regarding perceptions of credibility of counselor (Harari & Waehler, 1999; McNeill et al., 1987; Wade & Bernstein, 1991) did not assess attitudes toward counseling as a variable of interest when testing their hypotheses. The current study rectified this shortcoming and included a measure of attitudes toward counseling for possible moderating effects. This method paralleled what was done more recently by Constantine (2002) in a study evaluating perception of counselor competence as a predictor of satisfaction with counseling, as she included a measure of attitudes toward counseling. According to Constantine, attitudes toward seeking psychological help accounted for 19% of the variance between counselor competence ratings and counseling satisfaction.

Preferences for Discussing Religion and Spirituality

In order to strengthen the argument for examining therapist credibility as a function of attention to religious and spiritual issues at intake, extant research regarding preferences for the discussion of religion and spirituality in counseling and medical healthcare is reviewed. Preference for discussion of religious and spiritual concerns in patient medical care was discussed first, as religion and spirituality have become a recognized domain of individual functioning that is being assessed and discussed as
integral to patient recovery and well-being. Some research also suggested a substantial number of healthcare patients prefer that their physician address religious issues with them. For example, according to Miller and Thoresen (1999), “Medical patients often wish that their doctors would talk with them about spiritual matters, even pray with them, and many draw on spiritual coping resources in times of illness” (p. 10). Miller and Thoresen also reported that religious and spiritual involvement is linked to positive health outcomes; “When spiritual and religious involvement has been measured (even poorly), it has with surprising consistency been found to be positively related to health and inversely related to disorders” (p. 11).

Maugans and Wedland (1991) investigated the role of religion in the practice of family medicine. Family physicians (N= 126) and a convenience sample of adult patients (N= 135) filled out a 31-item questionnaire regarding the role religion played in the physician and patient relationship. Eighty nine percent of physicians felt they had the right to discuss religion with their patients. Physicians reported the frequency of religious inquiry as always (1%), frequently (10%), occasionally (77%), and never (12%). Forty percent of patients stated their physician should discuss religious issues with them, and 30% of patients indicated they would like their physician to address religious issues with them. However, this study’s physician population was predominantly male and the patient population was predominantly married white women from one area of Vermont. Therefore, according to Maugans and Wedland, a larger cross-sectional survey in other regions of the country where religious beliefs and practices may differ would enhance the generalizability of their results.
King and Bushwick (1994) surveyed inpatients (N= 203) at two hospitals in two states and found that many of the patients preferred physicians include spiritual considerations in treatment. Seventy seven percent of patients stated that a patient’s spiritual needs should be considered, while 48% wanted their physician to pray with them, and 37% wanted their physician to discuss religious beliefs with them more often. King and Bushwick recommended physicians attend to their patients’ religious functioning because based on their study, religious beliefs and experiences are important to hospitalized patients. However, like Maugans and Wedland (1991), King and Bushwick also suggested generalization of their results were limited to the population they surveyed (inpatients at two hospitals), and suggested further research is needed with different populations in other regions of the U. S.

Daaleman and Nease (1994) also explored patient (N= 80) attitudes toward physician-directed inquiry about issues related to patient religion and spirituality, and sought to identify screening variables that mark patients as receptive to religious and spiritual discussions with their physician. Daaleman and Nease found that 63% of patients who attended religious services regularly (n= 43) believed their doctor should ask religious and personal faith questions of them. Furthermore, a majority of the patients had a preference for discussing religious and faith issues with their physicians. Patients also felt that a religious and spiritual evaluation should be part of their personal medical record. As a result of their findings, Daaleman and Nease suggested inquiring at intake, in a discreet way (e.g., as part of an intake history form), religious and spiritual beliefs of
patients to determine whether they would feel comfortable with their physician broaching the subject during a doctor’s visit.

Daaleman and Nease’s (1994) study used a convenience sample of 80 patients. Because patients were from a university based, urban family practice residency training center and were predominantly Christian, generalizability of results are limited to their population of patients. However, their results increase support for inquiring at intake about religious and spiritual functioning of patients.

In a more recent study, MacLean, Susi, Phifer, Schultz, Bynum, Franco, Klioze, Monroe, Garrett, and Cykert (2003) investigated patient preference for physician discussions and practice of spirituality. Patient respondents (N= 456) were from primary care clinics at six medical centers in Florida, North Carolina, and Vermont. Findings were consistent with Maugans and Wedland (1991) and Daaleman and Nease (1994) in that a majority of patients believe it is appropriate for the physician to inquire about spiritual beliefs. Sixty six percent felt physicians should be aware of patients’ religious and spiritual beliefs. And, not surprisingly, as severity of illness increased, patient desire for discussion and practice of spiritual issues increased; fully 50% of patients in near-death situations desired discussion of spiritual issues with their physician.

A word of caution regarding generalizability of this study is warranted in that results may not be the same across a population of individuals who are not seriously or terminally ill. However, because this study used a large population (N = 456) from three states, and six different primary care clinics, it lends support to findings of previous studies reviewed, and suggests that different populations of patients, both inpatient and
outpatient prefer to have a discussion of religious and spiritual issues with their physician.

Thus, a significant number of people from a variety of health care settings who seek medical care express a preference for interaction of a spiritual nature on some level, with their physicians. Given that many individuals who present with a physical ailment desire healthcare providers to address patient religious and spiritual beliefs, it is reasonable to consider that those who present for psychotherapy or counseling may also prefer that mental health care professionals address these issues. Quackenbox, Privette, and Klentz (1985) conducted an exploratory survey about the relationship between religion and psychotherapy. In a telephone sample of residents (N= 86) in a Pensacola, Florida neighborhood who were randomly selected to participate in the study, and who returned research surveys mailed to them, 79% responded affirmatively that religious values are an important topic for discussion in psychotherapy. Although Quackenbox et al. suggested their findings are based on a sample in a more religiously geographic area and can’t be generalized to other regions of the country, they suggested that their findings clearly indicate: “…… a large number of people want religion to be included in psychotherapy” (p. 293).

In a subsequent study by Morrow, Worthington, and McCullough (1993), participants (N= 102) from a large southeastern university rated a counselor’s treatment of a religious issue brought into counseling by a client. Participants rated the counselor after viewing one of three role plays of a counseling session where, in the last three minutes of the session the counselor ignored (suggested religious values were part of
family influences), supported (suggested client should explore Christian values, and also maybe she should focus on God’s forgiveness), or challenged (suggested client was old enough to question religious upbringing and decide to make decisions based on what she wants rather than those values) client religious beliefs. In the role play where the counselor was depicted as challenging the client’s religious beliefs, the counselor was rated lowest by student participants. Findings also suggested participants believed the client would improve more in counseling where the counselor was supportive of religious views, than with the counselor who challenged those views.

Morrow et al.’s (1993) findings also suggested that highly religious students preferred religion play a more prominent role in psychotherapy than less religious student participants. A participant was considered to be highly religious or less religious if his/her score on a 4-point Likert type scale on a measure of Christianity was one-half standard deviation above or below the mean of the scale scores. Participants in this investigation were asked, “What emphasis should religion have in the personal counseling of the person you just observed?” (p. 454). Morrow et al. found that highly religious participants preferred religion play a larger part in counseling than the less religious participants.

A shortcoming in Morrow et al.’s study was the use of only one question to assess participant preference for discussion of religious and spiritual issues in counseling. The current study improved upon this shortcoming by assessing participant preferences using 4 pairs of items from a measure of attitudes regarding integrating spirituality in the therapeutic process.
Also addressing this issue, Rose et al. (2001) recruited client participants (N = 74) from seven counseling centers. Rose et al. found participants preferred to discuss religious and spiritual concerns in therapy. Moreover, clients with higher levels of past core spiritual experiences (greater religiosity) as measured by INSPIRIT (Kass et al., 1991) were more likely to have a preference for discussion of religious and spiritual issues than were those who had lower levels of religiosity. Some participants indicated that their preference for bringing in religious and spiritual discussions into therapy would depend on how they perceived the counselor viewed spirituality and whether the counselor would understand their religion.

A limitation to their study according to Rose et al. (2001) was that selection bias may have been an influencing factor on the results, because the therapists participating in the study recruited clients from their practices, and therefore those clients who chose to participate may have been more interested in religious and spiritual issues. In turn, this may have lead to a skewed percentage of clients responding positively toward a preference for discussion of religious and spiritual issues in therapy. Indeed, assessing a different population such as students in the current investigation may provide clarification to Rose et al.’s findings by either refuting or further supporting a preference for discussion of religious and spiritual issues in therapy.

More recently Hage (2006) explored whether psychology training programs should incorporate content related to religion and spirituality in their curriculum. Her examination involved a critical look at four specialty areas in psychology (clinical psychology, counseling psychology, marriage and family therapy, and rehabilitation
psychology) and how each approaches training in religion and spirituality. Hage stated there is a need for a critical discussion because two out of three Americans report religion is important to them and believe religion provides the answers to problems in their lives. Many people, according to Hage, say religion or spirituality is integral to their cultural and racial identity, and when faced with a serious problem, most prefer to see a therapist who holds similar beliefs and values, and also prefer a therapist who will integrate client beliefs and values into the counseling situation. Hage concluded that it is time for psychologists to obtain training in this area of client functioning and for participation in theoretically based research on religion and spirituality to improve client care with clients of diverse religious and spiritual belief systems.

Clearly, a significant number of medical patients and counseling clients have a preference for discussion of religious beliefs, values, and issues when they encounter medical and mental health professionals (Daaleman & Nease, 1994; King & Bushwick, 1994; MacLean et al., 2003; Maugans & Wedland, 1991; Miller & Thoresen, 1999; Morrow et al., 1993; Quackenbox et al., 1985; Rose et al., 2001). The current study sought to broaden the generalization of these findings to a student population at a public university. In the current study, preferences for discussion of religious and spiritual issues and their effect on ratings of counselor credibility in a student population were assessed indirectly through manipulation of session content. Students come from a variety of religious and spiritual backgrounds and findings from this study may broaden our understanding for preferences regarding discussion of religious and spiritual issues in therapy and their effect on counselor ratings. Many students are also potential future
clients and their input regarding preferences for discussion in this area and ratings of the counselor may provide valuable information for improved clinical care and may lead to enhanced ability of the student to make informed choices when selecting a therapist.

Religiosity Influence

Some previous research indicated that counselor ratings can be affected by level of religiosity of the participant rating the counselor. For example, Lewis and Epperson (1991) investigated pretherapy information, values, and informed consent in Christian counseling. In order to assess for differences in beliefs and values of their participants (N = 360 undergraduate students from introductory psychology classes at Iowa State) and their possible influence in their analyses, Lewis and Epperson included the Shepherd Scale (Bassett et al., 1981) as a measure of level of religiosity. Participants responded to the 38-item religiosity scale using a 4-point scale (1=not true to 4=true). High and low religiosity were differentiated by median split where a score of 41 or above indicated higher religiosity and a score of 40 or below indicated lower religiosity. This research examined how the different pretherapy statements might be related to informed consent and participant willingness to see the counselor for a variety of issues. Main findings suggested that providing more descriptive pretherapy information about counselor beliefs, values, and approach to therapy enhanced client ability to make more informed choices when selecting a therapist. According to Lewis and Epperson (1991), participants who were high on the religiosity scale rated all counselor descriptions more favorable than participants lower in religiosity. However, higher religiosity participants believed their values were more similar to Christian counselor descriptions than to traditional
counselor descriptions. In addition, high and low religiosity participants believed traditional counselors would be more flexible than Christian counselors in their approach to solving client problems. A limitation to Lewis and Epperson’s study is the use of the Shepherd Scale which is a measure specifically designed to differentiate evangelical Christians from others. Its use with other religious or spiritual populations outside the Christian faith may not be appropriate. Also, dichotomous differentiation of participants into high or low religiosity is a shortcoming.

In a related research vein, McMinn (1991) examined the effects of emphasizing religious values above clinical skills and the effects of using sexist language on perception of therapist likability, trustworthiness, and approachability. Participants (N=115) from a continuing education program at a Christian college in the Pacific Northwest completed a questionnaire after reading one of four possible self-descriptive statements reportedly from a therapist. Two of the statements emphasized religious sensitivity over clinical skills and two emphasized clinical skills over religious sensitivity. Additionally, one of the two clinical and one of the two religious sensitivity statements also used sexist language (i.e., implied therapist is male) in the statement. To evaluate the influence of religiosity on these findings, McMinn rated participant religiosity using a 7-point Likert type scale of religious commitment where ratings of 6 or 7 determined high religiosity and ratings of 1 through 5 were considered to be low religiosity.

Results indicated participants found therapists who valued religious commitment over clinical skills as more likable, approachable, and trustworthy. There was also an interaction effect with higher-religiously committed participants preferring therapists who
emphasize religious values and lower-religiously committed participants preferring therapists who emphasize clinical skills. Although McMinn’s findings are consistent with Lewis and Epperson (1991), McMinn did not indicate what measure he used to determine level of religiosity which suggests his findings lack scientific rigor because the measure’s psychometric properties are not known. The current investigation used a measure of religiosity that has been used extensively in other research (Benoit, 2007; Bergin, Masters, & Richards, 1987; Kahoe, 1974), and has been shown to have desirable psychometric properties (Leong & Zachar, 1990).

Guinee and Tracey (1997) examined the interaction between three different types of counselor descriptions (secular, religious-empathic, and Christian), religiosity, and problem type on counselor ratings of credibility and willingness to seek help. Utilizing an analogue design, Guinee and Tracey found that high religiosity individuals rated Christian counselors significantly more credible than did secular and religious-empathic (empathic to Christian beliefs) counselors. According to Guinee and Tracey, high religiosity individuals are also more willing to seek counseling than low religiosity individuals. Guinee and Tracey, like Lewis and Epperson (1991), used the Shepherd Scale which may not be appropriate for non-Christian populations. Therefore, findings with other religious or spiritual populations may be different than those found by these researchers.

Rose et al. (2001) investigated client beliefs and preferences for the appropriateness of discussing religious and spiritual issues in psychotherapy with client participants (N = 74) from seven counseling centers. As a related component of the
investigation, Rose et al. included a measure of level of religiosity. She and her colleagues found that level of religiosity (core spiritual experience), measured by INSPIRIT (Kass et al., 1991) was the only significant predictor of the belief about appropriateness and preference for discussion of religion and spirituality in therapy. High religiosity clients had more favorable views of integrating religion and spirituality into counseling where appropriate than did low religiosity clients.

Rose et al.’s investigation suggested clients higher in religiosity (higher past spiritual experiences) prefer to discuss religion and spirituality in counseling. A strength of Rose et al.’s study is the use of actual clients from seven different counseling centers. However, a limitation to her study was the size of her sample (N= 74). The current investigation used a larger sample (N= 226) of a student population to assess whether higher religiosity participants would rate a counselor more credible if that counselor inserts religious and spiritual items into an intake session. Guinee and Tracey (1997) found that level of religiosity was an influencing variable when rating counselor credibility. Conducting the current research with a larger student population added to the research literature in the area of religion and spirituality in the counseling environment.

In contrast, Morrow et al. (1993) examined perceptions of counselors and found students rated the counselor they viewed in a role play video according to how the counselor responded to the client’s religious values, regardless of level of religiosity. Morrow et al. developed 3 10-minute role play videos in which a counselor was depicted as supporting, ignoring, or challenging the client’s religious values in psychotherapy. Participants (N= 102) rated the counselor who challenged the client’s religious values
(suggested client was old enough to question religious upbringing and decide to make decisions based on what she wants rather than those values) as least likely to be persuasive toward therapeutic change with the client. Student participants were also more likely to indicate that they would not return for more sessions with the counselor who challenged the client’s belief system regardless of their level of religiosity.

According to Morrow et al., how a counselor demonstrates respect for a client’s religious values was more important to these student participants than whether or not they agreed with a particular set of values. These findings appear to suggest that in some instances, level of religiosity does not determine perception of therapist credibility. Therefore, continued research is needed to extend empirical evidence of this variable’s influence on counselor characteristics in the therapy setting.

Although some studies have suggested that being highly religious affects how people rate counselors (Guinee & Tracey, 1997; Lewis & Epperson, 1991; McMinn, 1991), and that highly religious people prefer to discuss religious and spiritual issues in therapy (Morrow et al., 1993; Quackenbox et al., 1985; Rose et al., 2001), none have examined whether higher religiosity affects ratings of counselor credibility in a student population when a counselor includes items of a religious and spiritual nature at intake. The current investigation examined this possible influence on counselor ratings.

Summary

It is apparent from the increase in research devoted to the interface of psychology and religion and spirituality in the last two decades that the domain of religion and spirituality has become a recognized variable of interest in psychological research and
practice with a multicultural population, thus justifying the need for further empirical research in this area at this time. In addition, research has demonstrated that religion and spirituality are, in many cases, an integral part of the client’s experience, which warrants assessing and addressing it in therapy where appropriate (Hathaway et al., 2004; Hill & Pargament, 2003; Kelly, 1997). Religion and spirituality are significant dimensions of cultural identity within the multicultural landscape which therapists will encounter during their professional lives (Hage, 2006; Richards & Bergin, 2000).

Several prominent theorists (Aten & Hernandez, 2004; Leach et al., 2009; Pargament, 2007; Plante, 2009) have directed counselors to include questions about religion and spirituality in counseling, especially at intake. What had yet to be explored were perceptions of the counselor when these questions are asked. Although it seems reasonable to expect counselors may be viewed as more credible if they address this important issue, empirical investigation is needed to explore the issue further. To date, related research has only demonstrated a preference by clients for discussing religion and spirituality in therapy (Rose et al., 2001). This is unfortunate as numerous other studies have examined empirically client perceptions of counselor credibility in relation to other important variables that affect counseling outcome (LaCrosse, 1980), retention (McNeill et al., 1987), and satisfaction with counseling (Constantine, 2002; Fuertes & Brobst, 2002). What is needed now is an empirical investigation of the effect of assessing religious and spiritual functioning at intake on perceptions of counselor credibility.
Hypotheses

To test various theorists’ and clinicians’ assertions that assessing religious and spiritual functioning as part of an initial intake interview enhances the client’s perception of counselor credibility (Aten & Hernandez, 2004; Constantine et al., 2000; Eck, 2002; Hage, 2006; Prest, 1999; Richards & Bergin, 2000), the current study included two versions of an intake interview to investigate differences, if any, between students’ perceptions of counselor credibility when the counselor did or did not explore religious issues. The following hypotheses were tested in the current study:

Hypothesis 1: Participants will rate the intake counselor who includes religious and spiritual items as part of the overall assessment of client functioning as more credible than the intake counselor who does not include religious and spiritual items as part of the overall assessment of client functioning.

Because research suggested that many clients have a preference for discussion of religious and spiritual issues in counseling (Morrow et al., 1993; Quackenbox et al., 1985; Rose, et al., 2001), this study also assessed whether preference for discussing religion and spirituality in counseling is related to counselor ratings in the two conditions. Hypothesis 2: Participant preference for discussing religious and spiritual issues in counseling will moderate ratings of counselor credibility based on whether or not the counselor includes religious and spiritual items as part of the overall assessment of client functioning. Participants with a stronger preference for discussing religious and spiritual issues are expected to perceive the counselor in the intake interview which includes...
religious and spiritual items as more credible than the counselor in the intake interview without religious and spiritual items.

Finally, because research also suggested that participant level of religiosity is related to counselor ratings of credibility (Guinee & Tracey, 1997; Lewis & Epperson, 1991; McMinn, 1991), this study assessed participant level of religiosity and its relation to counselor ratings.

*Hypothesis 3*: Participant religiosity will moderate ratings of counselor credibility based on whether or not the counselor includes religious and spiritual items as part of the overall assessment of client functioning. Participants with higher self-reported religiosity are expected to perceive the counselor in the intake interview which includes religious and spiritual items as more credible than the counselor in the intake interview without religious and spiritual items.
CHAPTER III

METHODOLOGY

This chapter describes the participants, measures used, experimental conditions, and procedures for the current research study. Details regarding the participants and measures used for the current investigation are discussed first. The development of the experimental conditions is explained next, followed by procedures. An explanation for the use of the audio tape analogue design in the current study is stated next.

A power analysis was computed for the current study that determined sample size based on requirements for a one-way ANOVA to test the first hypothesis in this investigation. In the current investigation a power analysis for a one-way ANOVA suggested a total $N = 128$ (64 per group) to obtain a minimum power of .80 for a medium effect size (Borenstein, Rothstein, & Cohen, 2001). Tabachnik and Fidell (2001) suggested that when using a one-way ANOVA, a large sample size is usually best to ensure that the sampling distribution of means for each level of the independent variable is normal, and for assuming homogeneity of variance within both groups. Schlomer, Bauman, and Card (2010), in a recent article regarding best practices for managing missing data, suggested that a small $N$ size in counseling psychology research is 100. Consequently, in the current investigation a total $N$ size of 226 (113 per group) was determined to be adequate. This sample size seemed reasonable when considering issues
of non-response to items, manipulation check errors, and other sources of errors that invariably occur in the research process. Moreover, comparable perceptions of counselor competence research in mental health literature included N sizes between 34 to 215 participants (Constantine, 2002; Epperson & Pecnik, 1985; Fuertes & Brobst, 2002; Harari & Waehler, 1999; Johnson, Pierce, Baldwin, Harris, & Brondmo, 1996; McNeil, May, & Lee, 1987). A power analysis was also computed for sample size based on requirements for hierarchical regression analyses for hypotheses 2 and 3 (Soper, 2010). The required sample size (N = 79) to obtain a minimum power of .80 for a medium effect size was smaller than that required for the one-way ANOVA computed for hypothesis 1, so the larger N was used in the current study.

Participants

Participants (N = 226) were undergraduate psychology students from a large Midwestern public university. As described in the results section, 50 of the participants’ data were excluded from the analysis. The final group of 176 student participants used for testing the current study’s supposition consisted of 124 (70.5%) women and 52 (29.5%) men, with a mean age of 21 (range = 18 – 52; SD = 5.39). By race or ethnicity, 38 (21.6%) of the participants self-identified as African American/Black, 3 (1.7%) as Asian American, 125 (71.0%) as Caucasian/White, 3 (1.7%) as Hispanic, 2 (1.1%) as Mixed, and 5 (2.8%) as Other (see Table 1). For educational level, 93 (53.1%) were freshmen, 40 (22.9) were sophomores, 28 (16%) were juniors, and 14 (8.0%) were seniors. Regarding religious affiliation/preference, 133 (76%) self-identified as Christians (Catholic, Baptist, Lutheran, Protestant, etc…., non-denominational), 1 (.6%) as Buddhist, 1 (.6%) as Hindu, 38 (21.7%) as Other, 2 (1.1%) as Not Religiously Affiliated, and 1 (.6%) participant did not indicate a
religious affiliation/preference. The “Other” group consisted of Pagan, Spiritual but not religiously affiliated, Agnostic, Shaman, Greek Orthodox and, I believe in a supreme being. There were 60 (34.3%) participants who had previously received psychological services and 115 (65.7%) participants who had never received psychological services. One participant did not indicate previous psychological services utilization.

Table 1
*Demographic Characteristics of the Sample by Group*

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<td>≥40</td>
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<td>3%</td>
<td>3</td>
<td>50%</td>
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<tr>
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<td>21.6%</td>
<td>21</td>
<td>23.9%</td>
</tr>
<tr>
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<td>1.7%</td>
<td>2</td>
<td>2.3%</td>
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<td>61</td>
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<tr>
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<td>.0%</td>
</tr>
<tr>
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<td>2.8%</td>
<td>3</td>
<td>3.4%</td>
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<tr>
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<tr>
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<tr>
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<td>22.9%</td>
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</tr>
<tr>
<td>Junior</td>
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<tr>
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<td>8%</td>
<td>8</td>
<td>9.2%</td>
</tr>
<tr>
<td>Rel. Affil/Pref.</td>
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<td></td>
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<td></td>
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<tr>
<td>Christian*</td>
<td>133</td>
<td>76%</td>
<td>63</td>
<td>72.4%</td>
</tr>
<tr>
<td>Buddhist</td>
<td>1</td>
<td>.6%</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>Hindu</td>
<td>1</td>
<td>.6%</td>
<td>0</td>
<td>.0%</td>
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62
Table 1 Demographic characteristics of the sample by group (continued)

<p>| | | | | | |</p>
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<td>Other**</td>
<td>38</td>
<td>21.7%</td>
<td>21</td>
<td>24.1%</td>
<td>17</td>
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<tr>
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<td>2</td>
<td>2.3%</td>
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</tr>
<tr>
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<td>.6%</td>
<td>1</td>
<td>1.1%</td>
<td>0</td>
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</tbody>
</table>

**Note.** (N=176). Not all totals add up to the total N because of missing data. *Christian included: Catholic, Baptist, Lutheran, Protestant, etc…, non-denominational. **Other included: Pagan, Spiritual but not religiously affiliated, Agnostic, Shaman, Greek Orthodox and, I believe in a supreme being.

Measures

*Demographic Questionnaire* (see Appendix A) was researcher composed and requested participants state certain personal information including age, race/ethnicity, sex, year in school, and previous psychological services received, if any. This information was used to describe the sample and to examine any correlations within this data set.

*Attitudes Toward Seeking Professional Psychological Help-Short Form* (*ATSPPH-S; Fischer & Farina, 1995*) (see Appendix B) was used in this study to assess, and control for, respondent attitudes toward counseling. The ATSPPH-S is a 10-item, 4-point Likert-type (0 = disagree, 1 = partly disagree, 2 = partly agree, 3 = agree) scale. The ATSPPHS-S is a shortened version of the 29-item ATSPPHS developed by Fischer and Turner (1970) for measuring attitudes toward seeking professional psychological help. A total score is obtained by summing all 10 items with a range of scores being 0 to 30. Depending on an item’s pro-help-seeking or anti-help-seeking content, each item was scored 3-2-1-0 (straight items) or 0-1-2-3 (reversal items). Higher scores are associated
with a more positive attitude toward seeking psychological help. Fischer and Farina’s scale development with an undergraduate student population (N = 389) in introductory psychology courses, demonstrated an internal consistency coefficient of .84, and a test-retest reliability of .80 for a 1-month interval was reported. Construct validity was established with the finding that the ATSPPH-S displayed significant point-biserial correlations between participants who sought help and those who had not: (.39, \( p < .0001 \)) overall, (.49, \( p < .0001 \)) for men, (.24, \( p < .03 \)) for women (Fischer & Farina, 1995). In a study by Constantine (2002), an internal consistency coefficient of .83 was obtained for the ATSPPHS-S with 112 clients of color where attitudes toward counseling were assessed for possible moderating effects. Constantine found that client attitudes toward counseling did not function as a moderator between counselor competence ratings and client satisfaction. The current investigation sought to extend Constantine’s (2002) findings by assessing respondents’ attitudes toward seeking psychological services prior to evaluating the main hypotheses to determine possible influence in participant’s ratings of counselor credibility. It is important to assess attitudes toward counseling because the current investigation sought to argue that it is the counselor’s inclusion of items of a religious and spiritual nature that influences counselor ratings of credibility and not participant attitudes toward counseling.

*Counselor Rating Form-Short* (CRF-S; Corrigan & Schmidt, 1983) (see Appendix C) was used in the current investigation to assess perceptions of counselor credibility. The CRF-S was designed to address the utility of the original Counselor Rating Form (CRF; Barak & LaCrosse, 1975) which was developed to investigate Strong’s (1968)
dimensions of perceived counselor expertness, trustworthiness, and attractiveness (credibility). The original CRF consisted of 36 7-point bipolar scales. Subsequent research with the original CRF suggested it is a reliable instrument which is able to discriminate on the three dimensions (Barak & Dell, 1977; Kerr & Dell, 1976).

The CRF-S (Corrigan & Schmidt, 1983) consists of 12 items, 4 for each of the dimensions of expertness, trustworthiness, and attractiveness. Total CRF-S scores range from 12 to 84 with higher ratings indicating stronger perceptions of counselor credibility. **Expertness** is defined as client belief in the counselor’s professional knowledge and skills that will help them deal effectively with their problems. **Trustworthiness** is client perception that the counselor is sincere, open, honest, and is not motivated for personal gain. **Attractiveness** is defined as client perception of liking, admiring, and similarity to his/her counselor. Strong’s (1968) theoretical model for counseling suggested that expertness, trustworthiness, and attractiveness of the counselor are vital ingredients in determining the counselor’s ability to exert interpersonal influence in counseling. The CRF-S improved the utility of the CRF by reducing the time it takes for administration and lowering the educational level to an eighth grade reading level using only items with high factor loadings from the previous scale (Corrigan & Schmidt, 1983; Epperson & Pecnik, 1985). Epperson and Pecnik reported that these requirements in general were met while preserving adequate levels of reliability in the CRF-S. According to Corrigan and Schmidt reliability coefficients on the CRF-S ranged from .82 to .91 for each scale and confirmatory factor analysis suggested that a 3-factor oblique model provided the best fit for the observed data across a college sample (N = 133) and a client sample (N = 155).
Although the three subscales of the CRF-S can be used as individual dependent measures (Corrigan & Schmidt, 1983), numerous studies have used the CRF-S as a global measure of perceived counselor credibility due to its high interscale correlations (Constantine, 2002; Fuertes & Brobst, 2002; Guinee & Tracey, 1997; Harari & Waehler, 1999; Kokotovic & Tracey, 1987; Tracey, Glidden, & Kokotovic, 1988). Thus, in the current study the total score of the CRF-S was used. The three subscale scores were explored in additional analyses.

**Manipulation Check.** Participants were asked to respond to a manipulation check (see Appendix D) for the current study. Following the completion of the CRF-S, the manipulation check was used to determine if participants paid attention to the type of activity that was depicted in the study, representing the group into which they were randomly assigned. This information was used to determine if the manipulation had its intended effect. These analyses were reported in the results section of this study, and those students who incorrectly respond to the manipulation check were dropped from the final analysis.

**Client Attitudes Toward Spirituality in Therapy.** (CAST; Rose, 1998; Rose et al., 2001). The CAST (see Appendix E) was used in the current study as a measure of participant preference for discussing religious and spiritual issues in therapy. The CAST was constructed as a measure of attitudes about appropriateness and preferences for discussing religious or spiritual issues in counseling. The scale was developed using clients (N=74) from seven different counseling centers and Rose (1998) found that a 2 factor solution was the best fit for the data. Factor I demonstrated high internal
consistency with a coefficient alpha of .96 and was determined to be a measure of preferences for discussing religion and spirituality in therapy. Factor II was determined to be a measure of the counselor’s willingness for discussing religion and spirituality in therapy with a coefficient alpha of .78. Total coefficient alpha for the CAST was .86 demonstrating good internal consistency.

The CAST includes 6 pairs of items, where each pair of items is identical except that in one item of the pair, the word *spiritual* is used and in the other item of the pair, the word *religious* is used. For example, “In general, how important do you believe discussion of *spiritual* issues is to counseling?” and, “In general, how important do you believe discussion of *religious* issues is to counseling?” One additional open-ended item asking respondents to comment on why they would or would not like to discuss religious and spiritual issues in counseling was included at the end. Responses to this question were subjected to additional analysis to explore why clients did or did not prefer these types of discussions. Rose’s CAST (1998) utilizes a 5-point Likert type scale, ranging from 1 (*not at all important*) to 5 (*extremely important*) where scores above the neutral value of 3 were considered indicative of a preference for discussion of religious and spiritual issues in counseling. The CAST-Factor I mean for Rose et al.’s sample was 3.39 (SD= .90).

Because Rose’s (1998) analyses suggested that the first four pairs of items (i.e., items 1 to 8) were a measure of client preference for discussing spiritual and religious issues in therapy, with good internal consistency (r=.96), she used only these four pairs of items in her analyses to determine preferences for discussing spiritual issues in
counseling. Consistent with Rose, although the full measure was administered to participants, only items from Rose’s first factor were used to measure preferences for discussing religious and spiritual issues in therapy. Additionally, consistent with Rose (1998), mean scores on the CAST-Factor I above the neutral value of 3 in the current investigation indicated a tendency for participants to prefer to discuss religious and spiritual issues in counseling. Conversely, mean scores below the neutral value of 3 indicated a tendency toward not preferring to discuss religious and spiritual issues in counseling. This method of analyses is consistent with Rose’s (1998) original development and research with the CAST. Follow-up analyses with the CAST were conducted whereby higher scores were used to indicate a higher preference for discussion of religious and spiritual issues in counseling. Responses to the open-ended question in this measure were analyzed in the same fashion Rose analyzed why clients did or did not prefer these types of discussions.

*Religious Orientation Scale* (ROS; Leong & Zachar, 1990). The ROS (see Appendix F) was included in the current investigation as a measure of religiosity. Allport and Ross (1967) developed the original 20-item ROS as a measure of religious orientation to delineate the differences between intrinsic and extrinsic religiosity. According to Allport and Ross, intrinsically motivated people live their religion while extrinsically motivated people use their religion. Leong and Zachar shortened the scale to 15 items and from a sample of American (N= 285) and Australian (N= 138) college students found that a three factor solution (one intrinsic and two extrinsic factors) best represented the data.
ROS is a 15-item scale that measures intrinsic (I) religiosity (9 items; item 5 is reverse scored) and two forms of extrinsic religiosity (3 extrinsic-social (ES) religiosity items, and 3 extrinsic-personal (EP) religiosity items). Items are endorsed on a 5-point Likert type scale ranging from Strongly Disagree to Strongly Agree. The alpha coefficient for the I scale were .87 for the American sample, and .90 for the Australian sample. Alpha coefficients for the ES scale were .63 and .65, and for the EP scale alpha coefficients were .62 for both samples. Alpha coefficients for E scales combined were .69 in both samples. The ROS was be used in the current investigation to examine the influence, if any, of a participant’s religiosity on predicting ratings of counselor credibility.

Similar to the CAST, the complete ROS was administered to participants, however, only the intrinsic (I) subscale was used in data analysis as a measure of religiosity. This is because only the I scale of the ROS has been found to demonstrate psychometric consistency and rigor across studies (Gorsuch & McPherson, 1980; Kass, Friedman, Leserman, Zuttermeister, & Benson, 1991; Kirkpatrick, 1989) and has been found to correlate strongly (r = .69, p < .0001) with INSPIRIT (Kass et al., 1991), a measure of religiosity used by Rose et al. (2001). Rose et al. found that clients higher in religiosity, significantly predicted preference for discussion of religious and spiritual issues in counseling. In the current investigation, mean scale scores on the ROS’s I subscale were used to determine religiosity of participant such that higher scores were indicative of a higher commitment to religion and spirituality (higher religiosity).
**Experimental Conditions**

The Independent Variable (IV) for the current study was a mock 8 minute audio taped initial intake interview with two levels of an experimental condition which were be of scripted material. Both versions of the intake interview were identical except for the manipulation regarding attention to religion and spirituality. The Dependent Variable (DV) was perception of counselor credibility measured by the CRF-S (Appendix C).

Two female graduate level counseling psychology students played the part of college counselor and student client in the mock initial intake interviews. Research has demonstrated mixed findings regarding the client-counselor dyad (Blier, Atkinson, & Geer, 1987; Hall, Guterman, Lee, & Little, 2002; Stamler, Christiansen, Staley, & Macagno-Shang, 1991). Therefore, in order to avoid introducing a possible influencing variable of a male and female counselor dyad, two female graduate students were selected for the role plays. The college counselor role was played by a post-internship female graduate student and the student client was played by a second year female graduate student. The scripted intake interviews were recorded at The University of Akron in a psychology department counseling room. The respondents in the current investigation were randomly assigned to listen to one of the two levels of the IV (the role play tapes): (1) religious and spiritual items inserted into an initial intake interview (see Appendix G) or, (2) no religious and spiritual items inserted into an initial intake interview (see Appendix H). Both of the initial intake interviews used in this investigation were approximately 8 minutes in length.
The two scripts for this investigation were developed by the researcher of the current study. Initially, religious and spiritual items recommended by Gorsuch and Miller (1999), Leach et al. (2009), Pargament (2007), and Plante (2009) were examined and compared with each other. A list of religious and spiritual statements and questions recommended for a counselor to use early in counseling was compiled. The four areas of recommended initial inquiry at intake were religious and spiritual background, importance of religion and spirituality in the client’s experience, current attendance at church or place of worship, and relevance of religious and spiritual issues to the client in counseling.

Next, several intake forms from a variety of college, university, community, and religious and spiritually oriented counseling centers were obtained from At the Office (Gilles-Thomas, 2009), and reviewed for use in the overall development of the script for the current investigation. At the Office provides a wide range of resources for the counseling center professional including examples of intake forms from a variety of college and university counseling centers. At the Office also provides additional links to community and religious and spiritually oriented counseling centers. Eighteen intake forms were examined (12 college/university intake forms, 3 community counseling center intake forms and 3 faith-based counseling center intake forms). These eighteen intake forms were used to develop a variety of areas of inquiry to include in the vignette used for the current investigation. For example, family of origin items, previous counseling, and current medications were on the intake forms, so they were included in the script for this study. Additionally, of the initial 18 intake forms reviewed, 8 intake
forms listed religious and spiritual questions or listed religious and spiritual concerns as one item on a problem checklist for the client to endorse if appropriate. Four of the eight intake forms with religious and spiritual items were from colleges and universities, one was from a community counseling center and three were from faith-based counseling centers. These items were reviewed and compared to the theorists’ recommendations.

After the scripts were constructed from the resources mentioned above, each went through several revisions in consultation with the faculty advisor for the study. Then the researcher and faculty advisor met with one of the committee members for consultation regarding the manipulation within the script and additional changes were made as a result of that meeting. Additionally, after these changes were made, the researcher enlisted feedback from 11 graduate counseling psychology students (i.e., 4th year or greater level graduate students) regarding the scripts. Nine graduate students responded. The general consensus was that the scripts were comparable. However, some additional changes were made as a result of the graduate students’ feedback to enhance the readability of the scripts by the two students performing the role play.

The final four religious and spiritual items included in the religious and spiritual items script (Appendix G) were “Did some of the family activities together also include religious or spiritual activities?” (addresses client religious and spiritual history), “Are you involved with a church now?” (addresses current religious and spiritual activity), “Is your faith important to you?” (addresses importance of religion and spirituality to client), and “Would you like to talk about those beliefs in counseling if it seems relevant?” (addresses relevance to counseling according to client). In essence, the addition of these
four questions is what distinguishes the experimental condition for the current study from the comparison condition.

In the comparison script (Appendix H), all items are identical to the experimental condition script except for the section with items about other activities. The 4 items used in this part of the script are “What types of family activities did the family do together?”, “So, do you enjoy being outdoors, going hiking, and camping?”, “Where is your favorite place to hike around here?” and, “It sounds like you find time to do some of the things you like to do away from your classes at the university.” These items were chosen by the researcher after consultation with the faculty advisor for this investigation. Additional changes were made after consultation with a committee member. The final four items were believed to be sufficiently different from the focus of the first script to be able to provide a clear distinction between the two experimental conditions. This script has an ending identical to the first script.

Procedures

Psychology undergraduate student participants received an Informed Consent Form (see Appendix I) to read and sign, and an Instructions Form (see Appendix J) stating the purpose of the investigation, that participation in this study was completely voluntary, and that they may discontinue their participation in the study at any time. After signing the informed consent, these forms were kept in a locked file cabinet in the researcher’s office, separate from other data collected for this experimental study for the purposes of maintaining confidentiality of participants.
When the experiment began, participants were stationed at one of four computers connected to a set of ear phones for listening to the intake interview in a laboratory in the Psychology Department of The University of Akron. Each participant then completed the CAST (Appendix E), the ROS (Appendix F), the ATSPPHS (Appendix B), and then the Demographic Information Form (Appendix A) on the computer before beginning to listen to one of two randomly assigned audio taped mock Initial Intake Interviews (Appendix G and Appendix H). At the beginning of each of the audio taped initial intake interviews, the participant heard the researcher give a brief description of the study and ask the participant to imagine he/she is the client in the initial intake interview, a procedure commonly used in analogue research (e.g., Ellingson & Galassi, 1995; Waehler, Hardin, & Rogers, 1994). The participant again heard the researcher at the end of the role play giving additional information about the remainder of the initial intake interview they listened to and then the audio recording ended. Additionally, as the participant was listening to the audio, the script he/she was listening to appeared on the computer screen in front of the participant so that he/she could follow along. Having the script in front of the participant while they were listening to the interview was designed to maintain participant attention and avoid distraction during this portion of the experiment.

Following the audio recording, participants completed the CRF-S (Appendix C) and the Manipulation Check (Appendix D) on the computer. The Religious Affiliation/Preference Form (see Appendix K) was then completed for descriptive purposes only. At the end of the experiment, participants were asked if they had any questions or comments for the investigator and then were given a Debriefing Statement.
(see Appendix L) regarding the experiment in which they just participated, along with information about available counseling on The University of Akron campus.

The current investigation used an audio taped initial intake interview method because similar research has utilized audio taped analogue designs for investigating perceptions of counselor competence (e.g., Harari & Waehler, 1999). Additionally, research has demonstrated that audio and video analogue formats demonstrated similar effects of client perceptions toward their counselor (Hardin & Yanico, 1981; Johnson, Pierce, Baldwin, Harris, & Brondmo, 1996; Schwab & Harris, 1984). Therefore, Hardin and Yanico, and Johnson et al., recommended that unless visual cues (e.g., physical attractiveness, attire) are necessary to the purposes of the study, audio presentation would be comparable in effect to video presentation.
CHAPTER IV

RESULTS

This chapter discusses the preliminary analyses and results of the main hypotheses and exploratory analyses. Initially, deleted cases, missing data, outliers, and assumptions of ANOVA and hierarchical regression including normality, linearity, homoscedasticity, and independence of residuals, and descriptive statistics are discussed. Hypothesis testing is then presented for the one-way ANOVA and the hierarchical regression analyses. An exploratory analysis concludes this section.

Preliminary Analysis

Two hundred and twenty six undergraduate students from psychology classes at The University of Akron completed a total of six questionnaires and a manipulation check for the current study. Four questionnaires (1 demographic) were completed prior to listening to one of two randomly assigned audio recordings of a mock intake interview (i.e., CAST, ROS, ATSPPH-S, and the demographic questionnaire, in that order). The CAST scale and ROS scale are religiously oriented scales and were responded to first by participants prior to the attitudes scale and the demographic questionnaire in an attempt to minimize the possibility of biases related to religious and spiritual beliefs affecting counselor ratings after listening to one of the role plays. The dependent measure for this study, a manipulation check, and a religious affiliation questionnaire (in that order) were
completed by student participants after listening to the audio recording of the intake interview.

Two participants’ data were deleted because it was determined they had listened to one complete version of the mock intake interview and at least a portion of the other version. This was determined by examining and matching the participant identification number recorded on the computer to the version of the mock intake interview recorded for that time. If a participant’s number showed up on the list twice then it was necessary to examine the actual recorded times of participation. Next, four participants reported their age to be below 18 and were deleted prior to data analysis.

Two manipulation checks were conducted after participants had listened to one of the two versions of the mock audio intake interview. Participants were initially asked to indicate whether they had just listened to a job interview or an initial intake interview. Participants indicated 100% of the time that they had listened to an initial intake interview. On the second manipulation check, participants were asked to indicate whether they had listened to an audio recording where the counselor and client talked about family activities like hiking, picnicking, and camping or whether they had listened to an audio recording where the counselor and client talked about family activities that included religious and spiritual activities. Three participants’ data were deleted because they responded to the second manipulation check incorrectly. In total, 9 participants’ data were deleted during preliminary screening prior to analyses so that the total number of participants for which further data analyses were run was 217.

Next, data were screened for patterns of participant responses. There were 33 student participants who did not vary their responses to individual items on the only
dependent measure used in the main analyses (CRF-S; Corrigan & Schmidt, 1983). These participants responded with the most positive score (7) in the range for this measure. It is possible that these participants had a very positive perception of the counselor, however their responses to previous measures used in this study did not demonstrate this pattern of responding. This pattern of responding likely demonstrated a desire to complete the experiment quickly without focused attention to individual items on the scale. The CRF-S was responded to at the end of students’ participation in the experiment after completing four previous questionnaires and listening to an 8 minute audio recording of an initial intake interview, all of which took between 18 to 22 minutes to complete. Additionally, because these participants did not vary their responses on the dependent measure, a final examination of these thirty three participants’ data was conducted to determine if group assignment was a factor in their responses. This was not the case; 17 of these 33 respondents listened to the religious and spiritual audio recording (experimental condition), and 16 respondents listened to the non-religious and spiritual audio recording (control condition). Data from these thirty three participants were removed and were not used in the final analyses. At this juncture, a total of 42 participants’ data were removed before any further analyses were conducted.

Data Screening Procedure

Missing Data. Data (N = 184) were screened for handling missing data values according to Field (2005), and Schlomer, Baumer, and Card (2010). Twenty nine missing data points were detected among the collected data of the remaining 184 participants who responded to the seven questionnaires (demographic and hypotheses questionnaires) in
this study. Six of these missing data points were from demographic questionnaires and therefore, were not included as part of the percentage of total missing data for participants since they were not needed for the main analyses. These calculations also did not include any data from the thirteenth item on the CAST variable because it was not used in the main analyses for this study. This item was an open-ended opinion question students responded to that was discussed after reporting all analyses related to the three hypotheses for this study. Regarding the variables of interest, one participant was missing two data points on one measure and another participant was missing two data points on two different measures. The remainder of the missing data points were scattered throughout the variables of interest to the current analyses in no apparent pattern. There were only 23 actual missing data points in the four variables of interest, thus less than 5% of overall data were missing, and the missing data were determined to be missing completely at random. The method used for dealing with these missing data points was to exclude cases listwise (Field, 2005; Schlomer, Bauman, & Card, 2010) which meant if an individual case was missing a data point, that individual case’s data were excluded when testing the hypotheses in the study.

Outliers. These 184 remaining cases were examined for univariate and multivariate outliers using strategies outlined by Cohen, Cohen, West and Aiken (2003), Tabachnick and Fidell (2001), and Field (2005). Items from each of the measures were first reviewed and determined to be within the normal scale ranges. Secondly, univariate outliers were examined. Tabachnick and Fidell (2001) suggested “univariate outliers are cases with very large standardized scores, $z$ scores, on one or more variables, that are
disconnected from the other z scores” (p. 73). Field (2005) and Tabachnick and Fidell (2001) suggested that cases with standardized scores above 3.29 (p < .001, two-tailed test) are potential outliers. Two cases demonstrated potential univariate outliers with z scores of 3.81 and 4.80 on total counselor ratings. Specifically, these cases had low individual item response scores on the CRF-S resulting in low total mean scores (M = 2.58; M = 1.75) on the CRF-S as compared to other cases on the CRF-S where the next lowest total mean score for an individual case was 4.33. Therefore, these cases were removed from further analyses in order to avoid undue influence of cases in the groups.

Multivariate outliers were examined next. Tabachnick and Fidell (2001; 2007) and Field (2005) recommended researchers examine values of Cooks Distance (D), and values of Mahalanobis Distance to look for values that are consistently identified as multivariate outliers for these techniques. Cooks D and Mahalanobis distance were evaluated by a regression equation where the dependent variable, counselor ratings (CRF-S) was regressed on the three independent variables, ATSPPH-S, CAST F1, and ROS-I, in this analysis. Tabachnick and Fidell (2001; 2007) and Field (2005) recommend the critical value for Cooks D is any value greater than one. Cook’s D, according to Field is a measure of overall influence of a case on the model. Tabachnick and Fidell (2001; 2007) also suggested researchers compare their Mahalanobis distance to the critical values of a Chi square distribution chart with n-1 degrees of freedom at the conservative alpha level of .001. Therefore, with 3 degrees of freedom, the critical Chi square value at p < .001 is 16.27. None of the cases reached this critical value. Similarly, no cases were found to be greater than the Cook’s D cutoff of 1. However, Cohen, Cohen, West and Aiken (2003) recommend examining the Studentized Deleted Residuals of the main study variables.
Studentized Deleted Residual values demonstrate influence of a case on the ability of the model to predict that case (Cohen, Cohen, West, & Aiken, 2003; Field, 2005). The value of the studentized residual is an index of distance between observed and predicted values of the dependent variable for each case. The recommended cutoff value according to Cohen et al for Studentized Deleted Residuals is 2.0, as about 5% of cases will likely fall above this point for smaller sample sizes (under 1000). Therefore, Studentized Deleted Residual values were examined for possible influence on the regression model. Examination of Studentized Deleted Residuals for this study identified 6 cases of influence with residuals ranging from -2.08 to -4.17. These cases were removed from further analyses.

**Normality of Distribution, Independence of Cases, Linearity, Homoscedasticity, and Independence of Residuals.** Data were screened using strategies recommended by Field (2005), Kline (1998), and Tabachnick and Fidell (2001; 2007) to determine whether the assumptions of ANOVA were met. According to Kline (1998), a scale item with skewness values greater than or equal to 3.0 or kurtosis values greater than or equal to 10.00 may be problematic and should be considered for removal. Results of the descriptive statistics for items in all scales revealed no violations of Kline’s criteria. A visual inspection of each histogram representing the variables of interest in the analyses revealed near normal distribution. Therefore, assumption of normality was met.

Next, independence of cases was examined. Procedures followed in the current study did not include a component where one participant’s behavior would have an influencing effect on another participant’s behavior. The assumption of independence of cases was met. P-plots of residuals were examined next to assess for linearity. Examination of P-plots demonstrated near linearity. Scatter plots of residuals showed no real pattern, indicating a
lack of pattern for the residuals and proving the assumption of heteroscedasticity. Lastly, independence of residuals was examined by looking at VIF values and the tolerance statistics. Tolerance values were well above .2, and the VIF values were well below 10. Therefore, errors in the residuals were determined to be independent. No further data were removed, leaving 176 cases retained for hypotheses analyses.

The experimental and control group were compared using Chi Square analyses for potential differences in sex ($\chi^2 = .983, \text{df} = 1, p = .322$), age ($\chi^2 = 21.558, \text{df} = 18, p = .252$), race or ethnicity ($\chi^2 = .570, \text{df} = 2, p = .752$), education level ($\chi^2 = 8.525, \text{df} = 5, p = .130$), religious affiliation ($\chi^2 = 1.220, \text{df} = 1, p = .269$), and previous psychological services utilization ($\chi^2 = .139, \text{df} = 1, p = .709$). Prior to running the chi square analyses, some groups were pooled within their respective categories (age, race/ethnicity, and religious affiliation) because according to Field (2005) no expected values should be below 5 (these different categories had totals less than 5) and no more than 20% of expected counts should be less than 5 for this type of analysis. Chi square analyses resulted in no statistically significant differences between the groups ($p > .05$).

Table 2 provides descriptive statistics and correlations for the variables of interest in the current study, including means, standard deviations, coefficient alphas, and range of scores. Internal consistency reliability coefficient for Attitudes Toward Seeking Professional Psychological Help-Short Form (ATSPPH-S; Fischer & Farina, 1995) was .80. This coefficient alpha was similar to Fischer and Farina’s (1995) alpha of .84 and Constantine’s (2002) alpha of .83. The internal consistency reliability coefficient for the Counselor Rating Form-Short (CRF-S; Corrigan & Schmidt, 1983) was .89, as compared to Constantine’s
The internal consistency reliability coefficient in the current study for the total Client Attitudes Toward Spirituality in Therapy (CAST; Rose, 1998; Rose et al., 2001) measure was .88. Rose’s (1998) alpha coefficient for the total measure (CAST) was .86, comparable to the current study’s total alpha. The internal consistency reliability coefficient for the CAST F1, the subscale used in the current study for measuring preference for discussing religion and spirituality in therapy, was .91. The internal consistency reliability coefficient was .94 for the CAST F2 (not used in the current analyses), which is a measure of the counselor’s willingness for discussing religion and spirituality in therapy. Rose et al.’s Factor 1 and 2 subscale coefficient alphas were .96, and .78. Only Factor 2 of Rose’s original scale development was considerably different from the current study’s alpha of .94.

The CAST (Rose, 1998; Rose et al., 2001) is a newly developed scale for measuring clients’ preference for discussion of religion and spirituality in therapy. Because of the
measure’s recent emergence into psychological research, a factor analysis was conducted on the CAST F1 in the current study for the purpose of providing additional psychometric validity and rigor for Rose et al.’s measure and to inform future research when using this portion of the instrument. Only Factor 1 demonstrated psychometric validity and rigor in Rose et al.’s study, and was the only portion of the complete instrument she used to measure preferences. The current investigation followed her example. A factor analysis using oblique rotation method for the CAST F1 was conducted in order to determine if items 1-8 (F1 subscale items) would load consistently on one factor with loadings of .35 or above, similar to Rose et al. CAST F1 items used in the analyses for this study consistently loaded above .35 on Factor 1 and accounted for 61% of the variance (eigenvalue = 4.91). When two factors were extracted, Factor 2 items accounted for an additional 12% of the total variance (eigenvalue = .996). However, the eigenvalue was below the recommended cutoff of 1 according to Kaiser’s guidelines (Field, 2005). Additionally, there was a strong correlation ($r = .68$) between the Factors and it was determined one factor was the best fit for the data.

CAST F1 was also significantly correlated ($r = .63$, $p < .001$) with the ROS Intrinsic subscale that measures level of religiosity. This is not surprising and is similar to other research (Rose, 1998) demonstrating a strong correlation ($r = .65$, $p < .0001$) between the CAST F1 and a measure of religiosity (INSPIRIT; Kass, Friedman, Leserman, Zuttermeister, & Benson, 1991) where clients with higher levels of religiosity preferred discussing religious and spiritual issues in counseling. Additionally, in a study by Benoit (2007) the ROS Intrinsic subscale correlated strongly ($r = .79$, $p < .01$) with the RCI-10 (Religious Commitment Inventory-10; Worthington et al., 2003) a measure of religiosity. Thus the observed
correlations between the CAST F1 and the ROS Intrinsic subscale appear to be consistent with previous research.

The internal consistency reliability coefficient for the total Religious Orientation Scale (ROS; Leong & Zachar, 1990) was .90. Leong and Zachar did not provide a total scale alpha for comparison. The internal consistency reliability coefficients for the subscales of the ROS were .89 in the current study for the Intrinsic subscale, .75 for the Extrinsic-Social subscale, and .67 for the Extrinsic-Personal subscale. Leong and Zachar’s subscale scores coefficient alphas were analyzed for two samples. Their reported Intrinsic subscale alphas were .87 and .90, comparable with the current study’s alpha of .89. The two additional subscale scores of Leong and Zachar’s study (ES = .63, .65 and EP = .62 for both) differed from the current study’s findings of .75 on the ES scale and .67 on the EP scale.

According to the procedures for this study, the ATSPPH-S was regressed on the CRF-S prior to testing the study’s hypotheses in order to determine if participants’ attitudes toward counseling influenced their ratings of the counselor in the groups. Participant attitudes were found not to significantly influence participant ratings of the counselor ($R^2 = .001$, df = 1, 174, $p = .626$). Attitudes toward counselors accounted for of variance on CRF-S ratings. The ATSPPH-S was then regressed on the CRF-S according to group assignment. Regression analyses for the ATSPPH-S are reported in Table 3. Participant attitudes were found not to significantly influence participant ratings of the counselor in the non-religious and spiritual group ($R^2 = .002$, df = 1, 86, $p = .237$), nor in the religious and spiritual group ($R^2 = .014$, df = 1, 87, $p = .648$). Accordingly, the ATSPPH-S was not included as a predictor in any subsequent analyses for the current study.
Table 3

Regression analysis for ATSPPH-S for Total Sample and by Group on CRF-S

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Sample</td>
<td>175</td>
<td>-.045</td>
<td>.093</td>
<td>-.037</td>
<td>-.488</td>
</tr>
<tr>
<td>R and S Grp</td>
<td>87</td>
<td>.06</td>
<td>.13</td>
<td>.05</td>
<td>.459</td>
</tr>
<tr>
<td>Non R and S Grp</td>
<td>88</td>
<td>-.16</td>
<td>.13</td>
<td>-.13</td>
<td>-1.190</td>
</tr>
</tbody>
</table>

Note. p > .05.

Hypothesis Testing

The first hypothesis stated that participants would rate the intake counselor who included religious and spiritual items as part of the overall assessment of client functioning as more credible than the intake counselor who did not include religious and spiritual items as part of the overall assessment of client functioning. Means, standard deviations, and range for the CRF-S by group are reported in Table 4. Results were analyzed using a one-way between subjects ANOVA and reported in Table 5. This analysis did not reveal a significant effect for group assignment (F = .158, df = 1, 174, p > .05). The sample means were similar for credibility of intake counselor across the experimental group condition and control group condition. These results demonstrated that hypothesis one was not supported. Subsequent subscale analyses of the CRF-S were examined to determine differential influence, if any, of the three domains of Strong’s (1968) social influence model of counselor credibility. Results of this analysis suggested differences in expertness (F = .219, df 1, 174, p > .05); attractiveness (F = .033, df 1, 174, p > .05); and trustworthiness (F = .466, df 1, 174, p > .05) based on which experimental condition the participant was in were also non-significant.
Table 4  
*Means, Standard Deviations, and Range for Counselor Rating Form-Short by Groups*

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>R and S Grp</td>
<td>88</td>
<td>5.95</td>
<td>.674</td>
<td>4.42</td>
<td>6.92</td>
</tr>
<tr>
<td>Non R and S</td>
<td>88</td>
<td>5.91</td>
<td>.664</td>
<td>4.33</td>
<td>6.92</td>
</tr>
<tr>
<td>Total</td>
<td>176</td>
<td>5.93</td>
<td>.668</td>
<td>4.33</td>
<td>6.92</td>
</tr>
</tbody>
</table>

Table 5  
*Summary of One-way ANOVA: Religious and Spiritual Group and Non-Religious and Spiritual Group*

<table>
<thead>
<tr>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>.071</td>
<td>.071</td>
<td>.158</td>
<td>.691</td>
</tr>
<tr>
<td>Within Groups</td>
<td>78.074</td>
<td>174</td>
<td>.449</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>78.145</td>
<td>175</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. (N = 176). p > .05.*

The second hypothesis posited an interaction effect such that the relationship between counselor ratings and group assignment would be moderated by preference for discussing religious and spiritual issues in therapy by participants. The 8-item CAST F1 subscale (Rose et al., 2001) is made up of two sets of 4-items that are identical save for the terms “religious or religion” in one set, and “spiritual or spirituality” in the second set (see Appendix E). These two sets of 4-items each in the subscale were compared by experimental group (religious and spiritual or non-religious and spiritual group) to determine if they would be different enough to require running moderating effects analyses separately for the second hypothesis. Results indicated no significant differences (t = -.061, p = .951) between the groups for the terms religion or religious, and no significant differences (t = -.009, p = .314)
between the groups for the terms spiritual or spirituality. Therefore, the entire 8-item CAST F1 subscale was retained to test moderating effects for preferences for discussing religious and spiritual issues in therapy.

To test the possible moderation effect of preference for discussing religious and spiritual issues in therapy, a hierarchical regression analysis was conducted using counselor ratings (i.e., CRF-S ratings) as the criterion variable (Table 6). Prior to running the analysis, group assignment and the CAST F1 variables were centered because predictor variables can be highly correlated with the interaction term created from them, thus creating problems of multicollinearity (Frazier, Tix, & Barron, 2004). Centering involved calculating the mean of both variables and creating new centered variables that were the difference between the measured variables and the mean of the variables. Group assignment (i.e., religious and spiritual items and no religious and spiritual items) and participant preference for discussing religious and spiritual issues in counseling (i.e., CAST F1) were entered into the first step of the equation. In order to assess the interaction effect of group assignment and CAST F1 scores, the “group Cast F1 interaction” variable was entered into the second step of the regression equation. A significant R^2 change at this step would indicate a moderating effect of preference for discussing religious and spiritual issues in counseling.

Table 6
Summary of Hierarchical Regression Analysis Testing for Moderation Effects on Hypothesis 2

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>-.04</td>
<td>.10</td>
<td>-.03</td>
<td>-.379</td>
</tr>
<tr>
<td>CAST F1</td>
<td>-.02</td>
<td>.06</td>
<td>-.03</td>
<td>-.417</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>-.04</td>
<td>.10</td>
<td>.03</td>
<td>-.381</td>
</tr>
<tr>
<td>CAST F1</td>
<td>-.10</td>
<td>.17</td>
<td>-.13</td>
<td>-.580</td>
</tr>
<tr>
<td>GrpCastInteract</td>
<td>.05</td>
<td>.11</td>
<td>.11</td>
<td>.470</td>
</tr>
</tbody>
</table>

Note. (N = 176). R^2 = .002 for Step 1; ΔR^2 = .001 for Step 2; p > .05
The results indicated that group assignment and preference for discussing religious and spiritual issues in counseling did not significantly predict counselor ratings ($R^2_{\text{Cha}} = .002; F_{\text{Cha}, (2,173)} = .166, p > .05$). Additionally, the interaction of group and preference for discussing religious and spiritual issues in counseling ($R^2_{\text{Cha}} = .001; F_{\text{Cha}, (1,172)} = .220, p > .05$) was not significantly related to counselor ratings. Therefore, based on this analysis, the second hypothesis was not supported. Preference for discussion of religious and spiritual issues in therapy did not moderate the relationship between group assignment and counselor ratings.

Hypothesis three posited an interaction effect such that the relationship between counselor ratings and group assignment variables would be moderated by level of religiosity (ROS Intrinsic subscale) of participant. To test this hypothesis, a hierarchical regression analysis was conducted with counselor ratings (i.e., CRF-S ratings) as the criterion variable (Table 7). Prior to running the analysis, group assignment and the ROS I variables were centered because predictor variables can be highly correlated with the interaction term created from them, thus creating problems of multicollinearity (Frazier, Tix, & Barron, 2004). Centering involved calculating the mean of both variables and creating new centered variables that were the difference between the measured variables and the mean of the variables. Group assignment (i.e., religious and spiritual items and family activities items) and participant religiosity (i.e., ROS I subscale scores) were entered into the first step of the equation. In order to assess the interaction effect of group assignment and ROS I scores, the “group ROS I interaction” variable was entered into the second step of the regression equation. A significant $R^2$ change at this step would indicate a moderating effect for level of religiosity of participant.
Table 7  
Summary of Hierarchical Regression Analysis Testing for Moderation Effects on Hypothesis 3

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>-.05</td>
<td>.10</td>
<td>-.04</td>
<td>-.458</td>
</tr>
<tr>
<td>ROS I</td>
<td>-.04</td>
<td>.05</td>
<td>-.05</td>
<td>.658</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>-.37</td>
<td>.36</td>
<td>-.28</td>
<td>-1.022</td>
</tr>
<tr>
<td>ROS I</td>
<td>-.11</td>
<td>.17</td>
<td>-.16</td>
<td>-.670</td>
</tr>
<tr>
<td>GrpROSInteract</td>
<td>.10</td>
<td>.11</td>
<td>.34</td>
<td>.931</td>
</tr>
</tbody>
</table>

*Note.* (N = 176). $R^2 = .003$ for Step 1; $\Delta R^2 = .005$ for Step 2; $p > .05$

The results indicated that group assignment and level of religiosity did not significantly predict counselor ratings ($R^2_{Cha} = .003; F_{Cha}, (2,173) = .295, p > .05$). Additionally, the interaction of group and level of religiosity ($R^2_{Cha} = .005; F_{Cha}, (1,172) = .867, p > .05$) was not significantly related to counselor ratings. The third hypothesis was not supported. Level of religiosity of participant did not moderate the relationship between group assignment and counselor ratings.

Prior to discussing the exploratory analyses with the CAST open-ended question in the current study, additional analyses were conducted based on the interesting fact that a majority (65.7%; 115) of the sample had no previous counseling experience and a majority (76%; 133) of the sample self-identified as Christian. Therefore, the question was posed as to whether these two groups of participants within this study’s sample would rate the counselors in the two role plays differently. Research has shown previous counseling experience is related to more accurate perceptions of the counseling process (Hensley, Cashen, & Lewis; 1985; Renjilian & Stites, 2002). Research has also suggested that Christians rate counselors higher than non-Christians (Guinee & Tracey, 1997). Two separate one-way between subjects ANOVA were conducted to test these suppositions.
The one-way ANOVA conducted with the religious affiliation groups and the CRF-S was discontinued because some of the religious groups had only one affiliated participant and analyses could not be completed. A one-way ANOVA was conducted between previous and no previous counseling groups and the CRF-S. Means, standard deviations, and range of scores are reported in Table 8. Those participants who had never received counseling before, rated the counselor in the previous counseling group significantly different (F = 8.911, df = 1, 174, p< .01) than the counselor in the previous counseling group.

Table 8
Means, Standard Deviations, and Range for Counselor Rating Form-Short (CRF-S) by Previous Counseling and No Previous Counseling Groups.

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prev Coun</td>
<td>60</td>
<td>5.72</td>
<td>.657</td>
<td>4.33</td>
<td>6.92</td>
</tr>
<tr>
<td>No Prev Coun</td>
<td>115</td>
<td>6.03</td>
<td>.653</td>
<td>4.42</td>
<td>6.92</td>
</tr>
<tr>
<td>Total</td>
<td>175</td>
<td>5.93</td>
<td>.669</td>
<td>4.33</td>
<td>6.92</td>
</tr>
</tbody>
</table>

Students who had no previous counseling experience rated counselors significantly higher (M = 6.03, SD = .655) than the students who had previously received counseling experience (M = 5.72, SD = .657). Means, standard deviations, and range of scores are reported in Table 9 (Trustworthiness), Table 10 (Attractiveness), and Table 11 (Expertness). Significant differences were found between students who had no previous counseling experience and students who had previously received counseling for the CRF-S subscales of trustworthiness (F = 14.003, df = 1, 174, p< .001) and attractiveness (F = 5.931, df = 1, 174, p< .05), but not for expertness (F = 2.309, df = 1, 174, p> .05).

Students who had no previous counseling experience rated counselors significantly higher on trustworthiness (M = 6.08, SD = .734) and attractiveness (M = 6.23, SD = .676)
than the students who had previous counseling experience (trustworthiness: $M = 5.62$, $SD = .819$ and attractiveness: $M = 5.96$, $SD = .772$). Students in the no previous counseling experience group did not rate the counselor they listened to ($M = 5.80$, $SD = .882$) as more credible than the students in the previous counseling experience group ($M = 5.59$, $SD = .762$) on expertness.

Table 9
Means, Standard Deviations, and Range for Counselor Rating Form-Short (CRF-S) Trustworthiness Subscale by Previous Counseling and No Previous Counseling Groups.

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prev Coun</td>
<td>60</td>
<td>5.62</td>
<td>.819</td>
<td>3.25</td>
<td>7.00</td>
</tr>
<tr>
<td>No Prev Coun</td>
<td>115</td>
<td>6.08</td>
<td>.734</td>
<td>4.25</td>
<td>7.00</td>
</tr>
<tr>
<td>Total</td>
<td>175</td>
<td>5.92</td>
<td>.792</td>
<td>3.25</td>
<td>7.00</td>
</tr>
</tbody>
</table>

Table 10
Means, Standard Deviations, and Range for Counselor Rating Form-Short (CRF-S) Attractiveness Subscale by Previous Counseling and No Previous Counseling Groups.

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prev Coun</td>
<td>60</td>
<td>5.96</td>
<td>.772</td>
<td>4.25</td>
<td>7.00</td>
</tr>
<tr>
<td>No Prev Coun</td>
<td>115</td>
<td>6.23</td>
<td>.676</td>
<td>4.50</td>
<td>7.00</td>
</tr>
<tr>
<td>Total</td>
<td>175</td>
<td>6.14</td>
<td>.721</td>
<td>4.25</td>
<td>7.00</td>
</tr>
</tbody>
</table>

Table 11
Means, Standard Deviations, and Range for Counselor Rating Form-Short (CRF-S) Expertness Subscale by Previous Counseling and No Previous Counseling Groups.

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prev Coun</td>
<td>60</td>
<td>5.59</td>
<td>.762</td>
<td>3.25</td>
<td>7.00</td>
</tr>
<tr>
<td>No Prev Coun</td>
<td>115</td>
<td>5.80</td>
<td>.882</td>
<td>3.00</td>
<td>7.00</td>
</tr>
<tr>
<td>Total</td>
<td>175</td>
<td>5.73</td>
<td>.846</td>
<td>3.00</td>
<td>7.00</td>
</tr>
</tbody>
</table>
These results suggested that students who had no previous counseling experience rated the counselor in both role plays as more trustworthy and more attractive than students who had previous counseling experience, but did not find either counselor portrayal as more expert than the other in the role plays.

Exploratory Analyses

The addition of the open-ended opinion question in the current study was included for several reasons. First, Rose’s (1998) original measure development for assessing why clients would or would not want to discuss religious or spiritual issues in counseling, used this strategy, and replication could be noteworthy. Secondly, it was included to extend the research on the CAST and to determine if a student population would, similar to Rose’s (1998) client population, demonstrate a preference for discussing religious and spiritual concerns, and why those students would or would not want to discuss religious and spiritual concerns in therapy. Third, had the CAST F1 subscale been found to moderate the relationship between group assignment and counselor ratings, the open-ended question would have added strong supporting data for the reasons students prefer to discuss such an important domain of the general public’s functioning. There were no significant findings for moderation; however, inferences may be drawn from a positive trend of participant responses on the CAST F1 subscale (M = 3.05; slightly above the mid-point [3] on subscale) of student participants who, according to their responses on the open-ended question, want to discuss religious and spiritual issues in counseling. Similar inferences can be made with the ROS I subscale (M = 3.20; slightly above the
mid-point [3] on subscale) in the current study. These trends and relationships are discussed further in the next chapter of this study.

Analyses were conducted on CAST item 13, an open-ended opinion question where participants were asked: “Please comment on why you would or would not like to discuss spiritual or religious issues in counseling.” Two hundred twenty six undergraduate students participated in this study and 168 of those participants responded to the open-ended question for a response rate of 74%. Fifty four (24%) students did not respond to the open-ended question. The percentage of response rate for participants was less than Rose’s (1998) response rate (over 90%); however the current study’s original N size (226) dwarfs the N size (74) of Rose’s study. In order to determine category placement of participant responses, six internship level graduate students (4 female, 2 male) agreed to independently place respondent answers to the open-ended question in one of four categories. The first three categories under which respondent answers were placed in the current study were the same as Rose et al (2001): “Want to discuss religious or spiritual issues,” “Preference dependent on other factors,” and “Do not want to discuss religious or spiritual issues.” The fourth category “Unclear/did not answer question” was added because some responses were unclear and raters were unable to definitively determine a category of placement among the other three choices. The six graduate students were then sent an email including the numbered respondent answers to the open-ended question instructing them on how to assign category placement and then asked to return their ratings via email when they were completed. Rater agreement is represented in Table 12.
Table 12
*Percentage of Rater Agreement for Respondent Answers to Open-Ended Question*

<table>
<thead>
<tr>
<th>Number of Raters in Agreement of Six</th>
<th>Category Placement Agreement Total</th>
<th>Percentage of Item Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six of six</td>
<td>80</td>
<td>47.6%</td>
</tr>
<tr>
<td>Five of six</td>
<td>37</td>
<td>22.1%</td>
</tr>
<tr>
<td>Four of six</td>
<td>33</td>
<td>19.6%</td>
</tr>
<tr>
<td>Three of six</td>
<td>17</td>
<td>10.1%</td>
</tr>
<tr>
<td>Two of six</td>
<td>1</td>
<td>.6%</td>
</tr>
<tr>
<td>Total</td>
<td>168</td>
<td>100%</td>
</tr>
<tr>
<td>At least 4 of 6*</td>
<td>150</td>
<td>89%</td>
</tr>
</tbody>
</table>

*Note.* (N = 168 respondents answered the open-ended question). *Criteria used in category placement for majority agreement among raters.

Raters were sent identical emails with instructions for placing responses to the open-ended opinion question in the four categories. It is important to include a thorough description of category placement because there was some disagreement among the raters. First, if at least 4 of the 6 raters (a majority) agreed on category placement, an individual respondent’s answer to the open-ended question was assigned to a category without further examination of the intent of the respondent. This meant that, of the total responses to the open-ended opinion question, 89%, or 150 out of 168 responses were agreed upon by the majority of the raters (Table 12). For example, originally, 48 participant responses were placed in the “Want to discuss religious or spiritual issues” category because a majority of raters (at least 4 of 6) agreed that the participants’ responses indicated they wanted to discuss religious or spiritual issues in counseling. The additional four participant responses that were eventually placed in the category of “Want to discuss religious or spiritual issues” for a total of 52 (see Table 13), were examined by this researcher prior to placement in a particular category.
category because, in these instances the six raters were split fifty percent of the time or more about the intention of the respondents’ answers to the question. This researcher determined the final intent of the participant response when these differences occurred. For instance, one participant’s response to the open-ended question was “I would not want to discuss religious issues in counseling unless I bring it up but otherwise my religion or the counselor religion shouldn’t be important! Unless, that was the issue.” Graduate student raters were split on this response in that half of them placed the student’s response under the “Do not want to discuss religious or spiritual issues” and half placed the student’s response under “Preference dependent on other factors.” This researcher determined, based on what she believed the participant was inferring, that it should be under the preference depends on other factors category because it seemed clear that the intent lies in this category. Another participant’s response to the open-ended question was “I am not religious but I think religion can serve as a drive for some people to try to be good people and do the right things.” Three raters placed this response under the “Unclear/did not answer question,” two placed it under the “preference depends” category and one placed it under the “want to discuss category.” This researcher agreed with the “unclear” categorization and it was placed there. This procedure was followed for all of the participant responses. Participant reasons for preferences for discussing religious and spiritual issues in counseling are described in Table 13.

Table 13

<table>
<thead>
<tr>
<th>Preference/Reason</th>
<th>Responses</th>
<th>Percentages</th>
</tr>
</thead>
</table>
| 1. Want to discuss religious or spiritual issues
*My faith is important to me and affects every aspect of my life, especially issues that would bring me in for counseling. | 52 | 31% |
Table 13 Participant reasons for preferences for discussing religious or spiritual issues (continued)

2. Preference dependent on other factors
   *Whether it is important to find the solution or meaningful to the task at hand would determine if I would or would not discuss either. 38 23%

3. Do not want to discuss religious or spiritual issues
   *I would not because it should not affect how the counselor views me. 70 41%

4. Unclear/did not answer question
   *I don’t really see the difference between spiritual and religious. 8 5%

Total 168 100%

Note. (N = 168). Name of each category is numbered. An * denotes an example of the types of responses participants gave under that category.

Thus, for the category “preference depends on other factors” at least 4 of the 6 raters placed 34 participant responses to the open-ended question under that category. According to the majority of raters, 34 participants indicated their preference for discussing religious or spiritual issues in counseling would depend on other factors. Four additional participant responses were added to this category based on the method explained above for a total of 38 participant responses in this category. Next, the majority of raters indicated 66 participants did not want to discuss religious or spiritual issues in counseling. An additional 4 responses were added after further examination by the researcher for a total of 70. Finally, a majority of raters indicated 5 participants either were unclear in their answer to the question or did not answer the question asked. An additional 3 participants were added after further examination by the researcher for a total of eight.

A total of thirty one percent (n = 52) of participants said they wanted to discuss religious or spiritual issues in counseling because they consider it to be helpful for what
they are going through or because it is part of their belief system. Twenty three percent (n = 38) of participants said their decision to discuss religious or spiritual issues in counseling would depend on other factors such as its relevance to the presenting concern or how it is received by the counselor. Forty one percent (n = 70) of participants said they did not want to discuss religious or spiritual issues in counseling based on a variety of reasons, and five percent (n = 8) of participants’ responses were unclear.

In order to fully explore possible relationships between quantitative and qualitative data based on the interesting results of the open-ended opinion question (CAST item 13) discussed previously which suggested that many of the students in the current study say they should be able to discuss religious and spiritual issues in therapy in general or if relevant to their presenting concern, the following analyses were conducted. These analyses were conducted with participants (n = 160) who provided a written answer to the qualitative short-answer opinion question in the current study, meaning that participant data on the CAST F1, ROS I, and CRF-S measures were included that had previously been removed during the screening process prior to main hypotheses analyses. Therefore, interpretation of these analyses is speculative and conclusions drawn must keep that in mind.

First, a one-way ANOVA was conducted to compare the effect of the CAST item 13 open-ended opinion question categories “want to discuss” (n = 52), “preference dependent on other factors” (n = 38), and “do not want to discuss” (n = 70) to the CAST F1 subscale for preference for discussing religious and spiritual issues in counseling, and the ROS Intrinsic subscale for level of religiosity. Participants’ written answer in the
“unclear/did not answer question” category (n = 8) of CAST item 13 were not included in this analysis. There was a significant effect of open-ended opinion question categories (F = 27.406, df = 2, 157, p < .001) on preference for discussing religious and spiritual issues in counseling, and a significant effect of open-ended opinion question categories (F = 16.917, df = 2, 157, p. < .001) on participant level of religiosity. Post hoc comparisons using Tukey HSD test indicated that the mean score for the CAST item 13 “want to discuss” category (M = 3.67, SD = .819) was significantly higher than the mean score for the “preference dependent on other factors” category (M = 3.02, SD = .788), and the mean score for the “do not want to discuss” category (M = 2.48, SD = .956) on preference for discussing religious and spiritual issues in counseling as measured by the CAST F1 subscale. The post hoc comparisons using Tukey HSD test also indicated that the mean score for the “want to discuss” category (M = 3.78, SD = .852) was significantly higher than the mean score for the “preference dependent on other factors” category (M = 3.17, SD = .771), and the mean score for the “do not want to discuss” category (M = 2.81, SD = 1.012) on level of religiosity of participant as measured by the ROS Intrinsic subscale. However, the mean score of 3.17 for the “preference dependent on other factors” category was not significantly different (p = .216) than the “do not want to discuss” category mean score of 2.81 on participant level of religiosity. Taken together, these results suggested those participants’ short-answer responses about whether they would or would not want to discuss religious and spiritual issues in counseling are related to their preference for discussing religion and spirituality in counseling, and their reported level of religiosity on the self-report measures. Participants with favorable
opinions about wanting to discuss religious and spiritual issues in counseling also prefer
to discuss religion and spirituality in counseling and have a higher level of religiosity.

The second analysis conducted was a two-way repeated measures ANOVA for the
open-ended opinion question categorical assignment, and counselor ratings based on group
assignment (religious and spiritual versus non-religious and spiritual group). This analysis
demonstrated a non-significant ($F = .341, df = 2, 154, p = .712$) main effect for open-ended
opinion question categories on counselor ratings; a non-significant ($F = .476, df = 1, 154, p =
.491$) main effect for group assignment on counselor ratings; and a non-significant ($F = .958,
df = 2, 154, p = .386$) interaction effect for categories of qualitative data on counselor ratings.
In other words, participants did not rate the counselor differently based on their short-answer
response as to whether they would want to discuss religious and spiritual issues in
counseling, or based on group assignment (religious and spiritual or non-religious and
spiritual). Participants’ opinions of why they would or would not want to discuss religious
and spiritual issues in counseling also did not influence how they rated the counselor based
on which experimental condition (religious and spiritual issues role play or non-religious and
spiritual role play) they heard.

In summary, the results of the current study did not support the three hypotheses
proposed for analyses. Counselor ratings were not seen as any different when a counselor
included religious and spiritual items as part of an intake session. Additionally,
preferences for discussing religious and spiritual issues in counseling nor participant level
of religiosity influenced the relationship between group assignment and counselor
ratings. These results, along with exploratory and follow-up analyses for possible
relationships between quantitative and qualitative data will be discussed in the context of extant literature in the chapter that follows.
The purpose of this study was to empirically test theoretical speculation that assessing religious and spiritual functioning in an initial intake interview enhances the credibility of the counselor conducting the interview (Constantine et al., 2000; Hage, 2006; Prest et al., 1999; Richards & Bergin, 2000), and to identify variables that may best explain why the counselor’s credibility would be enhanced. The current study assessed whether students would find a counselor who included religious and spiritual functioning in an intake session more credible than a counselor who included family activities. Students then responded to two questionnaires assessing their preferences for discussing religious and spiritual issues in counseling and their level of religiosity for possible influence regarding the ratings they gave the counselors in the two experimental conditions.

This chapter begins with a summary of results of the three main analyses conducted in this study, including results of the manipulation check, exploratory analysis with the qualitative open-ended opinion question data, and follow-up analyses for possible relationships between results of participants’ qualitative and quantitative data. Next, possible explanations for the non-significant findings are discussed. Then, limitations of the current study and future directions in the area of religion and spirituality in psychology research, training, and practice are discussed. The chapter ends with implications for future research in religion and spirituality in psychology.
Summary of Results

Results did not support the main hypothesis that attention to religious and spiritual functioning during intake would enhance counselor credibility. Student participants’ preference for discussing religious and spiritual issues in counseling and participant level of religiosity were not found to enhance counselor ratings when the counselor assessed religious and spiritual functioning during the intake session over and above when the counselor assessed family activities with the student client. Prior to discussing perspectives related to why the main hypotheses were not supported, the results of the manipulation check are discussed for their implications regarding future analogue research design.

The first manipulation check, which asked which audio recording a participant listened to (an intake counseling session or job interview), had a 100% response rate. For the second manipulation check, where participants were asked to indicate which role play they listened to (religious and spiritual items role play or family activities items role play), two hundred twenty three out of two hundred twenty six participants responded correctly. These manipulation check findings suggested the experimental procedures followed for participant involvement were successful in maintaining participant attention during the experiment. Participants were able to correctly report listening to the randomly selected experimental condition to which they were assigned. Students in the current study sat at a computer station and listened through headphones to the role play with the script on the computer screen in front of them to maintain their attention and avoid distractions during that portion of the experiment. Harari and Waehler (1999) had students listen to a role play of an initial counseling session in small groups. The current investigation chose a procedure where students listened to the audio recording individually because, according to Harari and
Waehler, listening to taped sessions in groups of 5 to 30 students at a time may have interfered with participant ability to maintain attention to their experimental condition and, therefore may have played a role in non-significant findings in that study. The current study’s improvement in the experimental procedure clearly enhanced the ability of the students to maintain attention throughout this portion of the experiment. Another reason this finding is significant to the current study is that it is important to note that the non-significant results of the three main hypotheses likely did not occur as a result of procedural confusion within the experiment. Following is a discussion regarding possible explanations for the non-significant findings in the current study.

Prior to analyses for the main hypotheses in the current study, attitudes toward counseling were assessed to determine if student participants’ attitudes influenced their ratings of the counselor in the role play vignettes. Student participants’ attitudes toward counseling were not found to influence participants’ ratings of the counselor at intake as a whole or as a function of which counseling intake role play they heard. This finding was surprising based on results in previous research suggesting participants’ attitudes toward counseling are important to the counseling environment. For example, in a study of 112 college students of color, Constantine (2002) found that attitudes towards counseling predicted likelihood of seeking counseling as well as views of counselors. Cramer (1999) reported that among a sample of 988 undergraduate psychology students, positive attitudes toward seeking counseling increased the likelihood of seeking counseling, and of having a favorable view toward counselors. The mean score on the attitudes scale (ATSPPH-S) was 1.72 with a range of 0 to 4 for the sample and the correlation between the CRF-S and the ATSPPH-S was $r = -.037$, which implies that students did not connect the two constructs in
any meaningful way. It is possible that in the current study, the non-significant results may have occurred because participants were inexperienced in counseling. The majority of participants in this investigation had never received counseling before and therefore, their attitudes toward counseling at this juncture would presumably be based on other information sources.

Pertaining to the analyses of hypothesis one in this investigation, one perspective accounting for non-significant findings for counselor ratings may be that, although some theorists espouse the view that assessing religion and spirituality at intake enhances counselor credibility (Constantine et al., 2002; Hage, 2006; Prest et al., 1999; Richards & Bergin, 2000), student participants in the current study were not convinced the counselor who assessed religious and spiritual functioning at intake was more credible than the counselor who asked about family activities. Student participants might have seen the discussion about family activities as equally important and valid as the discussion about religious and spiritual functioning, and hence, there were no measurable differences in counselor credibility ratings. Another way to look at this non-significant finding is that participants also did not find the counselor who assessed religious and spiritual functioning as less credible than the counselor who asked about the client’s family activities. Based on students’ responses indicating they rated the counselors as equally credible, asking about religious and spiritual functioning at intake does not negatively affect the initial counseling session, inferring that counselors can broach the subject of religious and spiritual functioning without fear of being perceived as less credible, thus jeopardizing their ability to influence the client toward change. These findings also demonstrate that those who do not want to discuss religion and spirituality in counseling are not averse to a counselor asking about their religious and spiritual functioning.
This finding is similar to results of a study by Harari and Waehler (1999) where students were asked to rate a counselor based on discussing or not discussing “termination” at intake. Students were not persuaded to perceive a counselor as more or less credible based on the counselor discussing or not discussing termination with the client at intake, suggesting the topic of termination, like the topic of religion and spirituality, would not jeopardize the counseling relationship when broached by a counselor at intake. A conclusion that may be drawn from these results is that assessing religious and spiritual functioning at intake was seen as a legitimate and expected area of inquiry by college students.

Another perspective accounting for non-significant findings in the current study may have been other elements of the mock intake interview role plays that led respondents in both the religious and spiritual experimental condition and the non-religious and spiritual control condition to perceive the counselors as comparably credible. According to Strong (1968), counselors attempt to “influence” clients toward therapeutic change through communication that demonstrates credibility (expertness, trustworthiness, and attractiveness). With the advantage of hindsight, there were likely elements of the counselor’s communication that garnered expertness, trustworthiness, and attractiveness in both versions of the experimental intake role plays. These elements of the counselor’s communication external to the manipulated portion of the scripts may have influenced participant attitudes in a way that was not altered by the manipulation. According to Bargh and Chartrand (2000), activating concepts, goals, or ideas, often known as priming, even when outside awareness, can influence attitudes in a way that dilutes the effect of a manipulation.

For instance, the dimension of expertness in Strong’s (1968) interpersonal influence model was assessed with four items (experience, expertness, preparedness, and skillfulness)
on Corrigan and Schmidt’s (1983) revised CRF-S scale. An argument can be made suggesting these components were expressed in the role plays when the counselor communicated a definitive structure throughout the interview by opening the session with an introduction, inquiring about the presenting concern, and then explaining her purpose regarding the line of questioning. These components were also expressed when the counselor asked specific questions about the client’s family history, medical history, and previous counseling experience, which are reasonable questions to ask in an intake session. Also, Strong’s dimension of trustworthiness was assessed with four items (honesty, reliability, sincerity, and trustworthiness) on the CRF-S scale. The role plays were recorded in a manner in which the segments before and after the manipulated portions of the experimental conditions were identical (played by two female graduate students), meaning they were recorded once and used both times. The manipulated portions of the two experimental conditions were the only sections that were different. The additional non-religious and spiritual portion (family activities discussion) of the role plays that differentiated the two experimental conditions was recorded as a separate segment immediately following the first recording and later inserted to make up the control condition for the current study. Therefore, the counselor’s tone, inflections, and manner of interacting with the student client in both recordings were the same except in the section inserted later. Both groups heard the same counselor demonstrating trustworthiness in her manner of speaking throughout the role play when she displayed genuineness and a lack of arrogance, and when she openly and sincerely spoke to the client about her right to privacy in her choice of answering the questions posed by the counselor. The final dimension of Strong’s (1968) model of interpersonal social influence, attractiveness, was assessed with four CRF-S items (friendliness, likeability,
sociableness, and warmth). Again, participants listened to the same role play (with the exception of the short manipulation portion), so the counselor’s tone, inflections, and manner of interacting with the student client may have attributed to perceptions by respondents that this counselor was being warm, friendly, sociable, and likeable throughout the intake session. She inquired about the student’s family, made reflective statements such as “It sounds like family is very important to you” and, “It sounds like it was a positive experience.” Ultimately, the presentation of the two role plays did not appear to have demonstrated a significant enough contrast for students to differentiate between the experimental and control conditions in the current study. In other words, students in both experimental conditions perceived both counselor depictions as comparably credible.

A third perspective accounting for non-significant findings may be the CRF-S itself. Prior to the development of the revised scale, the original CRF had been found to be subject to ceiling effects (Ponterotto & Furlong, 1985). According to Ponterotto and Furlong, Corrigan and Schmidt (1983) wanted to remedy the problem of ceiling effects in the original CRF and developed the 12-item three dimension (expertness, trustworthiness, attractiveness) revised CRF-S scale in part for that purpose. Their goal, according to Ponterotto and Furlong, was to increase the use of the items on the lower end of the rating scale, thereby alleviating the problem of ceiling effects that plagued the original CRF scale developed by Barak and LaCrosse in 1975. One of the methods employed to increase the use of the lower end of the item rating scale (to increase variance in ratings) was to delete negative adjectives with the hope of decreasing socially undesirable connotations (terms such as deceitful, phony, ignorant, stupid, disagreeable, unattractive) which Corrigan and Schmidt believed were leading respondents to rate a counselor toward the higher end of the scale. They also
alternated items from the three dimensions on the new scale, and then placed individual items of each subscale in alphabetical order in hopes of improving variance in the scale. Corrigan and Schmidt reported that the revision of the CRF scale increased variance (increased respondents’ use of the lower end of the scale) across the scale when compared to other studies. However, they admitted that the majority of ratings in their study (84%; N = 155 clients in outpatient clinics) remained at or above the mid-point of their newly developed 7-point CRF-S scale anchored by the adjectives “not very” to “very.”

Responding to these findings, Epperson and Pecnik (1985) replicated Corrigan and Schmidt’s study and conducted comparative analyses between the CRF and CRF-S and found that collapsed across scales, only 16% (N = 215 college students) of item ratings on the CRF fell below the mid-point of the 7-point scale, and only 14% of item ratings on the CRF-S fell below the mid-point of the 7-point scale. This meant that study participants had predominantly positive ratings (84%) of counselors using the CRF scale and predominantly positive ratings (86%) of counselors on the CRF-S scale (Epperson & Pecnik, 1985), which suggested the CRF-S did not improve the problem of ceiling effects (positive bias) in the original CRF. This is important because these overall positive ratings reported by Epperson and Pecnik suggest there is an issue of range restriction with the CRF-S toward the higher (positive bias) end of the scale. This problem with internal validity decreases the ability to find real differences that may exist between experimental conditions. Positive bias is also important because the current study’s lack of significant findings between groups may have been at least partially due to ceiling effects of the CRF-S. For instance, the total mean score for counselor ratings in the current investigation using the CRF-S was 5.93, almost two points above the mid-point of the scale. This observation was made even after removing 33
participants during data screening, who rated the counselor as a perfect “7” on all items of the scale. Moreover, when examining individual items on the CRF-S, the minimum total mean score for an item was 5.26 and a maximum total mean score of 6.41. The percentage of item ratings (N = 176) collapsed across the CRF-S below the midpoint of the 7-point scale was 1.8%, and the percentage of item ratings above the midpoint of the scale was 90%. Therefore, it is reasonable to consider ceiling effects (positive bias) of the CRF-S as a possible factor in non-significant findings.

A fourth and final reason for non-significant findings may be due to the student population that responded to the questionnaire. College students (N = 176) from a Midwest university who were enrolled in psychology classes in the spring of 2011 were recruited to participate in the current study. Students were not selected based on any other demographic criteria and in the final sample, one hundred fifteen (66%) of those students had never received counseling before. As a result, these students presumably were not knowledgeable about the intake process which would mean they may not have been prepared to make an informed determination for rating counselor credibility. Although previous counseling experience was not identified as a variable of interest in the current study’s main hypotheses, the fact that a majority of students in the sample had not experienced previous counseling suggested that counseling experience may be a factor in participant ratings as research has demonstrated that previous counseling experience is related to more accurate perceptions of the counseling process (e.g., Hensley, Cashen, & Lewis; 1985; Renjilian & Stites, 2002).

Hensley, Cashen, and Lewis (1985) conducted a study to assess the effects of previous counseling experience on preferences for different theoretical approaches for effective counseling. One hundred college students at a Midwestern college viewed four
videotapes of an initial personal concern counseling session and an initial vocational-educational concern counseling session in which each concern was approached from a client-centered approach and a behavioral approach to therapy. Findings suggested all of the students believed the behavioral approach to therapy was more effective, and those participants with previous counseling experience rated the videotaped sessions significantly different from those who had no previous counseling experience. Those who had no prior counseling experience found no differences in ratings of the four tapes which demonstrated that students with no previous counseling experience may not have been able to differentiate between the two approaches. According to Hensley et al. some experience may be necessary in order to adequately judge differences in a counseling environment.

Renjilian and Stites (2002) investigated how previous counseling experience affects college students’ perception of therapist stress. Students (N = 147) from introduction to psychology classes participated in the study and viewed three video-taped psychotherapy sessions developed for the study. Symptoms of burnout (yawning, brief inattention, clock watching) were presented in only one of the sessions depicted. After watching the vignettes, participants completed a questionnaire assessing their impressions of the therapist depicted in the videotape. Those participants who had previous counseling experience (n = 36) rated the therapist who displayed burnout significantly lower than the students (n = 111) who had no previous counseling experience. Renjilian and Stites stated “It appears that college students who have been in therapy have a sense of what is, and what is not, acceptable therapist conduct” (p. 15).

In response to the findings by Hensley et al. (1985) and Renjilian and Stites (2002), additional exploratory analyses were conducted in the current investigation to examine
whether students with no previous counseling experience (n = 115) would rate the counselor any differently than the students with previous counseling experience (n = 60). Results of these exploratory analyses suggested students with no previous counseling experience found the counselor in the role plays significantly more credible than those students with previous counseling experience. They found the counselor in both experimental conditions more trustworthy (sincere, open, no personal gain) and attractive (compatible, similar in background and opinions), but not more expert (demonstrating knowledge and skill) than the students who had previous experience in counseling. There is no clear conclusion as to why these students rated the counselor more credible. Perhaps the combination of counseling inexperience and the components of the scripts discussed earlier that may have contributed to an overall positive view of the counselor; and consequently, they rated the counselor in both role plays highly credible. What may be inferred, however, from the current study and the investigations by Hensley et al., and Renjilian and Stites is that students who have not experienced counseling before may not be adequately prepared to differentiate between approaches to therapy or therapists.

The second hypothesis in this study proposed that a participant’s preference for discussing religious and spiritual issues in counseling would influence their ratings of the counselor based on whether the counselor assessed religious and spiritual functioning or family functioning at intake. At least in this sample, students’ preferences for discussing religious and spiritual functioning in therapy did not influence the relationship between group assignment and counselor ratings. Students who preferred to discuss religious and spiritual functioning in counseling and students who did not prefer to discuss religious and spiritual functioning in counseling rated the counselor in the two role plays as comparably credible.
Several observations based on these results are noted. First, the mean scale score on preference for discussing religious and spiritual issues in counseling for undergraduate students enrolled in psychology classes was 3.05, just above the mean neutral value of 3 on the 5-point Likert type scale of the CAST F1 (Rose et al., 2001). In comparison, Rose et al.’s client population (N = 74) mean scale score for preferences to discuss religious and spiritual issues on the CAST F1 was much higher at 3.39. A second observation is the low non-significant correlation ($r = -.033$) in the current study between the CRF-S and CAST F1. The modest mean (3.05) and the non-significant correlation between counselor ratings and preferences for discussing religious and spiritual issues in counseling suggested that in the current sample students did not view their ratings of the counselor as related to their preferences for discussing religious and spiritual issues in counseling.

Additionally, the majority of participants in the current study had not received counseling before. And, according to Rose et al. (2001), previous counseling experience may impact whether a potential client wants to discuss religious and spiritual issues in counseling because research suggests clients are concerned that a therapist may try to undermine their religious beliefs (Quackenbos, et al., 1985). This is an important consideration because some of the students in the current study who responded to the CAST open-ended opinion question asking why they would or why they would not want to discuss religious and spiritual issues in counseling, had the same concerns. For instance, some participants responded to the question by saying “….Another reason is that the counselors spiritual or religious beliefs may be completely different from mine and may actually end up hurting me more than helping me (whether it be by accident or not)”; “I would not because it should not affect how the counselor views me”; “Others may not respect my religious beliefs”; and “The results could
be biased due to someone’s specific views.” Students, as well as actual clients, have concerns about bringing up religion and spirituality in counseling because of the counselor’s possible bias toward their religious and spiritual beliefs. Therefore, some students may actually fear, and be reluctant to discuss their faith in therapy sessions. One conclusion that can be drawn from these students’ concerns regarding how their counselor might respond to their religious and spiritual beliefs is the need for training and education in graduate psychology programs to inform and prepare trainees for encountering religious and spiritual clients in a sensitive and ethically appropriate way. The results here indicate quite clearly that many students are eager to include religious and spiritual considerations in their counseling while others are not. Being solicitous of these different preferences in order to attend to client differences are important skills to develop.

The third formal hypothesis in this study posited that a participant’s level of religiosity would influence their ratings of the counselor; specifically, it was hypothesized that participants who self-identified with higher religiosity would rate the counselor in the religious and spiritual role play higher than the counselor in the non-religious and spiritual role play. Regarding the sample as a whole, there was a modest trend toward higher religiosity in that the overall ROS Intrinsic subscale mean was 3.20 on a 5-point Likert type scale where the neutral value of three was the mid-point on the scale in which any score above three is assumed to be indicative of higher religiosity and any score below a three would be indicative of lower religiosity. However, participants’ higher level of religiosity did not account for significant additional variance in counselor ratings in the current study. Participants, regardless of level of religiosity, found both counselors comparably credible. This observation could be due to a number of reasons. First, previous research has
demonstrated similar results where level of religiosity was not the deciding variable in rating a counselor. For instance, in Morrow et al.’s (1993) investigation, students rated the counselor they viewed in a role play video according to how the counselor responded to the client’s religious values, regardless of level of religiosity. Participants in the current study, regardless of level of religiosity, may have rated the counselor in the experimental conditions similarly because they felt she responded equally well to the client in both role plays.

Additionally, it is also important to consider the argument discussed at the beginning of this section regarding the two role play scripts used in the current study. The role play scripts were identical except for the short experimental manipulation, and an argument could be made that the counselor in the role plays demonstrated expertness, trustworthiness, and attractiveness equally, which influenced participants to rate the counselor in both conditions, regardless of level of religiosity, similarly. Another possibility is the ceiling effect (positive bias) of the CRF-S mentioned earlier. A combination of this being a student population rather than actual clients, the lack of previous counseling experience, and the possible ceiling effects of the measure for counselor ratings may have interfered with participants’ level of religiosity having no effect on counselor ratings between groups. These combined possibilities seem more likely than the first reason given stating that level of religiosity is not related to ratings of counselor credibility because other research has demonstrated that these two constructs are related (Cashwell, Young, Cashwell, & Belaire, 2001; Guinee & Tracey, 1997; Lewis & Epperson, 1991; Morrow et al., 1993).

Responses to the open-ended question indicated two groups of students in the current study were open to discussing religion and spirituality in counseling. In their open-ended opinion question responses one group of students (31%) wanted to discuss religion and
spirituality in counseling in general, and another group of students (23%) reported their preference depended on other factors. These two groups of student participants’ responses along with the CAST F1 subscale’s mean score of 3.05 in the sample for preference for discussing religious and spiritual issues in counseling, and the modestly higher level of religiosity (M = 3.20) reported within the sample on the ROS Intrinsic subscale, suggested a favorable attitude among college students toward discussing religious and spiritual issues in counseling. The favorable opinions on the CAST item 13 open-ended opinion question for these two groups of students regarding discussing religious and spiritual issues in counseling also provided some support for the future use of the CAST F1 subscale as a measurement tool for assessing preference for discussing religious and spiritual functioning in counseling with a student population, and for continued use of the ROS Intrinsic subscale for assessing level of religiosity in student populations.

Thirty one percent of the students who were in favor of discussing religious and spiritual issues in counseling preferred to discuss religion and spirituality in therapy in general. Some of their reasons were “I would (be)cause things I do or don’t do are related to my religious beliefs”; “I would like to discuss spiritual issues because it will help me figure out how to solve the issue, and the counselors should be aware of this”; “I think it would be beneficial because religious and spiritual issues are just as prevalent and distressing as any other issue”; “I feel that talking about your beliefs in general would be important for the counselor to help you determine what is wrong and ways you could fix it.” These individuals seem to be suggesting that their religion and spirituality are core issues for them and they want to feel free to integrate these core beliefs into the counseling process.
Twenty three percent of the students who indicated their preference to discuss religious and spiritual issues in counseling depended on other factors responded with statements such as “If I needed, and it concerns the problems I am having or has an effect on what my problem is, I would discuss spiritual or religious issues in counseling, because it could help resolve any problem I may be having”; “Spiritual and religious issues are very subjective and controversial. I would have to have confidence in my counselor’s professional opinion before confiding in him or her about these issues”; “I would talk about my spiritual issues when I am confused or something has shaken my faith. I would not discuss my spiritual issues when there is no problem with my spirituality”; “It would depend if the counselor seems to be in the conversation about it or not to determine if I would discuss any spiritual or religious issues w/them.” These students seemed to be saying their choice to discuss or not to discuss would depend on the reason they came to counseling or on how it is received by the counselor.

Students who were not in favor of discussing religion and spirituality were in the minority. In the current study, forty two percent (n = 70) of students did not want to discuss religious and spiritual issues in counseling. A minority (17%) of Rose et al.’s (2001) sample (N = 74) indicated they did not want to discuss religious and spiritual issues in counseling. Rose et al. used actual clients and the current study used students to respond to the open-ended question. Eighty nine percent of Rose et al.’s client sample reported a belief in God or a higher power and seventy six percent of the current sample reported they were Christians. These patterns suggest that many counseling clients and college students agree with Pargament (2007) and Plante (2009) who suggested spirituality cannot be separated from psychotherapy and many people want spiritually sensitive help.
Only eight of the students who did not want to discuss religious and spiritual issues in therapy had concerns about how their counselor would respond to them if they were to discuss religion and spirituality. For example, one respondent answered the short-answer open-ended question (Please comment on why you would or would not like to discuss spiritual or religious issues in counseling) stating “I would not because it should not affect how the counselor views me,” and another stated “Others may not respect my religious beliefs,” and still another stated “Because I feel like it’s my personal opinion and I don’t need anyone to change that.” Similar findings were reported by Rose et al. (2001) in that only a few of the clients who participated in her study were concerned about how their religious and spiritual beliefs would be viewed and accepted by the counselor. This is probably due to the majority of the students in this study reporting they were Christians. Christians have been known to have favorable views toward counseling (Cashwell et al., 2001; Lewis & Epperson, 1991); integrating their Christianity into therapy, at least in the current study, may seem quite natural to them. It may also have been that their majority identity led them to believe their religion and spirituality would be well received by a counselor.

The preferences and reasons for discussing or not discussing religion and spirituality in the exploratory analyses of this study are varied, but a common thread that emerged is the desire to discuss a significant dimension of human functioning, in this case religion and spirituality, within the counseling environment. Students in this study and students and clients receiving mental health services in general believe the human domain of religious and spiritual functioning is an appropriate and, in some instances, an essential topic to the counseling process (Hage, 2006; Morrow et al., 1993; Quackenbox et al., 1985; Rose et al., 2001). The findings for the exploratory analyses with the CAST item 13 open-ended opinion
question in the current study regarding participant reasons for discussing religious and spiritual issues in counseling with a student population, and higher level of religiosity in the sample, expanded and validated theorists’ supposition that some people want spiritually sensitive help and want to integrate their religion and spirituality into the counseling process (Pargament, 2007; Plante, 2009).

Follow-up analyses were conducted in the current investigation to explore possible relationships between the exploratory analysis data obtained from the open-ended opinion question by category (want to discuss, preference dependent on other factors, and do not want to discuss) and quantitative data of participants on the CAST F1, ROS I, and CRF-S measurement scales used in the main hypotheses analysis of the study. It is important to keep in mind that these follow-up analyses included participants (n = 160) who provided an answer to the qualitative opinion question in the current study, which meant that participant data were included which had previously been removed during screening prior to main analyses. Data (n = 8) in the “unclear/did not answer question” category were not included in this analysis. Therefore, interpretation of these analyses is speculative and any conclusions drawn must keep that in mind. These follow-up analyses to the main hypotheses and exploratory analysis with the CAST item 13 open-ended opinion question conducted in the current study, although speculative, suggested there is a significant and positive relationship between participants (n = 160) who have more favorable opinions about why they should be able to discuss religion and spirituality in counseling, their level of religiosity, and their preference for discussing religious and spiritual issues in counseling. Although firm conclusions are cautioned, there is reasonable evidence from previous research (Rose et al., 2001) to suggest this is true.
Follow-up analysis was also conducted to investigate differences between categories of participants’ opinion about why they would or would not want to discuss religious and spiritual issues in counseling (qualitative data results in current study) and how they rated a counselor based on whether she did or did not discuss religious issues in counseling (group assignment). This analysis yielded non-significant results. Participants’ categorized opinion (want to discuss, preference dependent on other factors, and do not want to discuss) about whether they would or would not want to discuss religious and spiritual issues in counseling did not predict significantly different ratings of the counselor based on whether she asked about religious and spiritual activities or whether she did not. These non-significant results may have been due to participants’ view that both counselors were equally credible, as stated earlier in the main hypotheses findings. Another reason could be the ceiling effects of the CRF-S mentioned earlier. The participants’ data that were excluded previously for analyses of main hypotheses were re-entered for the purpose of running these analyses and of that data, many of them had rated the counselor a “7” on all items of the CRF-S scale. Therefore, these results may have been positively biased toward higher ratings for counselor credibility, thus restricting the possibility of a significant finding. In other words, range restriction toward the higher (positive) end of the CRF-S scale for counselor ratings may have been a factor.

**Limitations.** There are several limitations to the current study and results should be interpreted with caution. First, the current study’s participants were undergraduate students from one public university and results cannot be generalized beyond this population of students or to actual clients in a real counseling setting. Second, the current study used an analogue design to imitate an actual intake counseling session and should not be viewed as
generalizable to actual counseling intake sessions. Other limitations are that the population
was predominantly Caucasian (71%) and Christian (76%). The sample also overall reported a
modestly higher level of religiosity which is not surprising given the predominantly Christian
identity of the sample. Thus, the results cannot be generalized to other religious and/or
spiritual belief systems, nor can it be generalized to other ethnic or racial groups.

Additional limitations involve the use of the CRF-S in the current study. The CRF-S
has been found to be subject to ceiling effects (Corrigan & Schmidt, 1983; Epperson &
Pecnik, 1985; Ponterotto & Furlong, 1985) where participants tend toward selecting items at
the higher end of the scale and, therefore, may not be an appropriate stand alone choice for
assessing counselor credibility ratings. Another limitation is that a large percentage (66%) of
the student population who participated in the current investigation had no previous
counseling experience. Some research indicates that in order to accurately determine the
credibility of a counselor, one must first have had some experience in receiving counseling
(Cashwell et al., 2001; Renjilian & Stites, 2002). Another limitation may be that the
combination of possible priming effects (Bargh & Chartrand, 2000) from the script in the
current study, ceiling effects inherent to the CRF-S (Ponterotto & Furlong, 1985), and the
percentage (66%) of students who had never received counseling may have limited possible
statistically significant effects of the analyses conducted in the current study. A final
limitation involves the follow-up analyses using all participants who answered the open-
ended question “Please comment on why you would or would not like to discuss spiritual or
religious issues in counseling” and the CAST F1 and ROS Intrinsic subscales. The follow-up
analyses included participant data previously deleted prior to hypotheses testing and,
therefore, are speculative in nature and should be interpreted with that in mind.
**Future Directions.** The non-significant findings in the current study pose a challenge to future research using the CRF-S to assess credibility or competence of counselors during intake due to the possibility of ceiling effects (range restriction toward positive bias) interfering with differences between groups. The mean rating for counselor credibility in the current study was 5.93 and this was even after 33 participants’ data had been removed during preliminary analyses due to ratings of all “7s” on the CRF-S. Moreover, 90% of counselor ratings favored the positive end of the CRF-S counselor rating scale. The CRF-S has been used extensively in research since its development by Corrigan and Schmidt in 1983, but the issue of ceiling effects is noteworthy and should be evaluated before using the CRF-S alone as a rating scale for counselor credibility. Ponterotto and Furlong (1985) suggested the CERS (Counselor Effectiveness Rating Scale: Atkinson & Carskaddon, 1975) may be more appropriate for differentiating between the three factors of expertness, trustworthiness, and attractiveness. They point out however, that rating scales used for measuring counselor performance are imperfect. With that in mind, it may be advisable to use other measures concurrent with the CRF-S when assessing counselor credibility in the future. Constantine (2002) predicted counseling satisfaction would be affected by perceptions of general counselor competence and multicultural counselor competence. She measured general counselor competence using the CRF-S and multicultural counselor competence with the CCCI-R (Cross-Cultural Counseling Inventory-Revised: LaFromboise & Coleman, 1991). Both measures contributed unique variance in counseling satisfaction; however the CCCI-R contributed more variance in counseling satisfaction than did the CRF-S. Adding support to using multicultural counselor competence ratings to measure general counselor competence, Fuertes and Brobst (2002) found that multicultural competence ratings were strongly
correlated \((r = .72)\) with general counselor competence ratings and suggested that due to this strong correlation, the CCCI-R was a valid measure of general and multicultural counseling to be used as a standalone measure of counselor competence. Given the multicultural landscape of our country, multiculturally sensitive measures like the CCCI-R may be a better fit for examining credibility and competence in counselors today than the CRF-S. Of course, future researchers will have to take into account the potential problems with the different measures for counselor ratings and decide based on extant research which rating scale best fits their experimental needs.

Analogue designs have been used extensively in research and the quality of an analogue design’s construction may reduce the introduction of biases in a study, which conversely improves the likelihood of detecting significant findings when real differences exist between experimentally manipulated conditions. The scripts developed and used in the current analogue study may or may not have contributed to participants perceiving the counselor in both role plays as comparably expert, trustworthy, and attractive (comparably credible). Future analogue design studies involving a prepared script should be developed and examined closely by researchers prior to analyses. A key question the researcher should ask him/herself should be “Could the information external to the experimental manipulation contained in the design lead to conclusions by participants when responding to questionnaires related to the focus of the investigation?” It also may be wise to have a limited amount of information external to the experimental manipulation portion of a design to reduce the possibility of confusing your participants with too information. This may ensure the experimental manipulation in a script is the only portion that is shown to influence perceptions of participants.
In the current study, attitudes toward counseling were not related to counselor ratings. However, attitudes toward counseling (Constantine, 2002; Cramer, 1999) have been found to influence the way counselors and the counseling process is viewed, and is indicative of the likelihood of seeking counseling (Cepeda-Benito & Short, 1998; Guinee & Tracey, 1997). Thus, attitudes toward counseling should continue to be assessed in research with more religiously diverse samples, as the non-significant findings in the current study may be due to the majority (76%) of participants identifying Christianity as their religion. It may be beneficial to assess other religious and spiritual groups’ attitudes toward counseling for the purpose of increasing our understanding of cultural differences in attitudes toward counseling to enhance the use of counseling by other religious and/or spiritually oriented populations. Additionally, according to studies conducted by Hensley et al., (1985) and Renjilian and Stites, (2002), college students may not be able to differentiate between an effective counselor and an ineffective counselor if they have never received counseling before. Previous counseling experience may need to be a variable of interest in future studies where counselor credibility is rated. Students seeking counseling at a college counseling center might be an appropriate population in which to further investigate counselor credibility based on their experiences in counseling.

The CAST measure was used in the current study for assessing preferences for discussing religious and spiritual issues in counseling. The CAST was developed by Rose (1998) and has yet to receive sufficient research attention to be identified as a consistent psychometrically rigorous and robust instrument for assessing religious and spiritual preferences in counseling beyond the current study or Rose et al.’s (2001) study. That being said, the CAST F1 subscale, which was used in the analyses portion of the current
investigation, has now demonstrated good internal consistency with a client population and a
student population which warrants continued examination in research on religion and
spirituality. In addition, although speculative, results of follow-up analyses in the current
study suggested preferences for discussing religious and spiritual issues in counseling
measured by the CAST F1 subscale are related to reasons why participants believe religious
and spiritual issues should be discussed in counseling where appropriate. Additionally,
although not used in the current analyses, the CAST F2 subscale demonstrated a strong
internal consistency reliability coefficient of .94 with this student population which suggests
it may be useful in future research testing the willingness of counselors to discuss religious
and spiritual issues in counseling.

Level of religiosity was not found to be an influencing variable in the current study,
however, level of religiosity has been found to influence counselor ratings (Guinee & Tracey,
1997) in other studies and higher religiosity individuals have more favorable views of
integrating religion and spirituality into counseling (Rose et al., 2001). Additionally, the ROS
Intrinsic subscale was significantly correlated with the CAST F1 subscale in the current
study, and two measures of level of religiosity (INSPIRIT: Kass et al., 1991; RCI-10:
Worthington et al., 2003) in previous research (Benoit, 2007; Rose et al., 2001) suggesting
the ROS Intrinsic subscale is a robust measure of religiosity. And again, although speculative
in nature, results of follow-up analyses in the current study suggested level of religiosity
measured by the ROS I subscale is related to reasons why participants believed religious and
spiritual issues should be discussed in counseling where appropriate. A future study could
replicate Rose et al.’s investigation with a student population, because there is some initial
evidence in the current study that students, like clients, have a preference for discussing religion and spirituality in counseling.

Summarizing the above discussion related to the findings in the current research, the client’s experience in the intake session of psychotherapy should be one where he or she feels the counselor respects and is sensitive to his/her belief systems for the purpose of increasing the likelihood the client will return for more sessions with an overall goal toward therapeutic change. The non-significant results of the study suggested that religiously oriented students and non-religiously oriented students see the inclusion of religious and spiritual assessment during the intake session as valid inquiry for client care. Some people desire a therapeutic experience where they can openly integrate and freely discuss their religious and spiritual belief system and other people desire a therapeutic experience where religion and spirituality play no part in the process. As psychologists we are obligated to be aware of, respectful toward, and sensitive to both populations of clients (APA, 2002). Hage (2006) stated that religion and/or spirituality is integral to many Americans’ racial and cultural identity, and when faced with stress in their lives, many prefer a therapist with similar beliefs and values and one who will be open to integrating those beliefs and values into the counseling setting. Moreover, she concluded that it is time for psychologists to obtain training in the diverse religious and spiritual belief systems of their clients.

Secondly, broaching the subject of religion and spirituality during the intake session does not jeopardize the counselor’s credibility according to the current study. Therefore, consistent with Aten and Hernandez, (2004), Gorsuch and Miller (1999), Leach, Aten, Wade, and Hernandez (2009), Pargament (2007), Plante (2009), future research should continue to investigate ways in which counselors can explore the topic of religion and spirituality with
their clients in an appropriate way to ensure cultural sensitivity to individual beliefs and practices. According to Sperry and Shafranske (2005), “Religiosity or spirituality plays a role in the orienting systems of most individuals and therefore requires deliberate and thoughtful assessment in respect to its contributions to mental health and well being” (p. 18). For instance, Pargament (2007) recommended asking a few simple questions regarding a client’s religious and spiritual experience. Examples are “Do you see yourself as a religious or spiritual person? If so, in what way?” and, “Are you affiliated with a religious or spiritual denomination or community? If so, which one?” (p. 211). Plante (2009) suggested that the clinician should at least ask the client if he/she has a religious and spiritual affiliation and whether he/she would like to have those beliefs considered during the course of therapy. He also offered a set of questions developed by Puchalski and Romer (2000) “What is your faith tradition, if any?” “How important is your faith to you?” What is your church or faith community, if any?” and, “How would you like me to address these issues in your care?” (Plante, 2009, p. 58). These questions could be used when first meeting with a patient. Both of these options begin with questions that, if answered in the negative, provide the clinician with information needed when the client states he/she is not religious and/or spiritual. These questions are easily incorporated into the intake session with a client, and with the client’s response the counselor has a broader, fuller conceptualization of the client’s experiential world view.

Implications for Training and Research

The following are implications for training and research in counseling psychology programs to inform, educate, and prepare future graduates for clinical practice. Training implications are discussed first followed by research implications. Souza’s (2002) survey
of graduate students’ opinions related to the subject of spirituality in counseling found that graduate students want religion and spirituality to be addressed in training. Some of the findings that emerged from student responses to Souza’s survey were, a need for religious and spiritual training to help students recognize, resolve, and put aside personal feelings for and against religion to be able to keep it from interfering with the counseling process, and a need for clearer definitions of spirituality and related terms in order to have an informed understanding of terminology. Supervision was suggested as the ideal place to discuss how a supervisee would work with a religious and spiritual client. Souza also suggested there is a need for more training in counselor education for addressing ethical issues related to clients and their religious and spiritual identity in order to be sensitive to these issues in therapy.

Aten and Hernandez (2004) developed a model for supervisors to help supervisees develop competence in working with religious clients. Their model promotes competence in supervisees in the area of religion and spirituality using as a template, the eight domains of the Integrative Developmental Model (IDM) developed by Stoltenberg and Delworth in 1987 for training (Aten & Hernandez, 2004; Prieto & Stoltenberg, 1997). Aten and Hernandez’s (2004) model outlines specific actions that a supervisor can take to facilitate training supervisees toward increased competence in integrating issues of religion and spirituality into therapy with clients where it is an appropriate topic of discussion. The eight areas of competency include intervention skills competence, assessment, interpersonal assessment, client conceptualization, individual and cultural differences, theoretical orientation, treatment goals and plans, and professional ethics.
According to Aten and Hernandez (2004), an example for the domain of assessment, which is important in reference to the current study, would be for supervisors to introduce the supervisee to some of the formal assessments that are available to use with religious and spiritual clients. Examples of assessments are the Religious Commitment Inventory--10 (Worthington et al., 2003), or the Religious—Spiritual Assessment questionnaire (Richards & Bergin, 1997, in Aten & Hernandez, 2004). These measures or the series of questions suggested by Pargament (2007) or Plante (2009) could be useful for understanding clients’ religious and spiritual beliefs. In the domain of individual and cultural differences, Aten and Hernandez suggested supervisors can help supervisees approach religious and spiritual issues of clients with multicultural sensitivity. They could explore different religious issues and traditions to be able to gain understanding about epistemological assumptions of clients’ religious systems. The client conceptualization domain of this model can be used to help supervisees integrate religious issues and themes into case conceptualizations where appropriate. According to Aten and Hernandez, a supervisor can help a supervisee understand the need for integrating these issues when appropriate which would help the supervisee reduce the possibility of ignoring or overlooking a relevant source of support and strength for a client. For example, the concept of marriage in the Latter Day Saints faith is that marriage is not only for now but for eternity. Helping a supervisee integrate that information into a case conceptualization with a couple who is having marital problems and for whom that is a salient belief, may provide the couple with the motivation to work through their issues and to repair their marriage (Aten & Hernandez).
Another model for training is recommended by Russell and Yarhouse (2006) in their assessment of current levels of religious and spiritual training in accredited predoctoral internships. They suggest six strategies that can be implemented to remove constraints to religious and spiritual training. The first suggestion is to facilitate discussions on religion and spirituality in supervision. Russell and Yarhouse suggested supervision is one area in which the topic of spirituality and religion of clients is already salient because trainees are encountering these issues with their clients and have needed guidance from their supervisors. According to Russell and Yarhouse, religion should be discussed as a functioning domain in client assessment just as a therapist would assess for occupational and social functioning. Second, adding a didactic session on the recent trends of applying the psychology of religion and spirituality in therapeutic practice could give faculty and staff a chance to work with colleagues in their community. The didactic session could focus on recent work in addressing religion as a diversity variable, developing strategies for asking about specific beliefs and practices of a client, and incorporating those beliefs and practices into treatment planning (e.g., the use of prayer, forgiveness). A third strategy would be to include religion and spirituality as a diversity area in cultural diversity training. It can be included along with other topics of diversity such as gender, race, culture, ethnicity and even disability. Training would not be geared toward expertise in a specific religion but would recognize religion and spirituality in terms of diversity in the population and the need to be sensitive in treatment planning and assessment. The fourth strategy would be to form a partnership with colleagues who have a better understanding of religion and spirituality for consultation when needed.
These individuals could be part of a religiously oriented psychological organization or have a particular faith that informs their practice. Fifth, Russell and Yarhouse suggested forming relationships with faith community members. Forming these relationships could bring in referrals and establish credibility within the religious community. These relationships could also be a source of information about a client’s perspective within the context of their worldview. Finally, the sixth strategy suggests adding readings on religion and spirituality to a reading list during internship. Through these resources interns can be better informed of the specific models of psychotherapy to use with clients, specific religious and spiritual traditions of clients, and ethnic-centered faith and spirituality of clients. Russell and Yarhouse suggested that addressing religion and spirituality as a diversity issue can also serve to reduce some of the fears interns may have in broaching the subject of religion and spirituality in counseling. Although these strategies were introduced by Russell and Yarhouse for use during the internship year in doctoral programs, they would be useful for use in practicum group supervision as a didactic component or integrated into diversity issues in a class on multiculturalism.

Eck (2002) also provided a framework useful for assessing the appropriateness of spiritual interventions in therapy related to professional, ethical, and cultural contexts of psychotherapy. Eck identified over 30 specific interventions and divided them by function (cognitive, behavioral, and interpersonal). Eck reported that trainees are not sufficiently educated and trained in the use of spiritual interventions with religious clients. He recommended as an area of cultural diversity, “training curriculum needs to be developed that clearly identifies the role of religion in our society, the orienting framework it
provides in the client’s life, its proper clinical assessment, and best practice models for making spiritual interventions a standard part of treatment” (p. 276).

Hage (2006) also suggested several ways training programs can encourage students to explore spiritual issues. She suggested that graduate programs give students the opportunity to explore and reflect on their own religious heritage and religious and spiritual beliefs that might influence their psychotherapy with clients, including any biases they may have. She reported evidence of an increase in the students’ overall sense of therapeutic competence and self-awareness when students were allowed to self-explore across diversity issues. According to Hage, students need to be able to assess for a client’s spiritual and religious history and have a good understanding of spiritual and religious beliefs that are considered normative and healthy within a client’s religious tradition. She also suggested that because spiritual functioning is a fluid process, students need to be able to track their clients’ spiritual functioning before, during, and after treatment. Students need to know there are a variety of measures available to assist them in understanding areas of spiritual functioning that are important in understanding their client. Hage suggested the inclusion of spiritual and religious diversity into existing courses on multiculturalism.

Findings from the current study suggest that training models should be developed for graduate programs to approach the topic of religion and spirituality in counseling in an ethically responsible way. The current study’s qualitative findings along with non-significant differences between experimental conditions indicated that students are open to being asked about their religious and spiritual practices. Research regarding effective
training methods with religious and spiritual issues can also help with empirical support of best practices.

Future research in the area of religion and spirituality is vital given even a modest preference in this student population for discussion of religion and spirituality in counseling because, for the majority of Americans, spirituality and religion are important to their cultural identity (Hage, 2006; Richards & Bergin, 2000). Additionally, according to Boyd-Franklin (2010), the majority (81%) of African Americans identify as religious and spiritual. She suggested psychologists are not yet prepared to address the topic of religion and spirituality in counseling with these clients. Wade and Bernstein (1991), in a study explored earlier in the current research, found that low-income Black female clients returned for more counseling sessions when the counselors had received cultural sensitivity training prior to seeing these women for therapy. The mental health field, and counseling psychology in particular, should continue to expand research in this area for improved competence for trainees in assessing religious and spiritual functioning of their clients. Professional psychologists need to become more informed and capable of conversing with a client about his/her religious and/or spiritual belief systems within the multicultural context in which we live. To this end, Eck (2002) suggested clinical practices that integrate spiritual interventions with religiously oriented clients need to be guided by research in religion and spirituality.

Prest et al. (1999) also suggested there is a need for more research and training in religious and spiritual competence based on the number of people in the United States who identify with religious and spiritual worldviews. Prest et al. recommended that any integration of religious and spiritual issues needs to include discussions about the possibility of conflicts between belief systems of clients and therapists. According to Prest
et al., research focusing on barriers to open communication within the professional community should be conducted, and training in graduate school programs needs to be implemented to develop skills in this area.

Schulte, Skinner, and Claiborn (2002) surveyed training directors in counseling psychology programs on the state of training related to religious and spiritual issues in their counseling psychology training programs. Their findings suggested openness to research on topics of religion and spirituality. Schulte et al. suggested counseling psychology should continue research in the area of religion and spirituality for several reasons. First, counseling psychology has a long history of a commitment to cultural diversity and to the training of practitioners and supervisors in counseling psychology. Second, research in counseling psychology programs has the potential to influence the inclusion of and type of religious and spiritual research in applied psychology. Third, research should be conducted to determine whether the present state of training in religious and spiritual areas in counseling psychology is in line with practitioner needs. According to Schulte et al., research is needed because practicing psychologists consider spirituality as relevant in clinical practice, however, the training directors surveyed in Schulte et al.’s study reported religious and spiritual traditions are outside of their expertise. Another important conclusion from Schulte et al.’s survey of training directors important to the current study’s findings was that training directors were not averse, as students in the current study were not averse, to the inclusion of religious and spiritual issues in training programs suggesting that counseling psychology programs are open to exploration of religion and spirituality in research and training. Therefore, based on
Schulte et al.’s suggestion that counseling psychology could potentially influence the future of research in the area of religious and spiritual diversity, and the significant findings in the follow-up analyses in the current study, future research in counseling psychology should employ a mixed design using qualitative and quantitative data assessing relationships between participants’ level of religiosity, their preferences for discussing religious and spiritual issues in counseling, and their opinions about why they would or would not want to discuss religious and spiritual issues in counseling.

Miller and Thoresen (2003) pointed toward the need for psychologists to produce methodologically sound research on the link between religion and spirituality and health. They suggested that this area of research is an open frontier for scientific investigation of a neglected aspect of human nature that can lead to important clues which may be helpful for better health, fuller life experiences, and enhanced meaning and satisfaction in life. Empirical evidence has consistently shown positive correlations between mental health and religious orientation and activities (Curtis & Glass, 2002; Eck, 2002; Hill & Pargament, 2003) and therefore, research and training of religious and spiritual functioning in clients is needed.

In conclusion, the current study informed future training and research in the areas of religion and spirituality in counseling psychology. The results of this study demonstrated that broaching the subject of religion and spirituality during the intake session does not jeopardize the counselor’s credibility with the client. Student participants, regardless of their level of religiosity or preference for or against discussing religion and spirituality in counseling, rated the counselor in the experimental conditions comparably credible. What the current study adds to the literature is the recognition that many individuals want to be able to discuss their
religious and spiritual beliefs in counseling. These beliefs are either central to their world view, and therefore, integral to their daily living, or religion and spirituality are relevant to their presenting concern in counseling. This would suggest there is a need for continued attention and refinement in research and training practices in this area for the purpose of increasing trainee competence, increasing comfort level in addressing this issue in therapy, and enhancing counselor ability to adequately assess client religious and spiritual functioning. Hage (2006) suggested that APA guidelines should be changed to include a requirement for training to enhance religious and spiritual competency among graduate trainees. Additionally, numerous texts have been produced that would be useful for training in this area: *Handbook of Psychotherapy and Religious Diversity* (Richards & Bergin, 2000); *A Spiritual Strategy for Counseling Psychotherapy* (Richards & Bergin, 2005); *Spiritually Integrated Psychotherapy* (Pargament, 2007); *Integrating Spirituality Into Treatment* (Miller, 1999); *Spirituality and the Therapeutic Process* (Aten & Leach, 2009); *Spiritual Practices in Psychotherapy* (Plante, 2009); and *Spiritually Oriented Psychotherapy* (Sperry & Shafranske, 2005).

Further research is also needed to adequately inform clinical practice toward ethically sound and empirically supported treatment approaches in the appropriate integration of client religious and spiritual belief practices and norms in the counseling environment to both respond to the needs of this population and to improve the reputation and use of psychological services among religious and spiritual clients. Articles by Eck (2002), Gonsiorek, Richards, Pargament, and McMinn (2009), Hathaway, Scott, and Garver (2004), Miller and Thoresen (2003), Russell and Yarhouse (2006), and Schulte, Skinner, and Claiborn (2002); and texts by Pargament (2007), Richards and Bergin (2000; 2005), and
Sperry and Shafranske (2005) discussed and referenced in the current investigation are a good place to start for becoming more informed, educated, and prepared for religiously-identified clients accessing counseling services.
REFERENCES


of research methods in social and personality psychology, (pp. 253-285), New York: Cambridge University Press.


APPENDIX A

DEMOGRAPHIC INFORMATION

Please respond to the following demographic questions in the spaces below by placing a check in the spaces provided. Do not indicate your name. All responses will remain confidential.

Sex: Man ______________
     Woman ____________

Year in School: Freshman _________
                Sophomore _________
                Junior ____________
                Senior ____________
                Graduate __________

Age: ________yrs.

Race/Ethnicity:

African-American/Black ____________
Asian American ___________________
Caucasian/White ___________________
Hispanic _________________________
Native American __________________
Other (Please specify) ______________
Mixed (please specify) 

Have you ever received psychological services for yourself? _____yes _____ no
APPENDIX B

ATTITUDES TOWARD SEEKING PROFESSIONAL

PSYCHOLOGICAL HELP-SHORT

Please indicate the extent to which you agree or disagree with the following statements using the following scale:

<table>
<thead>
<tr>
<th>Disagree</th>
<th>Partly Disagree</th>
<th>Partly Agree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention. (S)

2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional difficulties. (R)

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy. (S)

4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help. (R)

5. I would want to get psychological help if I were worried or upset for a long period of time. (S)

6. I might want to have psychological counseling in the future. (S)

7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help. (S)

8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me. (R)
Please indicate the extent to which you agree or disagree with the following statements using the following scale:

<table>
<thead>
<tr>
<th>Disagree</th>
<th>Partly Disagree</th>
<th>Partly Agree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

9. A person should work out his or her problems: getting psychological counseling would be a last resort. (R)

10. Personal and emotional troubles, like many things, tend to work out by themselves. (R)

Note. Straight items (S) are scored 3-2-1-0, and reversal items 0-1-2-3, respectively, for the response alternatives agree, partly agree, partly disagree, and disagree.
APPENDIX C
COUNSELOR RATING FORM-S

On the following pages, each characteristic is followed by a seven-point scale that ranges from “not very” to “very.” Please indicate the number at the point in the scale that best represents how you viewed the counselor on the audio recording.

<table>
<thead>
<tr>
<th>Friendly</th>
</tr>
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<tbody>
<tr>
<td>1    2    3    4    5    6    7</td>
</tr>
<tr>
<td>not very</td>
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<td>very</td>
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<table>
<thead>
<tr>
<th>Experienced</th>
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<tbody>
<tr>
<td>1    2    3    4    5    6    7</td>
</tr>
<tr>
<td>not very</td>
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<tr>
<td>very</td>
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<table>
<thead>
<tr>
<th>Honest</th>
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<tbody>
<tr>
<td>1    2    3    4    5    6    7</td>
</tr>
<tr>
<td>not very</td>
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<tr>
<td>very</td>
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<table>
<thead>
<tr>
<th>Likeable</th>
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<tbody>
<tr>
<td>1    2    3    4    5    6    7</td>
</tr>
<tr>
<td>not very</td>
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<tr>
<td>very</td>
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<table>
<thead>
<tr>
<th>Expert</th>
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<tr>
<td>1    2    3    4    5    6    7</td>
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<tr>
<td>not very</td>
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<tr>
<td>very</td>
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</table>
Please circle the number at the point in the scale that best represents how you viewed the counselor on the audio recording.

<table>
<thead>
<tr>
<th>Scale</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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</thead>
<tbody>
<tr>
<td>Reliable</td>
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<tr>
<td>Sociable</td>
<td>not very</td>
<td>very</td>
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<td></td>
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<tr>
<td>Prepared</td>
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<td>very</td>
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<td>Warm</td>
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<td>very</td>
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<td></td>
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<tr>
<td>Skillful</td>
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</tbody>
</table>
Please circle the number at the point in the scale that best represents how you viewed the counselor on the audio recording.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<tbody>
<tr>
<td>Trustworthy</td>
<td>not very</td>
<td>very</td>
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</tbody>
</table>
APPENDIX D

MANIPULATION CHECK

The audio tape you listened to depicted a counselor and student client during a/an…..

_____ initial intake interview.

_____ job interview.

During the audio recording, the counselor and client talked about…..

_____________ family activities like hiking, picnicking, and camping.

_____________ family activities that included religious and spiritual activities.
APPENDIX E

CLIENT ATTITUDES TOWARD SPIRITUALITY IN THERAPY

DIRECTIONS: Imagine that you are coming in for counseling today. The following questions ask about your beliefs about how important it is to discuss spiritual and religious concerns in counseling, and also about your preferences for discussing these issues in counseling. Because some people make a distinction between religion and spirituality, separate questions are asked about each of these. For each question, please indicate the response that is closest to your own beliefs or preferences.

<table>
<thead>
<tr>
<th></th>
<th>Not at all Important</th>
<th>Not very Important</th>
<th>Uncertain</th>
<th>Somewhat Important</th>
<th>Extremely Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In general, how important do you believe discussion of \textit{spiritual} issues is to counseling?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. In general, how important do you believe discussion of \textit{religious} issues is to counseling?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. In order to resolve the concerns that bring you into counseling, how important will it be for you to be able to discuss \textit{spiritual} issues with your counselor?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. In order to resolve the concerns that bring you into counseling, how important will it be for you to be able to discuss \textit{religious} issues with your counselor?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
5. How much would you like to discuss *spiritual* issues with your counselor? 

<table>
<thead>
<tr>
<th>Not at all Important</th>
<th>Not very Important</th>
<th>Uncertain</th>
<th>Somewhat Important</th>
<th>Extremely Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</table>

6. How much would you like to discuss *religious* issues with your counselor? 

<table>
<thead>
<tr>
<th>Not at all Important</th>
<th>Not very Important</th>
<th>Uncertain</th>
<th>Somewhat Important</th>
<th>Extremely Important</th>
</tr>
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<td>1</td>
<td>2</td>
<td>3</td>
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</table>

7. To what extent is the most important problem that brings you in today related to *spirituality*? 

<table>
<thead>
<tr>
<th>Not at all Important</th>
<th>Not very Important</th>
<th>Uncertain</th>
<th>Somewhat Important</th>
<th>Extremely Important</th>
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<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
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</tbody>
</table>

8. To what extent is the most important problem that brings you in today related to *religion*? 

<table>
<thead>
<tr>
<th>Not at all Important</th>
<th>Not very Important</th>
<th>Uncertain</th>
<th>Somewhat Important</th>
<th>Extremely Important</th>
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<td>1</td>
<td>2</td>
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<td>5</td>
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</table>

9. How willing do you believe your counselor is to discuss *spiritual* issues with you? 

<table>
<thead>
<tr>
<th>Not at all Important</th>
<th>Not very Important</th>
<th>Uncertain</th>
<th>Somewhat Important</th>
<th>Extremely Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

10. How willing do you believe your counselor is to discuss *religious* issues with you? 

<table>
<thead>
<tr>
<th>Not at all Important</th>
<th>Not very Important</th>
<th>Uncertain</th>
<th>Somewhat Important</th>
<th>Extremely Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

11. In general, how willing do you believe counselors are to discuss *spiritual* issues with you? 

<table>
<thead>
<tr>
<th>Not at all Important</th>
<th>Not very Important</th>
<th>Uncertain</th>
<th>Somewhat Important</th>
<th>Extremely Important</th>
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<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</tbody>
</table>

12. In general, how willing do you believe counselors are to discuss *religious* issues with you? 

<table>
<thead>
<tr>
<th>Not at all Important</th>
<th>Not very Important</th>
<th>Uncertain</th>
<th>Somewhat Important</th>
<th>Extremely Important</th>
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<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</table>

Please comment on why you would or would not like to discuss spiritual or religious issues in counseling.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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APPENDIX F
RELIGIOUS ORIENTATION SCALE

Please indicate your level of agreement on the following scale:

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

_____ 1. Religion offers me comfort when sorrow and misfortune strike. (EP)
_____ 2. I try hard to carry religion over to all other dealings in life. (I)
_____ 3. Church membership helps establish a person in the community. (ES)
_____ 4. The purpose of prayer is to secure a happy and peaceful life. (EP)
_____ 5. What I believe doesn’t matter as long as I lead a normal life. (I)
_____ 6. I’ve often been keenly aware of the presence of a divine being. (I)
_____ 7. My religious beliefs lie behind my whole approach to life. (I)
_____ 8. Prayers said alone are as meaningful as when said during service. (I)
_____ 9. The church is most important as a place to form social relationships. (ES)
_____10. If not prevented by circumstances, I attend church once a week. (I)
_____11. Religion is important for answering questions about life’s meaning. (I)
_____12. Religion is interesting because church is a congenial social activity. (ES)
_____13. I read literature about my faith (or church). (I)
_____14. Private religious thought and meditation is important to me. (I)
_____15. The primary purpose of prayer is to gain relief and protection (EP)
Note: I = intrinsic scale (9 items; #5 reversed scored); ES = social extrinsic scale (3 items); EP = personal extrinsic scale (3 items).
APPENDIX G

AUDIO RECORDING SCRIPT: RELIGIOUS AND SPIRITUAL ITEMS

Researcher: In this study we are interested in learning about students’ perceptions of an initial intake interview for counseling. You are asked to listen carefully to the 8 minute portion of an initial intake interview between a counselor at a university counseling center and a student client. You can also follow along with the dialogue between the counselor and student client on the computer screen in front of you. This audio recording was developed for the sole purpose of this investigation and will not be used for any other purposes. The individuals in this audio recording are playing the part of a counselor and client.

Please pay close attention to what is being said during the intake interview by the counselor and client because you will be asked to respond to questions about your perceptions of the intake interview. As you listen to the audio recording of the intake session, try to imagine that you are the client who has decided to come for counseling and that this is your initial intake interview. The client’s name will be Rachel, and the counselor will be Carol. Carol will be asking Rachel questions about herself so that she can get to know Rachel a little better. Carol believes the information she receives from Rachel will help her understand Rachel’s presenting concern from the context of her life experience. The interview begins after Carol has already received initial intake form materials from the client pertaining to name, date of birth, contact information, presenting concern and insurance information. Carol has reviewed this information and enters the room to begin the intake interview.

C: Carol, the counselor speaking

R: Rachel, the client speaking

C: Hi Rachel, my name is Carol Lombardi. Thanks for coming in today. I read in your initial paperwork that you are here because you are not getting along with one of your housemates here at The University of Akron.

R: Yes, I am not sure how to approach her about what she did to me and how I feel about it. It has gotten so uncomfortable in the house that I avoid participating in house activities. We all do fun things together twice a month and everyone is noticing that I find excuses not to come.
C: I can see how that might be something you would want to talk to someone about. Now, I know you must be anxious to talk about how bad things have gotten, but before I have you do that would it be okay if I asked a few questions to begin with?

R: Sure.

C: After that, we can spend the remainder of our time together today talking about the problem you are having with the housemate. Okay, during this initial counseling session, I want to learn a lot about you, so the questions I will ask you will be about who you are, the family you grew up in, what you like to do in your own time, and other background information that may be relevant over the course of our counseling together. If at any time you do not want to answer a question or don’t know the answer, please feel free to let me know. Now, is it okay with you to continue?

R: Sure.

C: Looking at the forms you filled out when you came in I can see that you are single and that you are in your sophomore year, and working on a degree in teaching.

R: Yes, my parents are both teachers and I have also always wanted to teach.

C: Tell me a little bit about yourself.

R: I am 20 years old. I live in Cincinnati when I am not here at school. I like eating out and hanging out with my friends. Right now I am living in a college rental house just off campus with 5 other girls. It’s noisy, but I am used to that so it hasn’t been too bad.

C: Tell me about growing up in your family.

R: Well, I have my parents and then a brother and a sister. I’m the oldest, then my brother who is 17, and my little sister who is 13. We have had our share of arguments but we are really close. My dad teaches History and my mom teaches English. They are great at what they do and the students really like them. There are a lot of people in my extended family who are also teachers.

C: Tell me about your relationship with your parents.

R: We have a good relationship. I talk to them a couple of times a week. They are the kind of parents who are involved. Well, not so much now because I am on my own away at school, but they are supportive in what I want to do and I really appreciate that.

C: Did you have other family members close by when you were growing up?
R: Yes. My mom’s parents and her family live within a half hour’s drive and so we saw them regularly. My dad’s parents live in the same neighborhood as we did so we saw them at least once a week. Both my parents have large families so we got together a lot and I grew up around a lot of cousins.

C: What about close friends?

R: I have a best friend who I grew up with and a few close friends here at college that I met the first semester I came. They are also majoring in education. We hang out on the weekends and help each other study when there is a test coming up. We’ve become pretty close and I like hanging out with them.

C: Do you participate in any social activities here on campus or locally?

R: Yes, I usually try to go to the basketball and football games. They’re usually pretty good. Sometimes I go to the movies or try a new restaurant that someone recommended. Our house does things like this to help us get to know each other. Oh, and my favorite food is Mexican, so I try to get out to a Mexican restaurant when I can afford it.

C: Mexican food is one of my favorites too. Are you currently working?

R: Yes, part-time at the University Book Store. I work about 15 hours a week for spending money.

C: You told me that you have a big family; what is important to you about being in a big family?

R: I don’t know, I guess I feel loved and supported. We did a lot of activities together when I was growing up. They encouraged me to go to college. My family and my aunts, uncles, cousins, always vacation together and we have always been with each other. It just feels good.

C: It sounds like family is very important to you.

R: Yes, it is. I can’t imagine going through life without a family to rely on.

***Portion of script with “Religious and Spiritual Items” student participants will listen to

C: Did some of the family activities together also include religious or spiritual activities?

R: Yes, I was raised Catholic. A lot of my family went to the same church when I was growing up.
C: Are you involved with a church now?

R: Yes, I go to a Catholic Church in Stow. I don’t go every week, but I go most of the time.

C: Is your faith important to you?

R: I would say it is because it helps me cope with being away from my family. I believe in God and I believe He listens to my prayers.

C: Would you like to talk about those beliefs in counseling if it seems relevant?

R: Yes, I would. Thank you for asking.

C: Okay, well, feel free to talk about your faith at any time during our work together.

***Remainder of script is identical to “No Religious and Spiritual Items” audio recording

C: Well, changing gears a little now, I would like to ask you a few questions about your health. Do you have any current health concerns?

R: No, I am fairly healthy. I get an occasional headache, but nothing serious.

C: That’s good to hear. How about when you were growing up; any major illnesses, accidents, things like that?

R: Oh, I broke my leg in middle school during a soccer game. I missed the rest of the season. I hated missing out on the rest of the season, but I got back in to it the next year and played all throughout high school.

C: Sounds like it was a pretty nasty break. I am glad you were able to play again though. Were you on any medications when you were growing up, or are you on any now?

R: The only time I took medication was when my leg was broken. I am not currently on any medications.

C: Were there any other health concerns when you were growing up?

R: Umm, no I don’t think so, other than an occasional cold or flu bug. I can’t remember anything right now.
C: Okay then, I saw in your paperwork that you had received counseling before. Was it helpful?

R: Yes, when I was 15. A close friend of mine at school died in a car accident and I saw a grief counselor for a few sessions to help me deal with her death. I was very angry about the accident and my parents had me see someone because they thought it would help. The counselor listened to me and didn’t try to tell me what I should be feeling. That helped a lot.

C: It sounds like it was a positive experience.

R: It was.

C: I am glad to hear that.

Researcher: The initial intake interview continued as Carol and Rachel spent a few more minutes talking about other areas of Rachel’s life such as family mental health history, alcohol or drug use, what it is like living with 5 other girls, and expectations about counseling. Then Carol thanked Rachel for answering so many questions and asked Rachel about any questions she might have for her. Rachel did not have any questions, so Carol asked Rachel to tell her about why she came in for counseling. Rachel began telling the counselor about the problem she was having with one of her housemates and they spent the remainder of their hour together talking about the situation.

Recording ends.
APPENDIX H

AUDIO RECORDING SCRIPT: NO RELIGIOUS AND SPIRITUAL ITEMS

Researcher: In this study we are interested in learning about students’ perceptions of an initial intake interview for counseling. You are asked to listen carefully to the 8+ minute portion of an initial intake interview between a counselor at a university counseling center and a student client. You can also follow along with the dialogue between the counselor and student client on the computer screen in front of you. This audio recording was developed for the sole purpose of this investigation and will not be used for any other purposes. The individuals in this audio recording are playing the part of a counselor and client.

Please pay close attention to what is being said during the intake interview by the counselor and client because you will be asked to respond to questions about your perceptions of the intake interview. As you listen to the audio recording of the intake session, try to imagine that you are the client who has decided to come for counseling and that this is your initial intake interview. The client’s name will be Rachel, and the counselor will be Carol. Carol will be asking Rachel questions about herself so that she can get to know Rachel a little better. Carol believes the information she receives from Rachel will help her understand Rachel’s presenting concern from the context of her life experience. The interview begins after Carol has already received initial intake form materials from the client pertaining to name, date of birth, contact information, presenting concern and insurance information. Carol has reviewed this information and enters the room to begin the intake interview.

C: Carol, the counselor speaking
R: Rachel, the client speaking

C: Hi Rachel, my name is Carol Lombardi. Thanks for coming in today. I read in your initial paperwork that you are here because you are not getting along with one of your housemates here at The University of Akron.

R: Yes, I am not sure how to approach her about what she did to me and how I feel about it. It has gotten so uncomfortable in the house that I avoid participating in house activities. We all do fun things together twice a month and everyone is noticing that I find excuses not to come.
C: I can see how that might be something you would want to talk to someone about. Now, I know you must be anxious to talk about how bad things have gotten, but before I have you do that would it be okay if I asked a few questions to begin with?

R: Sure.

C: After that, we can spend the remainder of our time together today talking about the problem you are having with the housemates. Okay, during this initial counseling session, I want to learn a lot about you, so the questions I will ask you will be about who you are, the family you grew up in, what you like to do in your own time, and other background information that may be relevant over the course of our counseling together. If at any time you do not want to answer a question or don’t know the answer, please feel free to let me know. Now, is it okay with you to continue?

R: Sure.

C: Looking at the forms you filled out when you came in I can see that you are single and that you are in your sophomore year, and working on a degree in teaching.

R: Yes, my parents are both teachers and I have also always wanted to teach.

C: Tell me a little bit about yourself.

R: I am 20 years old. I live in Cincinnati when I am not here at school. I like eating out and hanging out with my friends. Right now I am living in a college rental house just off campus with 5 other girls. It’s noisy, but I am used to that so it hasn’t been too bad.

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R: Well, I have my parents and then a brother and a sister. I’m the oldest, then my brother who is 17, and my little sister who is 13. We have had our share of arguments but we are really close. My dad teaches History and my mom teaches English. They are great at what they do and the students really like them. There are a lot of people in my extended family who are also teachers.

C: Tell me about your relationship with your parents.

R: We have a good relationship. I talk to them a couple of times a week. They are the kind of parents who are involved. Well, not so much now because I am on my own away at school, but they are supportive in what I want to do and I really appreciate that.

C: Did you have other family members close by when you were growing up?
R: Yes. My mom’s parents and her family live within a half hour’s drive and so we saw them regularly. My dad’s parents live in the same neighborhood as we did so we saw them at least once a week. Both my parents have large families so we got together a lot and I grew up around a lot of cousins.

C: What about close friends?

R: I have a best friend who I grew up with and a few close friends here at college that I met the first semester I came. They are also majoring in education. We hang out on the weekends and help each other study when there is a test coming up. We’ve become pretty close and I like hanging out with them.

C: Do you participate in any social activities here on campus or locally?

R: Yes, I usually try to go to the basketball and football games. They’re usually pretty good. Sometimes I go to the movies or try a new restaurant that someone recommended. Our house does things like this to help us get to know each other. Oh, and my favorite food is Mexican, so I try to get out to a Mexican restaurant when I can afford it.

C: Mexican food is one of my favorites too. Are you currently working?

R: Yes, part-time at the University Book Store. I work about 15 hours a week for extra spending money.

C: You told me that you have a big family; what is important to you about being in a big family?

R: I don’t know, I guess I feel loved and supported. We did a lot of activities together when I was growing up. They encouraged me to go to college. My family and my aunts, uncles, cousins, always vacation together and we have always been with each other. It just feels good.

C: It sounds like family is very important to you.

R: Yes, it is. I can’t imagine going through life without a family to rely on.

*** Portion of script with “No Religious and Spiritual Items” student participants will listen to

C: What types of family activities did the family do together?

R: Well, we went on picnics; we went hiking and camping together. Things like that.

C: So, do you enjoy being outdoors, going hiking, and camping?
R: Oh yes, some of my friends here at school and I go for hikes on the weekends.

C: Where is your favorite place to hike around here?

R: Oh, I don’t know, probably the Sand Run Trail in Akron. It’s a really nice trail and I use it quite often.

C: It sounds like you find time to do some of the things you like to do away from your classes at the university.

***Remainder of script is identical to “Religious and Spiritual Items” audio recording

C: Well, changing gears a little now, I would like to ask you a few questions about your health. Do you have any current health concerns?

R: No, I’m fairly healthy. I get an occasional headache, but nothing serious.

C: That’s good to hear. How about when you were growing up; any major illnesses, accidents, things like that?

R: Oh, I broke my leg in middle school during a soccer game. I missed the rest of the season. I hated missing out on the rest of the season, but I got back in to it the next year and played all throughout high school.

C: Sounds like it was a pretty nasty break. I am glad you were able to play again though. Were you on any medications when you were growing up, or are you on any now?

R: The only time I took medication was when my leg was broken. I am not currently on any medications.

C: Were there any other health concerns when you were growing up?

R: Umm, no I don’t think so, other than an occasional cold or flu bug. I can’t remember anything right now.

C: Okay then, I saw in your paperwork that you had received counseling before. Was it helpful?

R: Yes, when I was 15. A close friend of mine at school died in a car accident and I saw a grief counselor for a few sessions to help me deal with her death. I was very angry about the accident and my parents had me see someone because they thought it would help. The counselor listened to me and didn’t try to tell me what I should be feeling. That helped a lot.
C: It sounds like it was a positive experience.

R: It was.

C: I am glad to hear that.

**Researcher:** The initial intake interview continued as Carol and Rachel spent a few more minutes talking about other areas of Rachel’s life such as family mental health history, alcohol or drug use, what it is like living with 5 other girls, and expectations about counseling. Then Carol thanked Rachel for answering so many questions and asked Rachel about any questions she might have for her. Rachel did not have any questions, so Carol asked Rachel to tell her about why she came in for counseling. Rachel began telling the counselor about the problem she was having with one of her housemates and they spent the remainder of their hour together talking about the situation.

Recording ends.
APPENDIX I

INFORMED CONSENT FORM

SUBJECT’S NAME: _____________________________ DATE: ________________

PROJECT TITLE: Student Perceptions of Therapist Credibility Based on Attention to Client Religious and Spiritual Functioning at Intake

INVESTIGATOR’S NAME: Brigette M. Shy, M.A.
FACULTY ADVISOR: Charles A. Waehler, PhD.

RESEARCH PURPOSE AND DESCRIPTION OF PROCEDURES:
The purpose of this research is to assess participant reaction to an initial intake interview. Randomly assigned participants (N = 200) will listen to one of two audio recorded initial intake interviews between a college counselor and a student client and will complete questionnaires regarding the intake interview along with a manipulation check. Each participant will then be debriefed about the purpose of the experiment and will be given information about available counseling on The University of Akron campus.

TIME COMMITMENT INVOLVED: 30 - 35 minutes
RISKS AND DISCOMFORTS: None
BENEFITS: Contribute to current research activity in the area of counselor credibility and earn 3 extra credit points.

ALTERNATIVES: Non-participation

COMPENSATION: Each group of 50 participants who complete the study (4 groups for a total N= 200) will be entered in to a drawing for a chance to win a $25.00 gift card. The gift card will be given out after each group of 50 has completed the study.

CONSENT:
I have fully explained to (please print) ______________________________, the subject, the nature and purpose of the above-described procedure and the risks that are involved in its performance. The confidentiality of your participation in this study will be maintained by keeping identifying forms with your signature and name in a locked file cabinet in the researcher’s office (3rd floor Arts & Science Building, Room 381) throughout the duration of this investigation. Upon completion of the current study, all
identifying information will be shredded. I have answered and will answer any other questions regarding this study to the best of my ability.

_________________________________  330.972.7280
Investigator’s Signature              Investigator’s Phone Number

I have been fully informed of the above described procedure with its possible benefits and risks. I also understand that my responses will be maintained in a confidential manner by the researcher. I voluntarily give permission for my participation in this study. I know that the investigator and her associates will be available to answer any questions I may have. If, at any time, I feel my questions have not been adequately answered, I may request to speak with the Faculty Advisor for this investigation: Dr. Charles Waehler @ 330.972.7280, or the Chair of the Department of Psychology (Dr. Levy, 330-972-7280). Additionally, this research has been reviewed and approved by the university Institutional Review Board for the Protection of Human Subjects (IRB). Any questions about my rights as a research subject can be directed to the IRB at 330.972.7666. I understand that I am free to withdraw this consent and discontinue participation in this project at any time without penalty. I will receive a copy of this consent form for my information.

____________________________________
Signature of Subject
APPENDIX J

PARTICIPANT INSTRUCTIONS

In order to ensure anonymity, the only time in which you will be asked to sign your name to any of the materials in this investigation is on the informed consent form. All other documents associated with the current investigation will be anonymously completed. The informed consent form will be kept separate from other materials you respond to in order to maintain this anonymity. Your participation in this experiment is completely voluntary and you may withdraw from participating at any time.

In this study we are interested in learning about students’ perceptions of an initial intake interview for counseling. After completing the consent form, three questionnaires related to this study, and the demographic information form, you will listen to a mock initial intake interview between a counselor at a university counseling center and a student client. The individuals in this audio recording are playing the part of a counselor and client. This audio recording was developed for the sole purpose of this investigation and will not be used for any other purposes. After the 8 minute mock interview, you will be asked to complete two additional brief questionnaires and a manipulation check. You will then be given a debriefing statement with information about available counseling on campus should you desire to see a counselor in the future. Thank you for your participation in this study.
APPENDIX K

RELIGIOUS AFFILIATION/PREFERENCE

Please indicate your religious affiliation/preference below:

_____ Christian (Catholic, Baptist, Lutheran, Protestant, etc…, non-denominational)

_____ Jewish

_____ Buddhist

_____ Hindu

_____ Muslim

_____ Other _______________________________________________

_____ Not Religiously Affiliated
APPENDIX L

DEBRIEFING STATEMENT

Thank you for your participation in this study regarding students’ perceptions of an initial intake interview for counseling. As a reminder, the individuals in this audio recording were playing the part of a counselor and client. The initial intake interview scenario that you listened to was a role play and was not a real intake interview.

Most people benefit from seeking a professional counseling experience when they have a problem. Factors which affect therapy outcome include client motivation and establishing a good working relationship with the person delivering the psychological services (Smith & Glass, 1977; Smith & Glass, 1980; Wampold, 2001).

If the need arises for you or someone you know to seek psychological services, there are three counseling clinics on The University of Akron campus.

The Psychology Department Counseling Clinic is located in the Arts & Science Building, 3rd floor, Rm 342 and can be reached at (330) 972-6714. It is free of charge to students, staff, and community members.

The Counseling Center for registered students only is located in Simmons Hall, Rms 304-306. They can be reached at (330) 972-7082.

The Clinic for Individual and Family Counseling is located in the Chima Family Center, College of Education, 27 South Forge Street, 2nd floor with fees charged on a sliding scale basis for students and community members. They can be reached at (330) 972-6822.

References


APPENDIX M

INSTITUTIONAL REVIEW BOARD APPROVAL

January 19, 2011

Brigette M. Sley
6149 Old Eight Road
Peninsula, Ohio 44264

From: Sharon McWhorter, IRB Administrator

Re: IRB Number 20110101 "Student Perceptions of Therapist Credibility Based on Attention To Client Religious and Spiritual Functioning at Intake"

Thank you for submitting your IRB Application for Review of Research Involving Human Subjects for the referenced project. Your application was approved on January 18, 2011. Your protocol represents minimal risk to subjects and matches the following federal category for exemption:

☐ Exemption 1 - Research conducted in established or commonly accepted educational settings, involving normal educational practices.

☒ Exemption 2 - Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior.

☐ Exemption 3 - Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior not exempt under category 2, but subjects are enrolled or appointed public officials or candidates for public office.

☐ Exemption 4 - Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens.

☐ Exemption 5 - Research and demonstration projects conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine public programs or benefits.

☐ Exemption 6 - Taste and food quality evaluation and consumer acceptance studies.

Annual continuation applications are not required for exempt projects. If you make changes to the study’s design or procedures that increase the risk to subjects or include activities that do not fall within the approved exemption category, please contact me to discuss whether or not a new application must be submitted. Any such changes or modifications must be reviewed and approved by the IRB prior to implementation.

Please retain this letter for your files. This office will hold your exemption application for a period of three years from the approval date. If you wish to continue this protocol beyond this period, you will need to submit another Exemption Request. If the research is being conducted for a master’s thesis or doctoral dissertation, the student must file a copy of this letter with the thesis or dissertation.

☒ Approved consent form/s enclosed

Cc: Charles Waehler - Advisor
Cc: Stephanie Woods - IRB Chair

Office of Research Services and Sponsored Programs
Akron, OH 44325-2102
330-972-7566 • 330-972-6281 Fax

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